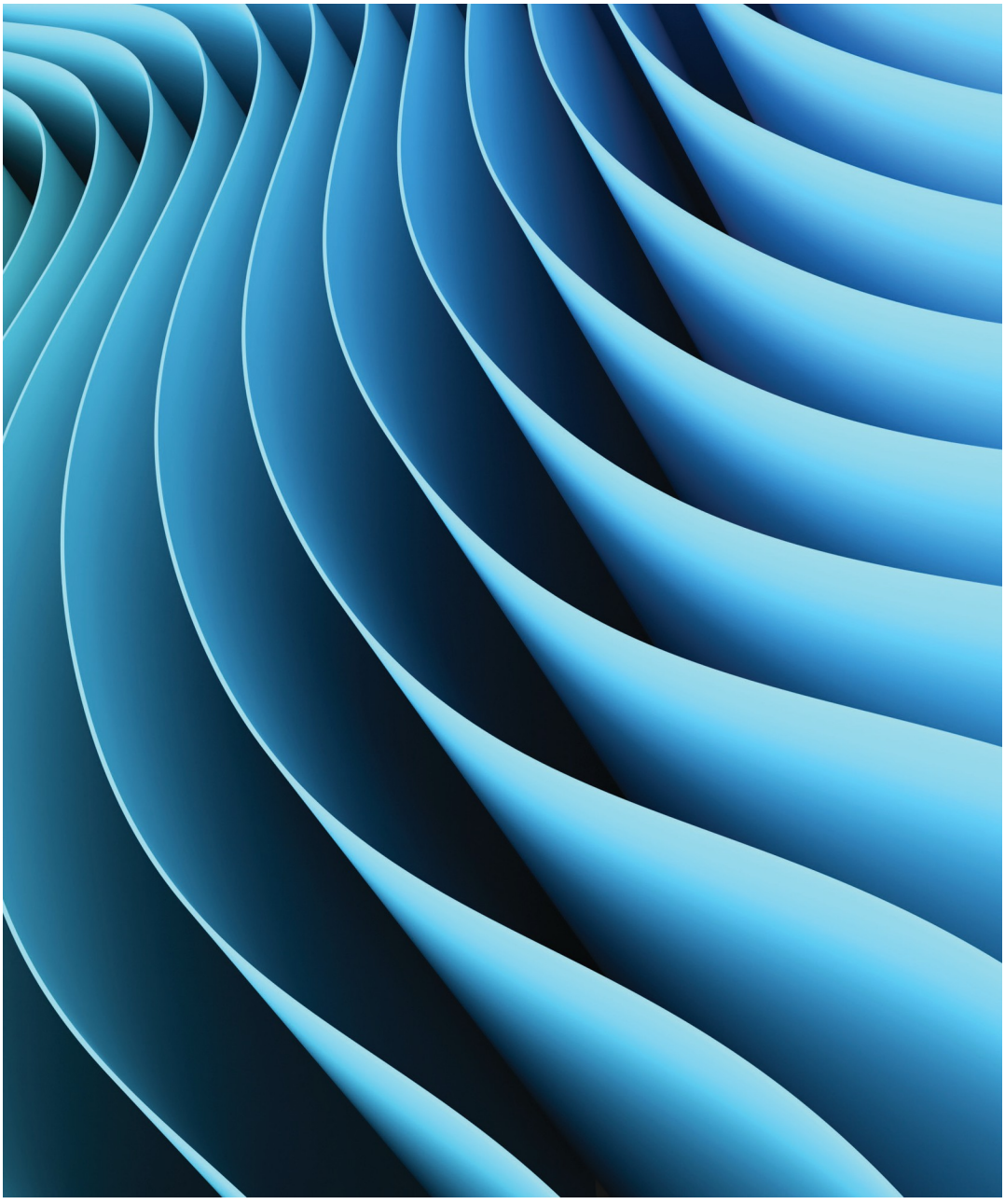
Morgan Stanley

Health Benefits and Insurance



2021 Summary
Plan Description

This Summary Plan Description (SPD) is for current and former employees (and their eligible dependents) of Morgan Stanley Services Group Inc. (the "Company" or "Morgan Stanley") and participating affiliates.

This SPD is in effect January 1, 2021, and is for the Morgan Stanley Health Benefits and Insurance Plan, the Morgan Stanley Medical Plan, the Morgan Stanley Retiree Medical Plan and the Morgan Stanley Employee Assistance Plan. The Morgan Stanley Health Benefits and Insurance Plan consists of the following components:

- Life Insurance
- Disability
- Business Travel Accident
- Accidental Death and Dismemberment
- Flexible Spending Accounts
- Vision
- Dental
- Long-Term Care Insurance
- Legal Assistance
- Accident, Critical Illness and Hospital Indemnity Insurance (not subject to ERISA guidelines)

Each of the components of the Morgan Stanley Health Benefits and Insurance Plan, the Medical Plan, the Retiree Medical Plan and the Employee Assistance Plan are referred to in this SPD as a "Plan" and collectively as the "Plans." Certain other programs that are available to employees are also described in this booklet.

The portions of this SPD that pertain to each Plan, along with any underlying insurance contracts relating to that Plan, together comprise that Plan's official documents. If there is any conflict between the terms of a Plan document and any other materials, including any verbal representation, the Plan document governs. Benefits under the Plans that are insured are payable under the Plans only to the extent payable under the relevant insurance contracts. If there is any discrepancy between the terms of the insurance contracts and any other Plan documents, the insurance contracts govern. Morgan Stanley and its benefit Plans are not responsible for any data errors or processing delays. The Plan Administrator may correct any errors at any time. If you notice an error, you must contact HR Services immediately. If you do not contact HR Services immediately to correct any errors, you may not do so at a later date, and you may be entitled only to those benefits shown on the confirmation statement and/or at the website. Check your confirmations and statements to ensure that your elections are correctly reflected.

The information contained in this document is general in nature, is not individual tax advice, and may not be used to avoid any tax or tax penalty. Tax laws are complex and may change, and their application may vary based on the circumstances. Morgan Stanley and its benefit Plans do not provide tax or legal advice. Morgan Stanley also cannot advise you on your rights, options or responsibilities under Medicare, Medicaid, any non-Firm benefit program in which you may participate, or any state or federally provided benefits. You are responsible for consulting your own advisors.

The plan administrator may require you to periodically verify your and your dependents' data. Providing false or misleading information may lead to legal or disciplinary action by Morgan Stanley, including employment termination and cancellation of executive compensation. This SPD does not guarantee coverage; the administrators of each Plan have ultimate authority for determining eligibility.

Morgan Stanley's benefit Plans may be amended or discontinued at any time, including to curtail benefits for some or all covered individuals, to change the cost of coverage and to implement changes required by federal, state and local legislation.

Certain other benefit plans and programs offered by Morgan Stanley are described in separate summary description documents. For more information, call HR Services or log in to the Benefit Center website.

Table of Contents

Introduction

At Morgan Stanley, benefits are an important part of your total compensation. This SPD was created to provide you with details about the programs available to you and your eligible dependents as an employee of Morgan Stanley.

Morgan Stanley Benefits

Morgan Stanley's U.S. benefits comprise the following Plans:

- Medical Plans (your home zip code will determine which regional options may be available to you):
  - Option A through UnitedHealthcare (UHC) or Cigna
  - Option B through UHC or Cigna
  - Option C through UHC or Cigna
  - HMSA Medical Plan—Hawaii
  - Kaiser Permanente Health Maintenance Organization (HMO)—Hawaii, Northern and Southern California (in-network coverage only)
  - Cigna Global Health Medical Plan—international locations
- Retiree Medical Plan
- Employee Assistance Plan (Lyra Mental Health Benefit)
- Dental Plans:
  - MetLife Dental Option A
  - MetLife Dental Option B
  - Delta Dental Plan
  - Cigna Global Health Dental Plan—international locations
- Vision Plans:
  - Vision Service Plan (VSP) Option A
  - Vision Service Plan (VSP) Option B
- Flexible Spending Accounts (FSA):
  - Health Care Flexible Spending Account
  - Dependent Day Care Flexible Spending Account
  - Limited Purpose Flexible Spending Account
- Health Savings Account (HSA)
- Life Insurance Plan, Accidental Death and Dismemberment Insurance Plan, and Business Travel Accident Plan (collectively, the "Life and Accident Insurance Plans"):
  - Basic Life
  - Employee Supplemental Life
  - Group Variable Universal Life (GVUL)
  - Spouse/Domestic Partner Life
  - Child Life
  - Basic Accidental Death & Dismemberment
  - Supplemental Accidental Death & Dismemberment
  - Business Travel Accident
- Disability Plans:
  - Short-Term Disability
  - Long-Term Disability
  - Individual Disability Policy
  - Corporate Excess Disability Insurance (CEDi) Policy
- Legal Assistance Plan
- Long-Term Care Insurance Plans:
  - Prudential LTC Program (no new entrants)
  - MetLife LTC Program (no new entrants)
  - John Hancock LTC Program (no new entrants)
  - Individual LTC Program (MassMutual)
- Critical Illness Insurance
- Accident Insurance
- Hospital Indemnity Insurance

Coronavirus-Related Coverage Changes

In response to the novel coronavirus (COVID-19) pandemic and related relief legislation, Morgan Stanley has enhanced some benefit offerings, including extending the time to take certain actions, expanding telehealth programs, and enhancing coverage for COVID testing and treatment. Given the evolving nature of the pandemic and related legislation, the benefits enhancements may be temporary, and are subject to change at any time and without notice or your consent. To find the most up to date COVID-19 related coverage information, please visit

https://mybenefits.morganstanley.com/keyword/covid-19-resources/ or contact HR Services.

2nd.MD Second Opinion Services

2nd.MD gives you quick access to the world's top doctors for virtual second opinions. Speak with a 2nd.MD specialist if you or a family member receives a serious diagnosis or recommendation for surgery, needs help understanding a treatment plan or wants new insight into how to better manage a chronic condition. The Firm makes this service available at no cost to you.

2nd.MD is available to all eligible employees, their dependents and certain extended family members, and does not depend on whether you are enrolled in other benefits described in this SPD.

Effective January 1, 2021, employees (and their dependents and certain extended family members) employed by a legacy E*TRADE entity, as determined by the Plan Administrator in their sole discretion are eligible for the benefits available under the 2nd.MD Program.

Benefits Advocates

Benefits Advocates can help you understand and use the Firm's benefits programs to meet all your health and wellness needs—from enrolling in coverage when first eligible or during Annual Enrollment, to finding high-quality doctors, to navigating the complexities of health care. Advocates will also connect you with the Firm's full range of employee offers and perks.

The Benefits Advocates Program is not affiliated with any benefit plan or provider, and its services are confidential. This service is available to eligible employees, retirees and COBRA participants, as well as their spouse/domestic partner, dependent children, parents and parents-in-law, and does not depend on whether you are enrolled in other benefits described in this SPD.

You may contact a Benefits Advocate from Monday through Friday, 8 a.m. to 7 p.m. ET, at 800-555-7187—or if you are an employee, you may type "benefitsadvocates" in the Morgan Stanley intranet browser.

HR Services

Throughout this SPD, there are references to HR Services and the Benefit Center.

HR Services is a full-service resource available to you as an employee of Morgan Stanley, and should be your first point of contact if you have any questions about the Plans. Representatives are available to assist you Monday through Friday, from 9 a.m. to 7 p.m. ET, and can be reached toll-free at 877-MSHR-411 (877-674-7411).

Whenever you use the Benefit Center website to initiate a transaction online or speak with an HR Services Representative, you are authorizing the plan administrator to process your elections as if you had given your written, signed authorization to do so. Morgan Stanley and the Plans are not responsible for any delay in processing transactions due to system unavailability, incomplete information, administrative delay or any other reason that may impact the processing of your transactions.

Telemedicine

If you or your dependents are enrolled in the Medical Plan through Cigna, UHC or Kaiser, and you need medical assistance and your regular physician is not available or you are unable to make it to the doctor's office, you may videoconference or speak with a U.S. board-certified doctor, day or night, about common conditions like bronchitis, allergies, rashes, ear infections, pink eye and urinary tract infections. Telemedicine physicians can even write a prescription, when appropriate, and send it to the pharmacy of your choice. The cost of a consultation varies based on your Medical Plan provider. Telemedicine appointments are covered at 80% after meeting your annual deductible for the Cigna and UHC Plans. There is no cost for telemedicine visits under the Kaiser Plan.

To register or consult with a doctor, visit www.myuhc.com (refer to "Virtual Visits") or www.mycigna.com (refer to "Telehealth Connection"). Kaiser members can call the number on the back of their Medical Plan ID cards.

Telemedicine is only available to employees and dependents enrolled in the Medical Plan through Cigna, UHC or Kaiser.

Telemedicine is not available in locations where prohibited by law and may only provide services in certain locations within the U.S.

Coronavirus Update

Due to recent coronavirus-related relief legislation, the cost of most telemedicine visits have been waived to encourage you to seek care virtually, per current COVID-19 social-distancing guidelines. Please note that given the evolving nature of the coronavirus pandemic and related legislation, these benefits enhancements are subject to change at any time and without notice or your consent. To find the most up-to-date COVID-19 related coverage information, please refer to https://mybenefits.morganstanley.com/keyword/covid-19-resources/ or contact HR Services.

Eligibility

Eligible Employee

Except as otherwise provided herein, you may elect to participate in the Plans if you are actively employed and a U.S. benefits-eligible employee of Morgan Stanley, which is defined as either:

- A full-time salaried employee;
- Effective January 1, 2020, hourly employees scheduled to work 50% of the standard workweek or a minimum of 20 hours per week;
- A part-time salaried employee regularly scheduled to work at least 50 percent of the full-time workweek;
- A former retiree (at least age 55 with a minimum of five years of service at termination) who has been rehired as a salaried employee and regularly scheduled to work at least 25 percent of the full-time workweek (see the “Continuation of Coverage During Work or Life Events” section on page 24 for more information);
- An hourly employee who was first hired as an hourly employee before July 1, 2004, and has continuously participated in the Medical Plan since July 1, 2004 (Medical Plan only);
- An hourly employee who transferred directly from Citigroup in connection with the creation of Morgan Stanley Smith Barney in 2009 (or was a Delayed Transfer individual) but only if they were eligible to participate in the Citigroup health and insurance plans immediately before the transfer date (continuous participation required); or
- An hourly employee working in Hawaii (Medical Plan only).

You must also either:

- Live in the U.S.,
- Be a U.S. expatriate or U.S. benefits-eligible international employee,
- Be an international employee who is eligible for U.S. benefits based on work location, or
- Be an inpatriate employee designated as “benefits eligible” by the Firm.

Please be advised that each plan administrator has sole discretion in determining whether an employee is a U.S. benefits-eligible employee for that Plan.

The Employee Assistance Plan is available to all U.S. employees of Morgan Stanley without regard to whether the employee is classified as “U.S. benefits eligible” but is subject to the exclusions listed in the section titled “Indiviuals Who Are Not Eligible.”

Individuals Who Are Not Eligible

You are not a benefits-eligible employee if you are classified by Morgan Stanley as a non-benefits-eligible worker, an intern, summer associate, contingent worker, leased worker, independent contractor or consultant, regardless of whether such classification is subsequently upheld for any purpose by a court or federal, state or local administrative authority.

Additionally, you will not be a benefits-eligible employee if:

- You are covered by a collective bargaining agreement to which Morgan Stanley or an affiliate is a party, unless such agreement provides for participation in the Plans;
- You were hired as part of an acquisition on or after January 1, 2006, unless the plan administrator provides for your participation in the Plans; and
- Certain transferees from Citigroup to Morgan Stanley Smith Barney who were not benefits eligible upon transfer.

Please Note: The STD benefits described in this SPD do not apply to Saxon employees of the Morgan Stanley U.S. Residential Mortgage Business. For more information about the STD policy, Saxon employees should consult the Benefit Center website.

E*TRADE Employees: Unless otherwise stated in the applicable sections, employees that are employed by a legacy E*TRADE entity, as determined by the Plan Administrator in his/her sole discretion, are not benefits-eligible, and the benefits described in this SPD do not apply to such employees.

If you have questions about whether you are eligible for a particular Plan, please contact HR Services at 877-MSHR-411 (877-674-7411).

Dependent Eligibility

Your eligible dependents include:

- Your spouse or domestic partner (see the "Domestic Partner Eligibility" section on page 9 for important information about domestic partner benefits);
- Your or your spouse's/domestic partner's dependent children through the end of the month in which they turn age 26. Dependent children up to age 26 are eligible for coverage even if they no longer live with you, are not dependents on your tax return and are no longer students; and
- Your or your spouse's/domestic partner's fully handicapped children, to the extent provided below

An eligible spouse includes your opposite-sex or same-sex spouse, provided you are not legally separated.

An eligible dependent child includes:

- Your biological children,
- Your stepchildren,
- Your legally adopted children,
- Your foster children and any children placed with you for adoption, and
- Any children for whom you are the legal guardian, have legal custody, may claim a tax exemption as a noncustodial parent or have an obligation to cover under a Qualified Medical Child Support Order.

If you divorce, your dependent children may be eligible for dependent coverage if they receive over one-half of their support from you during the year. Additionally, your former spouse/domestic partner must sign a written declaration that he/she will not claim the child as a dependent.

Children born to your dependent children are not your eligible dependents unless you have legal custody or may claim a tax exemption for them as a noncustodial parent. Additionally, your and your spouse's/domestic partner's parents and grandparents are not eligible dependents.

Please be advised that these dependent eligibility rules are not a guarantee of coverage. Each plan administrator has sole discretion in determining eligibility based on the Plan's coverage rules. Each plan administrator also reserves the right to request proof of dependent status.

Certain eligibility requirements differ for specific Plans, as noted in the appropriate section of this SPD.

Definition of "Fully Handicapped"

To be eligible for coverage as a fully handicapped child beyond a Plan's otherwise applicable maximum age, you must submit proof that your child is fully handicapped to each plan administrator within 31 days after your child loses Plan coverage due to reaching the Plan's maximum age of 26. Your child is considered fully handicapped if:

- They are not able to earn their own living because of a mental or physical handicap that started while a covered dependent under the Plan and prior to the date they lost Plan coverage due to reaching the maximum age for eligibility as a dependent (age 26), and
- They depend chiefly on you or another care provider for support. "Another care provider" means the child requires a community-integrated living arrangement, group home, supervised apartment, or other residential services licensed or certified by a state department of health.

Coverage will cease at the earliest of:

- Cessation of the handicap or dependency,
- 60 days after proof of the continuation of the handicap or dependency has been requested but not provided, or
- Termination of dependent coverage for any reason other than reaching maximum age.

Each Plan has the right to require proof of the continuation of the handicap, including the right to examine your child (at the Plan's own expense and the discretion of the plan administrator) from time to time, while the handicap continues. The plan administrators have sole discretion for determining whether your child qualifies as a fully handicapped dependent. Coverage under one Plan does not guarantee coverage under other Plans.

Please note: If your child has not been continuously covered under the Morgan Stanley Plans as a fully handicapped child since the Plan's maximum age, this coverage is unavailable to you and your child. If you first become eligible for a Plan after your child has reached the Plan's maximum age, your child is ineligible, even if covered by a prior employer's plan.

Qualified Medical Child Support Orders

A Qualified Medical Child Support Order (QMCSO) is a judgment, decree or court order that:

- Requires child support or health care benefits coverage (medical, dental and vision) for the child of an eligible participant in a group health plan and
- Enforces a law concerning medical child support under a group health plan (medical, dental and vision) as provided by state Medicaid laws.

A QMCSO can apply only to an employee's children. A QMCSO may not provide for coverage of current or former spouses or domestic partners, or the dependents of domestic partners. The plan administrator determines whether an order meets the requirements of a QMCSO based on the Plan's QMCSO procedures.

A QMCSO can require health coverage (medical, dental and vision) even if the eligible employee does not have legal custody of the child. A child who receives benefits under a QMCSO is known as an "alternate recipient." Children eligible for benefits under a QMCSO include any children who would be eligible dependents under the terms of the group health plan if the employee had legal custody.

Morgan Stanley's QMCSO procedures and a sample QMCSO are available on the Benefit Center website. You may request free paper copies from HR Services.

If a Plan receives a valid QMCSO, the employee and all relevant parties will be notified by the plan administrator. An employee who is responsible for providing benefits to a child under the terms of a QMCSO may change his/her coverage election as necessary to comply (see the "Qualified Life Events" on page 18).

Domestic Partner Eligibility

Morgan Stanley extends benefits under the Plans[1] to eligible employees' unmarried domestic partners of the same or opposite sex. To be eligible for coverage, your domestic partnership must meet one of the following criteria:

- You and your partner have entered into a lawful civil union or similar relationship that is permitted by state or foreign law.
- You and your partner are registered as domestic partners through a governmental domestic partnership registry.
- You and your partner are registered as domestic partners through HR Services.

For your domestic partner to be registered through HR Services, your relationship must meet all of the following criteria:

- You are both at least 18 years of age and mentally competent.
- You share a close and committed personal relationship.
- You are not married to, in a civil union or similar relationship with, or a domestic partner of anyone else.
- You are not related by blood closer than permitted for marriage under the law of your state.

[1] Except the Health Care, Dependent Day Care, and Limited Purpose FSAs and the Health Savings Account, as required by the Internal Revenue Code.

- You share a primary residence.
- You are not married to each other.

If you divorce and enter into a domestic partner relationship with your prior spouse, a six-month waiting period applies before you may register your former spouse as a domestic partner.

Additionally, you must request and complete a Domestic Partnership Affidavit from HR Services and return it to register your domestic partnership.

If your domestic partner and his/her eligible dependents qualify as your dependents under federal tax law, you may pay for their coverage under the Medical, Dental and Vision Plans with before-tax dollars. See IRS Publication 502 for the applicable rules. If they qualify as your eligible dependents, you may indicate so on the Benefit Center website during enrollment by selecting the appropriate box on the enrollment page.[1]

You cannot claim a person as a dependent under federal tax law:

- If you could be claimed as a dependent by another taxpayer;
- Unless that person is a U.S. citizen, U.S. resident alien, U.S. national, or a resident of Canada or Mexico for some part of the year; and
- Unless that person is your qualifying child or qualifying relative.

To be a qualifying child:

- The child must be your son, daughter, adopted child, stepchild, foster child, brother, sister, half-brother, half-sister, stepbrother, stepsister or a descendant of any of them.
- The child must be (a) under age 19 at the end of the year and younger than you or your spouse, (b) under age 24 at the end of the year and a full-time student as well as younger than you or your spouse, or (c) any age if permanently and totally disabled.
- The child must have lived with you for more than half of the year.
- The child must not have provided more than half of his or her own support for the year.
- If the child meets the rules to be a qualifying child for more than one person, you must be the person entitled to claim the child as a qualifying child.

To be a qualifying relative:

- The person cannot be your qualifying child or the qualifying child of anyone else.
- The person must be (a) your child, stepchild, foster child or descendant of any of them, (b) your brother, sister, half-brother, half-sister, stepbrother or stepsister, (c) your father, mother, grandparent or other direct ancestor (not a foster parent), (d) your stepfather or stepmother, (e) a son or daughter of your brother or sister, (f) a son or daughter of your half-brother or half-sister, (g) a brother or sister of your mother or father, (h) your son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law, or (i) must live with you as a member of your household and your relationship does not violate local law. Any of these relationships that are created by marriage and have not ended by death or divorce.
- The person's gross income for the year must be less than $4,300 (2021).
- You must provide more than half of the person's total support for the year.

If your domestic partner and his/her eligible dependents are not your dependents under federal tax law, the full cost of their medical coverage will be added to your taxable income and reported on your Form W-2 as imputed income.

If your domestic partnership status changes (for example, you marry or terminate your civil union or partnership), you must contact HR Services within 31 days to make the appropriate changes and elections. Notifying HR Services in a timely manner will ensure your proper tax status and withholdings are reported to Payroll.

If your domestic partner (and his/her eligible dependents) becomes your same-sex spouse or dependent under state tax law, please contact Payroll, as your tax withholding may be impacted.

[1] The final determination of the tax status of a dependent is made by the IRS. Checking the box on the enrollment page is no guarantee that the IRS will not impose a tax or penalties on the cost of coverage.

Important Dependent Eligibility Information

You cannot be covered under the Plans as both an employee and a dependent. Additionally, an individual cannot be covered as a dependent of more than one employee (for example, if both parents are eligible employees, both parents cannot cover the same child). If you are married to another eligible employee, you may both elect individual coverage, or one of you may elect "Yourself + Spouse or Domestic Partner" or "Family" coverage (see the "Coverage Levels" section on the next page). If you choose "Yourself + Spouse or Domestic Partner" or "Family" coverage, your spouse/domestic partner must decline coverage as an employee.

Dependent Verification and Audit

When enrolling dependents for coverage, you must verify that they meet the requirements for dependent coverage. Morgan Stanley and the plan administrators have the right to audit elections and representations made by employees and dependents. Any misrepresentation may result in legal or disciplinary action, including termination of employment and forfeiture of executive compensation. Additionally, Morgan Stanley has the right to recover the amount of any benefits paid to or on behalf of an ineligible person.

Changes to Dependent Status and Coverage

If your dependent becomes ineligible for coverage due to divorce, marriage or any other reason, you must notify HR Services within 31 days of the event. Additionally, if your dependent is eligible for COBRA continuation coverage (see the "Continuation Coverage Rights Under COBRA" section on page 184 for more information), you must notify HR Services within 60 days of the date of the qualifying event. Regardless of when you notify HR Services, your dependent's coverage will end retroactive to the last day of the month in which they no longer meet the dependent eligibility requirements, and you will be responsible for any benefits paid after eligibility ends.

Coronavirus Update

The time frames mentioned above may be extended due to recent coronavirus-related relief legislation to a date that is 60 days after the announced end of the national emergency (date unknown as of January 1 2021), or later as may be determined by the appropriate federal agencies. Given the evolving nature of the pandemic and related legislation, these extensions may change without notice or your consent. For up-to-date information regarding enrollment periods, contact HR Services.

Participating in the Plans

Coverage Levels

Morgan Stanley offers the following coverage categories:

- **No Coverage**: You are waiving coverage for yourself and all eligible dependents.
- **Yourself Only**: Coverage for you only.
- **Yourself Plus Spouse/Domestic Partner**: Coverage for you and your spouse/domestic partner only.
- **Yourself Plus Children**: Coverage for you and your children only.
- **Yourself Plus Family**: Coverage for you, your spouse/domestic partner and children.

You may enroll your dependents only in the Plans in which you also choose to participate, unless otherwise noted.

You may elect "coverage" or "no coverage" for the Legal Plan and "no coverage" for the automatically enrolled LTD portion of the Disability Plan, and the amount of coverage (based on eligibility) desired for Employee Supplemental Life Insurance, Supplemental AD&D Insurance, Spouse/Domestic Partner Life and Child Life. If you elect "coverage" under the Legal Plan, all eligible family members (spouse/domestic partner, eligible dependents and extended family members, as applicable) will have access to the Legal Plan.

Cost of Coverage

Listed below is an overview of how costs are calculated.

Paying for Benefits on a Before-Tax and After-Tax Basis

Costs for any optional benefits programs in which you enroll will be deducted from your pay on either a before-tax or after-tax basis. Different rules apply to domestic partner coverage.

If you are paid from a U.S.-dollar-based Payroll, your Medical, Dental and Vision Plan, FSA, and HSA contributions made through Payroll are generally before-tax Payroll deductions. This means that your share of the costs of these benefit programs is deducted from your pay before federal and, in most cases, state and local income taxes are withheld. Your premiums for Long-Term Disability, Legal Plan, Long-Term Care Insurance, Accident, Critical Illness and Hospital Indemnity Insurance Plans, and Life and Accidental Death and Dismemberment insurance benefits are generally after-tax Payroll deductions; as a result, benefits paid from these Plans are generally not subject to federal income tax. Employees on a non-U.S.-dollar-based Payroll typically pay for all coverage through after-tax Payroll deductions.

Premiums are also deducted on an after-tax basis for your domestic partner and his/her dependent children if they do not qualify as your dependents under federal tax law. By law, the full value of their coverage is added to your taxable income and reported on your Form W-2 as imputed income.

For more information, please see the “Domestic Partner Eligibility” section on page 9.

Medical, Dental and Vision

Morgan Stanley generally shares the cost of medical and dental coverage. You pay the full cost of vision coverage.

For medical coverage, your share of the cost is determined by the coverage level you elect and your Benefits-Eligible Earnings (as defined in the “Benefits Eligible Earnings” section on page 13). The cost for dental and vision coverage is based only on the coverage level you elect.

Employee Assistance Plan

Morgan Stanley pays the full cost of coverage under the Employee Assistance Plan for active employees and their eligible dependents.

Life and Accident Insurance

Morgan Stanley pays the full cost of:

- Basic Life Insurance,
- Basic Accidental Death and Dismemberment (AD&D) Insurance, and
- Business Travel Accident Insurance (BTA).

You pay the full cost of:

- Employee Supplemental Life Insurance
  - Your cost is based upon your attained age at the beginning of the calendar year and the amount of coverage selected.
- Spouse/Domestic Partner and Child Life Insurance
  - Your cost for Spouse/Domestic Partner and Child Life Insurance is based upon your attained age at the beginning of the calendar year and the amount of coverage selected.
  - The cost of Child Life Insurance does not depend on the number of children that you cover or your age.
- Supplemental AD&D Insurance coverage for yourself and your eligible dependents
  - Your cost is based on the type and amount of coverage you elect (your “Principal Sum”).
  - The cost of coverage does not depend on your age or the number of children that you cover.

Supplemental Life and Accident Insurance programs are after-tax Payroll deductions.

Disability

- Short-Term Disability
  - Morgan Stanley pays the full cost of Short-Term Disability (STD) coverage. However, if you live or work in California, Hawaii, New Jersey, Rhode Island or Puerto Rico, you will incur a Payroll deduction for a state-mandated STD program.
- Long-Term Disability
  - You pay the full cost of Long-Term Disability (LTD) coverage with after-tax Payroll deductions. If you claim LTD benefits, they are

generally free from federal income tax. See the section on page 13 for information about how Benefits Eligible Earnings are used to determine the cost of LTD and the benefit amount.

- Individual Disability Insurance
  - You pay the full cost of Individual Disability Insurance coverage and will be billed directly by the plan administrator.
- Corporate Excess Disability Insurance (CEDi)
  - You pay the full cost of CEDi coverage and will pay through after-tax Payroll deductions. The cost of this coverage is determined by and available from the administrator.

Legal Assistance

You pay the full cost of Legal Assistance coverage through after-tax Payroll deductions.

Long-Term Care

You pay the full cost of Long-Term Care (LTC) coverage through either after-tax Payroll deductions or direct billing with after-tax dollars.[1] Premiums are based on the coverage option you select, including your Daily Benefit Amount and your age on the date your coverage first becomes effective. Individuals who have coverage but are not receiving a paycheck from Morgan Stanley are billed directly by the plan administrator. The cost of LTC coverage is determined by and available from the applicable LTC plan administrator.

Accident, Critical Illness and Hospital Indemnity Insurance

You pay the full cost of coverage and we will pay Aflac through after-tax Payroll deductions. The cost of this coverage is determined by and available from Aflac.

Please Note: If you take an unpaid leave of absence, you must pay for all health and insurance benefits coverage on an after-tax basis and be billed directly from HR Services. If you are enrolled in supplemental insurance, you will be billed directly by your provider.

For information about your personal benefit costs, please visit the Benefit Center website.

Benefits Eligible Earnings

Benefits Eligible Earnings (BEEs) are calculated at your hire date and again each fall prior to the annual enrollment process ("Annual Enrollment") for use in the upcoming calendar year. For example, if BEEs are calculated for 2021 Annual Enrollment, prior year's Eligible Pay is determined with reference to 2019 Eligible Pay. Benefits Eligible Earnings for a year are not necessarily the same as your W-2 pay. Benefits Eligible Earnings are used to determine:

- Your Medical Plan contributions,
- The amount of LTD and BTA coverage available to you,
- The cost of your LTD coverage,
- The amount of Supplemental Life Insurance and Supplemental AD&D Insurance coverage available to you, and
- Your eligibility for an individual disability policy. (To determine if you are eligible, please see the "Individual Disability Policy" section on page 142.)

Your Benefits Eligible Earnings are generally the higher of your:

- Annualized base pay upon hire or prior to Annual Enrollment, or
- Prior calendar year's Eligible Pay (at the time of hire (for new hires) or prior to Annual Enrollment, which is your actual full calendar year earnings, including deferred compensation in the year paid, less certain other amounts. This is generally similar, but not identical, to your prior year's Form W-2 earnings.

If you are a new hire who is not a Financial Advisor, you may submit your prior year's Form W-2 earnings to your HR Representative within 31 days of your hire date.[2] Newly hired Financial Advisors are required to submit their prior year's Form W-2. If you submit your Form W-2 within 31 days, your Benefits Eligible Earnings and Payroll deduction amounts may change. If you do not

[1] Certain enrollees in Long-Term Care Insurance whose coverage transferred from MetLife to Prudential pay for coverage through direct billing or direct debit and not through Payroll deductions. All MassMutual LTC policies have been designed to be paid for via direct billing.

[2] If you submit a prior year's Form W-2 in your year of hire, the earnings reported may also be used in determining your Benefits Eligible Earnings for subsequent years if you do not have a full year of Eligible Pay on file and the prior year's Form W-2 is greater than both your Eligible Pay and your annualized base pay.

submit a prior year's Form W-2 and you do not have an annualized base pay rate on file, your Benefits Eligible Earnings are calculated based on a default amount. However, if your Form W-2 from the prior calendar year is not yet available, you may submit your last pay stub of the year from your former employer that shows your annualized earnings.

If you rejoin the Firm within 31 days of your termination of employment, your Benefits Eligible Earnings will be the same as prior to your termination.

If you have any questions about Benefits Eligible Earnings, please contact HR Services.

If your Benefits Eligible Earnings are at least two pay bands higher than your actual Form W-2 earnings from all sources (determined by Morgan Stanley), you may be eligible for a hardship adjustment to your Benefits Eligible Earnings. You must contact HR Services and submit appropriate documentation no later than March 15 of the year for which you are requesting an adjustment.

Hardship adjustments are granted at the discretion of the plan administrator and do not carry over from year to year. No adjustments will be made unless you submit your request by March 15 and all of the requirements for an adjustment are met.

Eligible Pay

For the purposes of calculating your Benefits Eligible Earnings, Eligible Pay is your annual (full-year) gross salary from Morgan Stanley reflected on your Form W-2, less any amounts not related to performance (such as taxable relocation expenses). Eligible Pay is limited to a maximum of $500,001.

Eligible Pay includes, but is not limited to:

- Base pay,
- Most bonus payments,
- Incentive and deferred compensation (when paid),
- Commissions,
- Cash performance awards (when paid),
- Overtime,
- Premium pay,
- Night premiums,
- Retroactive pay,
- Shift differential,
- Vacation pay,
- Allowances, and
- Amounts deferred under the Flexible Spending Accounts, Health Savings Account, Commuter Benefits Program and 401(k) Plan.

Eligible Pay does **not** include:

- Referral fees;
- Relocation expenses and allowances;
- Amounts paid prior to your start date (except prior employer W-2 pay (see the discussion in "Benefits Eligible Earnings" section on page 13);
- Employee expense reimbursements;
- Imputed income;
- Certain bonuses to satisfy a loan;
- Benefits paid under any Plan or Payroll; practice due to retirement, disability or death of an employee, or his or her dependents;
- Retention awards; and
- Similar types of pay, as determined by the plan administrator.

Benefits Enrollment

You may elect coverage under the Plans within 31 days of the date of your health benefits eligibility, which is generally your hire date. Elections made during this 31-day window are retroactive to your first day of employment or benefits eligibility, whichever is later.

You may also make certain benefit elections up to 90 days after your health benefits and insurance eligibility. However, if you make elections more than 31 days after benefits eligibility, coverage will be prospective only from the date of your election, and you will need to provide Evidence of Insurability (EOI) under some Plans. Additionally, if you do not enroll in certain benefit programs within 31 days of your initial eligibility date but elect at a later date, such as during Annual Enrollment, you may be required to provide EOI. **You must enroll new dependents in a timely manner in order for them to be covered.**

If you wish to participate in a Flexible Spending Account (FSA) or a Health Savings Account (HSA) for the current year, you must enroll prior to

November 1. If your hire or benefits eligibility date is on or after November 1, you will be unable to contribute to an FSA or HSA until the start of the new calendar year.

You will receive coverage under the Employee Assistance Plan (at no cost to you) without regard to any other benefits elections you may make (including default coverage for benefits-eligible employees who make no elections).

Unless you make elections or waive coverage through the Benefit Center website or HR Services during your enrollment period, you will be automatically enrolled in the following benefits:

- Medical Plan:
  - Option B through either Cigna or UHC based upon your home state of residence, at the "Yourself Only" coverage level
  - HMSA, if located in Hawaii, at the "Yourself Only" coverage level
  - Cigna Global Health Medical Plan, if an expatriate or a U.S. benefits-eligible international employee, at the "Yourself Only" coverage level
- STD coverage (no cost to you)
- LTD coverage
- $50,000 Basic Life Insurance (no cost to you)
- $50,000 Basic AD&D Insurance (no cost to you)
- BTA Insurance (no cost to you)

You will receive **no coverage** in the following benefits:

- Dental
- Vision
- Flexible Spending Accounts (FSA)
- Health Savings Account (HSA)
- Supplemental Life
- Supplemental AD&D
- Individual Disability Insurance
- CEDi
- Legal Assistance
- Long-Term Care (LTC)
- Commuter Benefits Program (CBP)
- Critical Illness Insurance
- Accident Insurance
- Hospital Indemnity Insurance

If you do not elect or waive coverage during Annual Enrollment and you were enrolled in Morgan Stanley benefits during the prior year, your default coverage, in addition to LTD, will be your prior year's coverage, with the exception of FSA and HSA. You must make an active election each year if you want to fund an HSA. You will be automatically reenrolled in LTD coverage unless you decline coverage each year.

If you do not actively elect or waive coverage within the required time frame of 31 days of your eligibility for health benefits and insurance, you may not change your coverage until the next Annual Enrollment, unless you experience a Qualified Life Event (QLE) (see the "Qualified Life Events" section on page 18 for more information).

To elect or waive benefits, visit the Benefit Center website at morganstanley.com/benefits or through the Morgan Stanley intranet. If you have any questions, contact HR Services at 877-MSHR-411 (877-674-7411). **Please be sure to enroll in benefits within the 31-day time frame and check your elections so that you and your family have the coverage you want.**

Coordination of Benefits

The Medical (including Prescription Drug) and Dental Plans contain a "nonduplication of benefits" provision. This ensures that Morgan Stanley's Plans in combination with any other plans, including Medicare, do not pay more than the amount they would pay on their own.

For example, if you cover your spouse as a dependent and your spouse is covered by another medical or dental plan that pays benefits equal to or greater than those paid under the Morgan Stanley Plan, the Morgan Stanley Plan will not make any additional payment with respect to your spouse. If the other plan pays benefits that are less than the Morgan Stanley Plan would pay, then the Morgan Stanley Plan will pay the difference, up to the amount that would have been paid for your spouse's claim on its own.

The following coordination-of-benefits rules apply when an individual is covered by more than one plan:

The plan covering the individual as an employee is considered "primary" and pays benefits up to plan limits.

- The plan covering the individual as a dependent is considered "secondary" and pays only to the extent that charges are eligible for reimbursement under the second plan. This means that your bills are first submitted to the plan covering the individual as an employee, and any unpaid balances are then submitted to the plan covering the individual as a dependent.
- If an expense is for a child, the plan covering the parent whose birthday occurs earlier in the year (month and day) is primary and pays the child's benefits first. The other parent's plan is secondary.
- The plan providing coverage to the active employee (or dependent of an active employee) is primary and will pay benefits before the plan that covers the individual as a retired employee (or dependent of a retired employee).

For dependents of divorced or legally separated parents:

- If there is a court order that makes one parent financially responsible for the medical or dental expenses of the child, that parent's plan is primary.
- If there is no court order and the parent with custody has not remarried, that parent's plan is primary.
- If there is no court order and the parent with custody has remarried, that parent's plan is primary to the plan of the stepparent. The plan of the stepparent is primary to the parent without custody.

Please note that these rules assume that the individual covered by both plans is enrolled under both plans.

Right to Receive and Release Necessary Information

Certain facts about health care coverage and services are needed to apply these coordination-of-benefits rules and to determine benefits payable. The plan administrator may obtain the necessary information it needs from, or give such information to, other organizations or persons for the purpose of applying these coordination-of-benefits rules and determining benefits payable under this Plan and other benefit plans. The plan administrator need not inform nor solicit the consent of any person to share or receive this information. Any person claiming benefits under the Plans must give the plan administrator any information required to apply relevant rules and determine benefits payable. If you do not provide the necessary information, your claim for benefits will be denied.

Medicare

If you are eligible for Medicare and actively working for Morgan Stanley, the Morgan Stanley Medical Plan is primary. You need not enroll in Medicare until you are no longer actively working for Morgan Stanley.

If you are eligible for Medicare and no longer actively working for Morgan Stanley **or you are on Long-Term Disability** (or your spouse is no longer actively working for Morgan Stanley) but are covered under the Morgan Stanley Medical Plan (for example, as a retiree, a COBRA participant or Medicare-disabled employee), Medicare is considered primary and pays first. Once Medicare has determined how much it will pay, you may submit any uncovered expenses to the Morgan Stanley Medical Plan as the secondary payer.

To receive maximum medical coverage, it is important to enroll in Medicare (medical insurance) once you are no longer an actively working Morgan Stanley employee, because your benefits under the Medical Plan will be computed as though you have received Medicare benefits, even if you have not enrolled in this coverage.

Note: If you are on Long-Term Disability and you or your spouse is eligible for Medicare due to age (generally at age 65), it is important to enroll in Medicare, as benefits under the Morgan Stanley Plan will be computed as though you are receiving Medicare benefits, even if you haven't enrolled.

You must enroll in Medicare Parts A and B when you first become eligible or you may incur a penalty. If you decide to enroll in Medicare at a date later than your initial Medicare eligibility date, you may be subject to a late enrollment penalty from Medicare.

Morgan Stanley is **not** responsible for advising you as to your rights and responsibilities under Medicare. You are solely responsible for your decision as to whether and when to enroll in Medicare; Morgan Stanley does not monitor enrollment in Medicare and therefore will not advise you when you should enroll in Medicare.

For Medicare Part D (Prescription Drug coverage), you will have a special enrollment period after your Morgan Stanley coverage ends, and you will not have to pay a penalty as long as proof of creditable coverage is provided. All Morgan Stanley Medical Plans provide creditable Prescription Drug coverage.

If you are eligible for Medicare and are still actively working, you are entitled to the same Morgan Stanley medical benefits offered to other active employees. If you elect Medicare coverage, Medicare is the secondary payer, paying only for those charges not covered by the Morgan Stanley Medical Plan. If you defer enrollment in Medicare because you are actively working and covered under the Morgan Stanley Medical Plan, there will not be a penalty for late enrollment, provided you enroll in Medicare in a timely manner upon retirement, termination or loss of coverage.

These rules also apply to your spouse and eligible dependents covered under the Morgan Stanley Medical Plan, regardless of your age, for as long as you are still working for Morgan Stanley. **Your domestic partner must enroll for Medicare as soon as they are eligible.** For your domestic partner, Medicare is primary and pays first, even if you are still actively working for Morgan Stanley and your domestic partner is covered under the Plan as an eligible dependent.

If you are on Long-Term Disability and approved for Medicare, Medicare will be your primary medical plan coverage, and the Morgan Stanley Medical Plan (if enrolled) will be your secondary coverage.

To receive maximum medical coverage, it is important to enroll in Medicare Parts A and B once you are approved for Medicare, because your benefits under the Medical Plan will be computed as though you have received Medicare benefits, even if you have not enrolled in this coverage.

If you are age 65 or over and enrolled in Morgan Stanley Retiree medical coverage with Kaiser, you **must** enroll in Medicare and assign your Medicare benefits to Kaiser. Failure to assign your Medicare benefits to Kaiser within 60 days after you enroll in Medicare will result in termination of your and your dependents' Morgan Stanley medical coverage, retroactive to the date of your Medicare eligibility.

Important Information About the Morgan Stanley Medical Plan

Right to Reimbursement (Subrogation Agreement)

If you or any other person receives a Recovery in any form, including (but not limited to) a judgment, settlement, payment or compensation of any type with respect to an injury or condition for which the Medical Plan has provided benefits or advanced money (regardless of fault, negligence or wrongdoing) from any tortfeasor, liability insurer, uninsured or underinsured motorist insurer, medical plan coverage, or other source (a "Recovery"), you or such other person must repay the Medical Plan in full for any benefits that have been or may be paid, payable or advanced by the Medical Plan (the "Subrogated Amount"), including any reasonably foreseeable expenses not yet incurred, whether or not you or such other person has been "made whole" for the injuries or condition suffered.

Each person receiving benefits or advanced money from the Plan has an obligation and duty to reimburse the Plan to the extent of the Subrogated Amount and is deemed to give the Plan a first lien on any Recovery for the Subrogated Amount.

The Plan may also, in its sole discretion, seek to impose a constructive trust through the courts on a Recovery to the extent of the Subrogated Amount. This right of first priority in contravention of any "make whole" doctrine shall not be affected or limited in any way by the manner in which the person or entity responsible for paying any Recovery designates or characterizes the Recovery. The Plan specifically disclaims the "common fund doctrine," and any payment of the Subrogated Amount to the Plan shall be without reduction, setoff or abatement, or attorneys' fees or

costs incurred by you or any other person in obtaining the Recovery. You or any other claimant of a Recovery must promptly inform the Plan of the filing of a lawsuit, making a claim against any third party, the scheduling of settlement negotiations, or the intention of any third party to make payment of any kind to your benefit or on your behalf to which this section may reasonably apply.

If it is determined that a third party may be responsible for the payment of benefits or money advanced by the Plan, you or any other person may be contacted by the Plan or its Representative to provide information regarding any potential Recovery, and you or such other person consent to being so contacted and agree to cooperate in obtaining any Recovery. Furthermore, you and any other person who may receive a potential Recovery agree to segregate and hold any Recovery in a separate fund for the purpose of reimbursing the Plan the Subrogated Amount until such time as the Subrogated Amount has been reimbursed to the Plan.

The Plan may, in its sole discretion, require you or any other person, as a precondition of payment of benefits or advance of money, to sign a written assignment of any Recovery to the Plan to the extent of the Subrogated Amount. In the event that the Plan does not receive payment of the Subrogated Amount, the Plan and the plan administrator have the full discretion and authority, either together or individually, to bring any action against you or any other person who has received or may receive a Recovery in any capacity, or against any person responsible for the injuries or condition suffered, or for the payment of any potential Recovery, or to reduce or set off the Subrogated Amount against future benefit payments. Such action may include filing suit against you or such other person in a court of law to recover 100 percent of the Subrogated Amount plus the Plan's attorneys' fees and court costs related to such suit.

Except as stated in the Plan or as required by applicable law, the Plan is not required to pay any expenses for past illnesses or injuries that are settled where you or another person have received a Recovery, and the Plan's rights of subrogation and reimbursement of the Subrogated Amount apply even if the original injury or illness happened before coverage under the Plan began.

The payment of benefits under the Plan is conditioned upon the terms of this section, and each person receiving benefits or advanced money from the Plan agrees that such benefits or money is paid or advanced on condition of full reimbursement to the Plan in the event of a Recovery. By accepting any benefits under the Plan, you are indicating your agreement to repay the Subrogated Amount. The Plan's rights to subrogation and reimbursement of the Subrogated Amount will not be reduced by any equitable defenses that may be raised by you or any third party (whether such third party has received benefits or is responsible for payment of a Recovery), including, but not limited to, any common fund doctrine, contributory negligence doctrine, "make whole" doctrine, or uninsured motorist rules or statutes. If any court of competent jurisdiction finds any portion of this section void or unenforceable, such portion shall be of no force and effect but shall not affect the validity or enforceability of any other portion hereof.

These subrogation and related rights also apply to the coverage and Prescription Drug features under the Medical Plan, Retiree Medical Plan, Dental Plan, Vision Plan and Disability Plan.

Qualified Life Events

When you enroll in benefits, your elections generally are irrevocable for the entire calendar year. There are special situations that are referred to as Qualified Life Events (QLEs), in which you may change your elections during the year. QLEs are events that affect your or your spouse's legal marital status, number of dependents, employment status, other newly available coverage or dependent eligibility status, as well as certain plan costs or coverage changes.

If you have a QLE and are eligible to make changes to your benefits, you must contact HR Services within 31 days of the QLE. Any changes you make to your benefits as a result of your QLE within this 31-day window will be retroactive to the date of the QLE. You may also make certain changes to your benefit elections up to 90 days after your QLE. However, if you make changes to your elections more than 31 days after your QLE,

your election will be prospective from the date of that election only, except for the birth or adoption of a child, in which your elections will be retroactive to the QLE. Additionally, if you make changes to your elections more than 31 days after your QLE, you will need to provide EOI under some benefit programs. Call HR Services at 877-MSHR-411 (877-674-7411) for more information.

Any changes you make to your benefits as a result of a QLE must meet the following criteria:

- **Consistency Rule:** You may only change your elections in a manner consistent with your QLE. For example, if you have a new dependent due to birth, adoption or marriage, you may add medical coverage for that dependent.
- **Domestic Partners:** You may enroll your domestic partner in the Plans within 31 days of the date you first meet the criteria listed in the "Domestic Partner Eligibility" section on page 9. Note that in general, FSA expenses for your domestic partner are not eligible for reimbursement (see the "Flexible Spending Accounts (FSA) for Health Care and Dependent Day Care" section on page 104).
- **Supplemental Aflac Coverages Excluded From Retroactive Application:** You may enroll in Aflac coverage as a result of a QLE. However, the Aflac coverage will only be effective from the effective date established by Aflac and will not be effective retroactively back to the date of the QLE.
- **FSA:** If you increase your FSA contribution amount as a result of a QLE, **only expenses incurred on or after the date of the QLE are eligible for reimbursement from the additional amount**.
- You cannot decrease your FSA contribution amount below the amount already contributed to, or—if higher—paid from, your FSA during the year. You may only change your FSA election for a given year prior to November 1 of that year.

Note: You *do not* need to experience a QLE to make changes to your HSA contribution amount. You may change your HSA contribution amount at any time, up to the IRS contribution limit.

Note: These provisions relating to QLEs do not allow a retiree who has waived coverage to elect coverage at a later date. Once a retired or terminated employee ceases to participate in a Plan, he/she may not enroll in that Plan again.

HIPAA

You may also be eligible to make a special enrollment election under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If you decline enrollment for yourself or your dependents (including your spouse) because of other health coverage, and you are an eligible employee under Morgan Stanley's Plans, you may be able to enroll in the Morgan Stanley health Plans if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents under the HIPAA special enrollment rules.

Qualified Life Events[1] Chart

This chart identifies the different types of Qualified Life Events (QLEs) that may occur throughout your employment with Morgan Stanley and actions you may take. Any election change must be consistent with your QLE. For more information, call HR Services or log on to the Benefit Center website and choose "Life Event" from the top menu bar.

QUALIFIED LIFE EVENT	ALLOWED CHANGES	ACTIONS TO TAKE
• Marriage (Same-Sex and Opposite-Sex Marriages) • Addition of Dependents (including Birth, Adoption or Placement of Adoption)	• Medical, Dental and Vision: – Elect, increase or change coverage for yourself, your spouse/domestic partner and/or eligible dependents – Drop coverage if enrolled in spouse's plan • Employee Assistance Plan: – Spouses and dependents to age 26 are automatically enrolled • FSAs:[2] – Start or increase contributions if prior to November 1 – Stop or decrease contributions if prior to November 1 • Life (may be subject to EOI) and Accident Insurance: – Elect, increase or change coverage for yourself, your spouse/domestic partner and/or eligible dependents – Drop coverage if enrolled in spouse's/domestic partner's plan • LTD and CEDi (may be subject to EOI); Accident, Critical Illness and Hospital Indemnity Insurance; and Legal Assistance: – Elect coverage – Drop coverage if enrolled in spouse's/domestic partner's plan	• Contact HR Services within 31 days of the QLE3 • Visit the Benefit Center website and select the "Change Your Benefits" tab on the homepage, or choose "Your Profile," "Health and Insurance" or "Life Event" in the top menu bars to: – Review and modify your elections – Review and update your beneficiaries – Review any QLE-specific next steps and/or additional forms to complete – Update your personal information via the Workday link on me@MS, the employee portal – Confirm that your dependents are eligible for coverage

[1] IRS rules limit the changes you may make for a QLE related to a domestic partner. Call HR Services for more information.
[2] If you start or increase contributions, only expenses incurred after the QLE can be applied to the new amount.
[3] Changes initiated more than 31 days after but within 90 days of the QLE will be prospective from the date of your election. Certain changes may require you to provide EOI. This period may be extended by recent legislation. Contact HR Services for up-to-date information on enrollment periods.

Qualified Life Events[1] Chart (continued)

QUALIFIED LIFE EVENT	ALLOWED CHANGES	ACTIONS TO TAKE
• **Death of Spouse**	• Medical, Dental and Vision: – Elect coverage for yourself and/or eligible dependents if you lose coverage under spouse's plan – Drop coverage for spouse • FSAs:[2] – Start or increase contributions if prior to November 1 and you or dependents lose coverage under spouse's plan – Stop or decrease contributions if prior to November 1 • Life (may be subject to EOI) and Accident Insurance: – Elect or change coverage • LTD (may be subject to EOI), Critical Illness and Accident Insurance, and Legal Assistance: – Elect or drop coverage	• Contact HR Services within 31 days of the QLE4 • Visit the Benefit Center website and select the "Life Events" tab to: – Review and modify your elections – Review and update your beneficiaries – Review any QLE-specific next steps and/or additional forms to complete – Update your personal information via the Workday link on me@MS, the employee portal
• **Employee or Spouse/Domestic Partner Gets Other Coverage**	• Medical, Dental and Vision: – Change or drop coverage for yourself, your spouse/domestic partner and/or eligible dependents • FSAs:[2] – Stop or decrease contributions if prior to November 1 • Life (may be subject to EOI) and Accident Insurance: – Elect, change or drop coverage • LTD (may be subject to EOI), Accident, Critical Illness and Hospital Indemnity Insurance, and Legal Assistance: – Elect or drop coverage	• Contact HR Services within 31 days of the QLE[3] • Visit the Benefit Center website and select the "Life Events" tab to: – Review and modify your elections – Review and update your beneficiaries – Review any QLE-specific next steps and/or additional forms to complete – Update your personal information via the Workday link on me@MS, the employee portal

[1] IRS rules limit the changes you may make for a QLE related to a domestic partner. Call HR Services for more information.
[2] If you start or increase contributions, only expenses incurred after the QLE can be applied to the new amount.
[3] Changes initiated more than 31 days after but within 90 days of the QLE will be prospective from the date of your election. Certain changes may require you to provide EOI.

Qualified Life Events[1] Chart (continued)

QUALIFIED LIFE EVENT	ALLOWED CHANGES	ACTIONS TO TAKE
• **Employee or Dependent Loses Eligibility (e.g., Due to Death, Age Maximum)**	• Medical, Dental and Vision: – Decrease coverage level – Drop coverage for dependent • FSAs:[2] – Start contributions if prior to November 1 – Stop or decrease contributions if prior to November 1 • Life (may be subject to EOI) and Accident Insurance: – Change or drop coverage	• Contact HR Services within 31 days of the QLE[3] • Visit the Benefit Center website and select the "Life Events" tab to: – Review and modify your elections • Coverage ends on the last day of the month that the dependent loses eligibility • Your dependent may be eligible to elect COBRA and extend Medical, Dental and/or Vision benefits, or the Employee Assistance Plan at his/her own expense
• **Unpaid Leave of Absence (including Unpaid Military Leaves)**	• Medical, Dental, Vision, Life and Accident Insurance; LTD; Accident, Critical Illness and Hospital Indemnity Insurance; Legal Assistance: – Drop coverage • FSAs[2]	• Contact HR Services within 31 days of the QLE[3] • Visit the Benefit Center website and select the "Life Events" tab to: – Review and modify your elections • Except for FSAs, coverage ends on the last day of the month that unpaid leave of absence begins
• **Return From Unpaid Leave of Absence (including Unpaid Military Leaves)**	• Medical, Dental and Vision: – Elect or increase coverage • FSAs[2] – Start or increase contributions if prior to November 1 • Life (may be subject to EOI) and Accident Insurance: – Elect or increase coverage for yourself, your spouse and/or eligible dependents • LTD (may be subject to EOI), Accident, Critical Illness and Hospital Indemnity Insurance, and Legal Assistance: – Elect coverage	• Contact HR Services within 31 days of the QLE[3] • Visit the Benefit Center website and select the "Life Events" tab to: – Review and modify your benefit Plan elections

[1] IRS rules limit the changes you may make for a QLE related to a domestic partner. Call HR Services for more information.
[2] If you start or increase contributions, only expenses incurred after the QLE can be applied to the new amount.
[3] Changes initiated more than 31 days after but within 90 days of the QLE will be prospective from the date of your election. Certain changes may require you to provide EOI. This time frame may be extended under recent legislation. Please contact HR Services for up-to-date information on enrollment periods.

Qualified Life Events[1] Chart (continued)

QUALIFIED LIFE EVENT	ALLOWED CHANGES	ACTIONS TO TAKE
• **Transfer to or Return From an Expatriate or Short-Term International Assignment**	• Medical, Dental and Vision: – Elect, change or drop coverage for yourself, your spouse/domestic partner and/or eligible dependents – Drop coverage if enrolled in spouse's/domestic partner's plan • FSAs:[2] – Start or increase contributions if prior to November 1 – Stop or decrease contributions if prior to November 1 • Life (may be subject to EOI) and Accident Insurance: – Elect, change or drop coverage • LTD (may be subject to EOI) and Legal Assistance: – Elect or drop coverage	• Contact HR Services within 31 days of the QLE4 • Visit the Benefit Center website and select the "Life Events" tab to: – Review and modify your elections – Review and update your beneficiaries – Review any QLE-specific next steps and/or additional forms to complete – Update your personal information via the Workday link on me@MS, the employee portal – Confirm that your dependents are eligible for coverage – If transferring to an Expatriate or Short-Term International Assignment, coverage through the Employee Assistance Plan ends on the last day of the month in which you transfer; you will be eligible to elect COBRA and extend coverage at your own expense
• **Qualified Medical Child Support Order (QMCSO)**	• Medical, Dental and Vision: – Allow employee to comply with QMCSO • FSAs:[2] – Start or increase contributions to comply with QMCSO if prior to November 1 • Life and Accident Insurance, LTD, and Legal Assistance: – Not applicable	• Contact HR Services within 31 days of the QLE[4] • Visit the Benefit Center website and select the "Life Events" tab to: – Review and modify your elections
• **Dependent Loss of Other Health Coverage (e.g., Employer Coverage, CHIP, Medicaid)**	• Medical, Dental and Vision: – Elect or change coverage for yourself, your spouse/domestic partner and/or eligible dependents • FSAs:[2] – Start or increase contributions if prior to November 1 • Life and Accident Insurance, LTD, and Legal Assistance: – Not applicable	• Contact HR Services within 31 days of the QLE[3] • Visit the Benefit Center website and select the "Life Events" tab to: – Review and modify your elections – Confirm that your dependents are eligible for coverage

[1] IRS rules limit the changes you may make for a QLE related to a domestic partner. Call HR Services for more information.
[2] If you start or increase contributions, only expenses incurred after the QLE can be applied to the new amount.
[3] Changes initiated more than 31 days after but within 90 days of the QLE will be prospective from the date of your election, except for the birth, adoption or foster placement of a child. Certain changes may require you to provide EOI. This period may be extended due to coronavirus-related rules. Please contact HR Services for more information.

Continuation of Coverage During Work or Life Events

If your work status changes, you may lose eligibility for certain benefit Plans. In some cases, you may be permitted to elect COBRA to continue health benefits at your own cost for a period of time.

For more information, please see the “Continuation Coverage Rights Under COBRA” section on page 184.

This chart shows the impact of certain changes in your work status.

CHANGE IN WORK STATUS	IMPACT ON BENEFITS	ACTIONS TO TAKE
• **Terminate Employment, Retire or Become Ineligible for U.S. Benefits**	• Coverage under the **Medical, Dental, and Vision Plans and the Employee Assistance** for you and your dependents ends on the last day of the month that the change in work status occurs. • Depending on your age and service, you may be eligible for retiree medical coverage; see the “Retiree Medical Coverage” section on page 73 for more information.	• You may continue medical, dental, and vision coverage and the Employee Assistance Plan at your own expense through COBRA, typically for up to 18 months. See “Continuation Coverage Rights Under COBRA” section on page 184 for more information. • If you are eligible for retiree medical coverage, you may (but are not required to) elect COBRA first before electing retiree medical coverage.
	• Contributions to your **FSAs** end when your work status changes. FSA contributions do **not** continue to the end of the month. • If you have a balance in your Health Care FSA (HCFSA) or Limited Purpose Flexible Spending Account (LPFSA), you are only eligible to receive reimbursement for eligible health care expenses incurred while actively employed.	• If your LPFSA or HCFSA account has a positive balance, you may elect to continue COBRA coverage through the end of the calendar year (which will allow you to submit expenses for reimbursement through your HCFSA or LPFSA while you participate through COBRA). This coverage is paid on an after-tax basis. • If you transfer to a non-U.S. benefits-eligible position at Morgan Stanley, you may submit claims for HCFSA or LPFSA expenses incurred through the end of the calendar year of your transfer.
	• Payroll contributions to your **HSA** end when your work status changes.	• The money in your HSA remains yours to use to pay for qualified health care expenses now or in the future. You may roll your HSA balance over to a new account.

Continuation of Coverage During Work or Life Events (continued)

CHANGE IN WORK STATUS	IMPACT ON BENEFITS	ACTIONS TO TAKE
• **Terminate Employment, Retire or Become Ineligible for U.S. Benefits (continued)**	• **Life and Accident Insurance** (except BTA) ends on the last day of the month in which your employment ends or you lose eligibility. • **BTA** coverage ends as of your date of termination, retirement or loss of eligibility date.	• You may convert or port your Basic and Supplemental Life Insurance coverage by contacting MetLife within 60 days of your loss of coverage. Refer to the "Life and Accident Insurance" section on page 114 for more information.
	• **LTD coverage** ends on your termination, retirement or loss of U.S. benefits-eligibility date.	• You may be able to convert or port some or all of your coverage by contacting MetLife within 60 days of your loss of coverage. Refer to the "About the LTD Program" section on page 136 for more information.
	• **Accident, Critical Illness and Hospital Indemnity Insurance** coverage ends on termination, retirement or loss of U.S. benefits-eligibility date.	• You may be able to convert or port some or all of your coverage. Refer to the "Accident, Critical Illness" section on page 165 for more information.
	• **Legal Assistance Plan** coverage ends on termination, retirement or loss of U.S. benefits-eligibility date. Open matters will continue to be covered.	• You may be eligible to continue coverage at your own expense for 30 months. See the "Legal Assistance Plan" section on page 149 for more information.
	• **CEDi** coverage ends on your termination, retirement or loss of U.S. benefits-eligibility date.	• You may be able to port your coverage. Refer to the "Corporate Excess Disability Insurance (CEDi) Program" section on page 144 for more information.
• **Dependent Becomes Ineligible for Benefits**	• Coverage under the Medical, Dental, and Vision Plans and the Employee Assistance Plan for your dependent will end on the last day of the month in which the dependent becomes ineligible for benefits. • Reimbursements for your dependent's FSA expenses will end when they no longer qualify as your eligible dependent.	• Your dependent may continue medical, dental, and vision coverage and the Employee Assistance Plan at their own expense, generally for up to 36 months through COBRA. • You must notify HR Services within 60 days of your dependent's ineligibility.

Continuation of Coverage During Work or Life Events (continued)

CHANGE IN WORK STATUS	IMPACT ON BENEFITS	ACTIONS TO TAKE
• **Dependent Becomes Ineligible for Benefits (continued)**	• Coverage for your dependent under the **Supplemental Life and Accident Plans** will end on the last day of the month that they become ineligible for benefits.	• Coverage under **Supplemental Life Insurance** may be converted to an individual policy. • Refer to the "Life and Accident Insurance" section on page 114 for more information.
	• **Legal Assistance Plan** coverage will end when your dependent no longer qualifies as your eligible dependent. Coverage will continue for matters that were open prior to the loss of eligibility.	
• **Rehire**	• If you are rehired within 31 days of your termination and in the same calendar year, your previous **benefits coverage** will automatically be reinstated. – FSA and HSA coverage will be reinstated only if you are rehired prior to November 1. • If you are rehired more than 31 days after your termination or in a new calendar year, you must make new benefits elections or you will receive default coverage (subject to EOI, where applicable). – FSA and HSA coverage for the year of rehire may be elected only if you are rehired prior to November 1.	• If you are **not** eligible to make new benefits elections: – Confirm that your dependents are eligible for coverage. • If you are eligible to make new benefits elections: – Log on to the Benefit Center website to elect coverage within 31 days or you will receive default coverage. – You may be required to provide EOI upon enrollment in certain benefit Plans. – Confirm that your dependents are eligible for coverage. • Generally, prior service with Morgan Stanley will count in determining eligibility for retiree medical coverage. Prior service as a consultant or other person classified by Morgan Stanley as a nonemployee does not count. Special rules may apply to employees with prior service from an acquired or merged company. Call HR Services at 877-MSHR-411 (877-674-7411) for more information.

Continuation of Coverage During Work or Life Events (continued)

CHANGE IN WORK STATUS	IMPACT ON BENEFITS	ACTIONS TO TAKE
Leaves of Absence (LOA)		
• **Paid LOA (Includes STD and Paid Military Leaves)**	• Coverage continues under the **Medical, Dental and Vision Plans**, and you will continue to pay premiums through Payroll deductions.	• If you incur claims while on a paid military leave and are covered under both Morgan Stanley's Plans and the U.S. Defense Department plan, the Morgan Stanley Plan is considered primary. For more information, see the "Coordination of Benefits" section on page 15.
	• **BTA** terminates on the day leave begins.	• BTA will automatically resume when you return from leave.
	• Coverage continues under the **FSA, HSA, Life, LTD, LTC, Accident, Critical Illness and Hospital Indemnity Insurance, CEDi, and Legal Assistance Plans**, and you will continue to pay premiums through Payroll deductions. • Coverage continues under the **Employee Assistance Plan**.	• Any disability you incur during your military leave may be subject to exclusions under the LTD Plan. For more information, see the "Disability Plan" section on page 130.
• **Unpaid LOA (Includes LTD and Unpaid Military and Political Leaves)**	• Coverage under the **Medical, Dental and Vision Plans** continues; you must pay premiums on time. • For political leaves, you may continue coverage under the Medical and Dental Plans, and pay premiums at the COBRA rate.	• You will be billed monthly by HR Services. • The Company cannot share in the cost of coverage while you are on a political leave.
	• **HCFSA and LPFSA** coverage continues while on leave and will be billed monthly on an after-tax basis. • **HSA** contributions will cease. You may choose to contribute directly to your HSA with personal contributions or reinstate your Payroll deductions upon your return from leave.	• If you do not pay for LPFSA or HCFSA coverage in a timely manner, expenses incurred while on leave will not be eligible for reimbursement. • You may submit Eligible Expenses to your HSA for reimbursement.
	• **DDCFSA** terminates on the day leave begins.	• You may reinstate your DDCFSA Payroll deductions upon your return from leave.
	• **BTA** terminates on the day leave begins.	• BTA will automatically resume when you return from leave.

Continuation of Coverage During Work or Life Events (continued)

CHANGE IN WORK STATUS	IMPACT ON BENEFITS	ACTIONS TO TAKE
Leaves of Absence (LOA) (continued)		
• **Unpaid LOA (continued)**	• **Basic and Supplemental AD&D Insurance** may continue for up to 24 months. – Employees on a political leave may participate in Supplemental AD&D Insurance only. Basic AD&D Insurance will terminate on the day your leave begins and resume when you return. • You may continue **Basic and Supplemental Life Insurance** coverage up to age 65. – Employees on a political leave may continue for Supplemental Life Insurance only.	• You will be billed monthly by HR Services. • Any disability you incur during your leave may be subject to exclusions under the Disability Plan. For more information, see the "Disability Plan" section on page 130.
	• You may continue **LTD** coverage for six months as long as you continue to pay for coverage on time.	• If you are on an Unpaid LOA (except approved FMLA leaves) and become disabled, you are not eligible for **STD** payments unless you return to work prior to beginning your disability leave. • You may elect LTD coverage within 31 days of your return. You may be required to provide EOI.
	• You may continue **LTC** coverage by making payments directly to your provider.	• You will be billed monthly by the provider.
	• You may continue **Accident, Critical Illness and Hospital Indemnity Insurance** coverage by making payments directly to Aflac.	• You will be billed by HR Services.
	• You may continue **CEDi** coverage by making payments directly to the provider.	• You will be billed monthly by the provider.
	• You may continue **Legal Assistance Plan** coverage. You must pay premiums on time.	• You will be billed by HR Services.
	• Coverage continues under the **Employee Assistance Plan**.	• You will be billed monthly by the provider.

Continuation of Coverage During Work or Life Events (continued)

CHANGE IN WORK STATUS	IMPACT ON BENEFITS	ACTIONS TO TAKE
• **Death**	• If you are an active employee at the time of your death, coverage under the **Medical, Dental and Vision Plans** for your covered dependents will continue at the same level of coverage for one year, as long as they remain otherwise eligible. Morgan Stanley pays the cost of this coverage. • If you are an active employee and eligible for retiree medical coverage at the time of death, your covered dependents may be eligible for retiree medical coverage after the year of Company-provided coverage ends. See the "Retiree Medical Coverage" section on page 73 for details. • If you are retired at the time of your death, your dependents may continue retiree medical coverage at their own expense, if enrolled at the time of your death. See the "Retiree Medical Coverage" section on page 73 for details.	• After the year of Company-provided coverage ends, your covered depepndents may continue medical, dental and vision coverage at their own expense, through retiree medical coverage, if eligible, or COBRA. See the "Continuation Coverage Rights Under COBRA" section on page 184 for details. • If your dependents are eligible for Medicare, the year of coverage provided by Morgan Stanley will be primary to any Medicare coverage. After the year of coverage provided by Morgan Stanley ends, Plan benefits will be paid as if Medicare is primary, regardless of whether you enroll in Medicare. Your dependents should enroll in Medicare Part B as soon as eligible to avoid incurring a late enrollment penalty.
	• Contributions to an **FSA** will end at the time of your death.	• Your dependents may submit eligible LPFSA or HCFSA claims for reimbursement through April 30 of the calendar year following your death. • Your dependents may submit eligible DDCFSA claims for reimbursement through the end of the calendar year of your death.
	• Your contributions to an **HSA** will end at the time of your death.	• Treatment of HSA will depend on designated HSA beneficiary. Contact HR Services for more information.
	• Dependent coverage under the **Life and Accident Insurance Plans** will cease on the date of your death.	• Dependents may convert their Supplemental Life Insurance to an individual policy within 60 days of your death. Refer to the "Life and Accident Insurance" section on page 114 for more information.
	• If you were disabled for at least 180 consecutive days and receiving or due to receive an **LTD** monthly benefit at the time of your death, your eligible survivor or estate will receive a lump-sum payment equal to three times your monthly benefit, paid by the LTD provider.	

Continuation of Coverage During Work or Life Events (continued)

CHANGE IN WORK STATUS	IMPACT ON BENEFITS	ACTIONS TO TAKE
• **Death (continued)**	• Coverage under the **Legal Assistance Plan** will end on the date of your death. • The Plan covers eligible legal fees for covered services that were open and pending prior to your death.	
	• **LTC** coverage will end on the date of your death.	• Your contributions to the cost of your coverage that were paid before your 65th birthday may be refunded to your estate. The amount returned will be reduced by the amount of benefits paid to you. This feature is not available to residents of the state of Washington.
	• Coverage under the Employee Assistance Pllan will cease for eligible dependents on the date of your death.	• Eligible dependents may continue coverage under the Employee Assistance Plan at their own expense through COBRA, typically for up to 18 months. See “Continuation Coverage Rights Under COBRA” section on page 184 for more information.
Transfers		
• **U.S. Local to U.S. Expatriate**	• Coverage under the **U.S. Medical and Dental Plans** will end and you will be automatically enrolled in the Cigna Global Health Medical and/or Dental Plan options, at your current coverage level. • Coverage under the **Employee Assistance Plan** will end. • All other coverage continues except FSA, including **Vision, LTD, Life and Accident, and Legal Assistance**.	• You will continue to pay premiums through Payroll deductions.
	• If you are a U.S. expatriate or receive a portion of your pay from a U.S.-dollar-based Payroll, your **FSA** contributions will continue. • If you do not receive any portion of your pay from a U.S.-dollar-based Payroll, your FSA contributions will end on your transfer date. • Your **HSA** contributions will end on your transfer date (unless covered by another high-deductible health plan).	• If your LPFSA, DDCFSA and HCFSA contributions end, you may continue to incur claims for reimbursement through the end of the calendar year while actively employed.

Continuation of Coverage During Work or Life Events (continued)

CHANGE IN WORK STATUS	IMPACT ON BENEFITS	ACTIONS TO TAKE
Transfers (continued)		
• **U.S. Local to Short-Term Assignee (Domestic and International)**	• All **benefits Plan** elections remain the same, except coverage under the **Employee Assistance Plan** will end. • You may choose to elect Cigna Global Health Medical and/or Dental Plan options if your new work location is not in the U.S. • You may choose to elect a different Medical Plan option if your current option is not available in your new U.S. work location.	• You will continue to pay premiums through Payroll deductions.
• **Benefits-Eligible Employee to Non-U.S. Benefits-Eligible International Location**	• You will no longer be eligible for U.S. benefits coverage. • All **Medical, Dental, Vision, Employee Assistance Plan, HSA, FSA, Life and AD&D** coverage will end on the last day of the month in which you transfer. • **LTD** coverage ends as of the date of transfer. • **LTC** coverage ends the last day of the month in which coverage is terminated. • The **Legal Assistance Plan** will continue to cover eligible legal fees only for services that were open prior to the date of your loss of U.S. benefits eligibility.	• You may continue Medical, Dental, Vision and Employee Assistance Plan coverage for a period of time at your own expense, through COBRA. See the "Continuation Coverage Rights Under COBRA" section on page 184 for details. • You may continue to incur DDCFSA, LPFSA and HCFSA claims for reimbursement through the end of the calendar year while actively employed. • You may continue LTD, LTC and Legal coverage by making payments directly to the plan administrator.
• **U.S. Expatriate Short-Term Assignee or U.K. Global on U.S. Benefits to U.S. Benefits Eligible**	• If enrolled in the Cigna Global Health Medical and Dental Plans, coverage will end. – Medical coverage will automatically default to Option B administered by UHC or Cigna, or if you are a resident of Hawaii, the HMSA Medical Plan, at the coverage level you had in the Cigna Global Health Medical Plan. – Dental coverage will default to the MetLife Dental Option A at the coverage level you had in the Cigna Global Health Dental Plan. • Coverage under the Vision, LTD, Life and Accident, Legal Assistance and LTC Plans will remain the same. • If you participate in the FSAs, your contributions will continue. • If you were not previously enrolled in FSA coverage, you may begin contributions only if prior to November 1.	• You may contact HR Services within 31 days of the transfer to make changes to your elections.[1] • You will continue to pay premiums through Payroll deductions.

[1] In addition, you may also make changes to your benefit elections up to 90 days after your transfer. However, if you make changes to your elections more than 31 days after your transfer, coverage will be prospective from the date of your election only, except for the birth, adoption and foster placement life event, and you will need to provide EOI under some benefit programs. The 31-day period may be extended based on recent legal updates. Please contact HR Services for more information.

Medical Plan

The Morgan Stanley Medical Plan is designed to help you and your family maintain your health and well-being while managing medical expenses.

Morgan Stanley offers eligible employees a choice of national medical coverage options administered by national providers. Morgan Stanley generally shares in the cost of your medical care premiums. Your Medical Plan options include:

- Option A administered by Cigna or UHC
- Option B administered by Cigna or UHC
- Option C administered by Cigna or UHC

Please note that the national options are not available to residents of Hawaii.

Based on your home zip code, you may be eligible to participate in one or more of the following regional medical coverage options:

- HMSA Medical Plan—Hawaii
- Kaiser Permanente HMO—Hawaii, Northern and Southern California (in-network coverage only)
- Cigna Global Health Medical Plan—international locations

Each of the coverage options features quality service and support as well as Prescription Drug coverage, but one may be more ideally suited to your individual situation. To help you understand the differences between the coverage options and which may be best for you, below is a brief summary with more detailed descriptions to follow.

- **Options A, B and C**: These options are all administered by Cigna or UHC. You may use both in- and out-of-network services, but may receive significant cost savings when using providers within the Cigna or UHC networks. The Cigna network is the Cigna Open Access Plus network and the UHC network is the UHC Choice Plus network.
- **Option A**: Covers the same benefits as Options B and C but has a lower deductible and out-of-pocket maximum. As a result, your per-paycheck premium will be higher.
- **Option B**: Designed for employees who wish to keep their per-paycheck premiums lower and pay higher out-of-pocket expenses when medical services are received.
- **Option C**: Covers the same benefits as Options A and B, but has higher deductibles and out-of-pocket maximums than the other coverage options and lower per-paycheck premiums. Under Option C, eligible participants can enroll in a Health Savings Account (HSA), a pre-tax account funded with your own contributions to be used to pay for eligible future health care expenses.
- **HMSA Medical Plan**: This option is available only to employees who live in Hawaii. HMSA features in- and out-of-network coverage options.
- **Kaiser Permanente HMOs**: These options are available only to employees living in Hawaii, Northern California and Southern California. The Kaiser Permanente HMOs are designed for those employees who wish to keep medical care costs low and receive all services within the Kaiser network. Out-of-network benefits are not available with Kaiser options.
- **Cigna Global Health Medical Plan**: The Cigna Global Health Medical Plan is available only to certain U.S. benefits-eligible international employees, U.S. expatriates and certain U.S. inpatriates. Employees and dependents receiving care in the U.S. may access the Cigna Open Access Plus network under this coverage option.

Executive Health Program

Members of the Morgan Stanley Operating Committee are eligible to participate in the Morgan Stanley Executive Health Program. The Executive Health Program includes an annual executive physical. In addition, Operating Committee members with three or more years of service at retirement may participate in the UHC Retiree Medical Plan (“Core Plan”). For the purposes of determining years of service for eligibility to participate in the Core Plan, service at certain legacy entities, as determined by the Plan Administrator’s sole discretion, including service with E*TRADE Financial Corporation, E*TRADE Financial LLC, and E*TRADE Financial Holdings, LLC and each of their respective business units,

shall count toward calculation of the “three or more years of service” requirement. See the “Grandfathered Coverage” section on page 76 for details.

COBRA

When you are no longer eligible to participate in the Medical Plan (under any coverage option), you and your eligible dependents may have an opportunity to continue coverage at your own expense under COBRA for a period of time. See the “Continuation Coverage Rights Under COBRA” section on page 184 for more information.

Summary of Benefits Coverage

As part of the Affordable Care Act, Summaries of Benefits and Coverage (SBC) are available on the Benefit Center website. You may also wish to review the Plan Coverage Comparison Charts in this SPD and the SBC Uniform Glossary, which can be found on the Department of Labor website at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/summary-of-benefits.

Medical Plan—National Coverage Options

With Options A, B and C you will pay a percentage of the cost of services or coinsurance. When using doctors and hospitals in the Cigna and UHC networks, Options A, B and C will all pay 100 percent for office visits for preventive care. Most other in-network services are reimbursed at 80 percent of the charge after you meet an annual deductible. You are not required to designate a Primary Care Physician (PCP) to coordinate your care. Additionally, you do not need referrals to see a specialist. In-network care is intended to offer you quality coverage and administrative ease at a lower out-of-pocket cost to you.

Options A, B and C offer you the freedom to choose in-network and out-of-network care. Out-of-network care generally is covered similarly to benefits for in-network care, except that you have a higher annual deductible to meet and a higher coinsurance percentage. Benefit reimbursements are based on Eligible Expenses, determined by the plan administrator after you meet the annual deductible. You are responsible for charges over Eligible Expenses, as determined by the plan administrator.

For UHC Members: Depending on your geographic location and the service you receive, you may have access through UHC's Shared Savings Program to out-of-network providers who have agreed to discounts negotiated from their charges on certain claims for Covered Health Services. Refer to the definition of “Shared Savings Program” in the “Glossary” section of the SPD for details about how the Shared Savings Program works. All Medical Plan participants who retain a private Primary Care Physician may submit any services received for reimbursement to your Medical Plan Administrator (Cigna or UHC) based on the provider’s otherwise applicable billing rates and the terms of the Plan. A statement from the provider showing the service codes and rates must be provided to the Medical Plan Administrator to obtain reimbursement.

Eligible Expenses

Morgan Stanley has delegated to UHC and Cigna the discretion and authority to decide whether a treatment or supply is a Covered Health Service and how the Eligible Expenses will be covered by the Plan.

For Cigna, Eligible Expenses are determined based on the lesser of either the health care professional's normal charge for a similar service or supply, or a percentile of charges made by health care professionals of such service or supply in the geographic area where it is received. The health care professional may bill the customer the difference between the health care professional's normal charge and the Maximum Reimbursable Charge as determined by the benefit Plan, in addition to applicable deductibles, copayments and coinsurance.

For UHC, Eligible Expenses are the amount UHC determines that it will pay for benefits. For Covered Health Services provided by an in-network provider, you are not responsible for any difference between Eligible Expenses and the provider’s normal charge. For Covered Health Services provided by an out-of-network provider (other than Emergency Health Services or services otherwise arranged by UHC), you will be responsible for any amount billed by the out-of-network provider that is

greater than the amount UHC determines to be an "Eligible Expense" as described below. For out-of-network benefits, you are responsible for paying directly to the out-of-network provider any difference between the amount the provider bills and the amount UHC pays for Eligible Expenses. Eligible Expenses are determined solely in accordance with UHC's reimbursement policy guidelines, as described in the SPD.

Eligible Expenses for in-network services are covered as follows:

- When Covered Health Services are received from an in-network provider, Eligible Expenses are UHC's contracted fee(s) with that provider.
- When Covered Health Services are received from an out-of-network provider as a result of an emergency or as arranged by UHC, Eligible Expenses are an amount negotiated by UHC or an amount permitted by law. Please contact UHC if you are billed for amounts in excess of your applicable coinsurance, copayment or deductible. The Plan will not pay excessive charges or amounts you are not legally obligated to pay.

For out-of-network services, Eligible Expenses are covered as follows:

- When Covered Health Services are received from an out-of-network provider, Eligible Expenses are determined based on:
- Negotiated rates agreed to by the out-of-network provider and either UHC or one of UHC's vendors, affiliates or subcontractors, at UHC's discretion.

Wellness Prevention and Resource Programs

- If rates have not been negotiated, then one of the following applies, based on claim type:
  - For Covered Health Services other than Pharmaceutical Products, Eligible Expenses are determined based on available data resources of competitive fees in that geographic area.
  - When Covered Health Services are Pharmaceutical Products, Eligible Expenses are determined based on 110% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic market.
  - When a rate is not published by CMS for the service or data resources of competitive fees in a geographic area are not available, UnitedHealthcare uses a gap methodology established by OptumInsight and/or a third-party vendor that uses a relative-value scale or similar methodology. The relative-value scale is usually based on the difficulty, time, work, risk and resources of the service. If the relative-value scale currently in use becomes no longer available, UnitedHealthcare will use a comparable scale(s). UnitedHealthcare and OptumInsight are related companies through common ownership by UnitedHealth Group. Refer to UnitedHealthcare's website at **www.myuhc.com** for information regarding the vendor that provides the applicable gap-fill relative-value scale information.

IMPORTANT NOTICE: Out-of-network providers may bill you for any difference between the provider's billed charges and the Eligible Expenses described here.

Wellness Prevention and Resource Programs

If you enroll in the Medical Plan through Cigna or UHC, there are a number of additional benefits in which you may be able to participate free of charge. For more information, type "offers" in your intranet browser to view the available Morgan Stanley wellness programs.

- 24/7 Access to Care
- Bariatric Surgery Centers of Excellence and Support Services
- Transplant Resource Services
- Kidney Resource Services
- Fertility Solutions
- Cigna Healthy Babies Program and UHC Maternity Support Program
- Chronic-Condition-Management Program
- Lifestyle/Behavioral-Management Programs
- Personal Wellness Coaching
- Licensed Behavioral Therapists
- Health Assessment
- Cancer Support Program
- Preferred Facilities for Substance and Alcohol Use Treatment

Choosing a Medical Plan Coverage Option

To help you determine which coverage option is best for you, log on to the Benefit Center website and:

- Go to the "Enroll in Your Benefits" page.
- Under "Tools and Calculators," click "Medical."
  - Select "Compare Your Medical Options" to compare up to three options at one time.
  - Select "Find a Doctor" to check if your doctor, hospital or other health care provider participates in a network.

Based on your home zip code, you may be eligible to participate in a regional Medical Plan; see the "Medical Plan – Regional Coverage Options" beginning on page 70.

The "Schedule of Benefits" describes your share of the cost for covered services under each option. The "Exclusions" chart defines services not covered under the Medical Plan options.

Important Information About the Medical Plan Administered by Cigna or UHC

Traveling Abroad

If you become sick or injured while traveling outside of the U.S., Eligible Expenses for nonemergency services will be reimbursed at the out-of-network benefit level and are subject to the annual deductible. Emergency services received outside the U.S. will be paid at the same level as emergency services received inside the U.S.

You will have to pay upfront for the services received and then submit a claim form for reimbursement. You may also need to provide receipts and an itemized bill from the provider explaining what services were rendered. You are encouraged to obtain copies of all medical documents and records before returning to the U.S. in case your claims administrator needs additional information. Consider seeking all routine medical treatment in the U.S. prior to going abroad.

Preauthorization and Medical Necessity Requirements

To help guide your course of treatment, Cigna and UHC require that you receive preauthorization before receiving certain services. This includes a review of the treatment or procedure by your health Plan option to ensure that it meets the definition of "medically necessary."

- If you are receiving services from an in-network provider, your doctor will submit the necessary information.
- If you are receiving services from an out-of-network provider, you must follow up with your doctor to ensure the required information is submitted for approval **prior to obtaining the service**.

Medical Necessity

When evaluating requests for preauthorization, the plan administrator will review the recommended course of treatment to ensure that it meets the plan administrator's standards for medical necessity.

Medical necessity is based on the following principles, as evaluated by the health Plan option:

- Clinical evidence: Credible, published scientific evidence supported by controlled clinical trials or observational studies.
- Rigorous and consistent clinical management of:
  - Clinical effectiveness: Treatment of illness, injury, disease or symptom must be proven to be clinically effective.
  - Clinical appropriateness: Type, frequency, extent and duration of services must be appropriate for the individual member.
  - Cost effectiveness: Services must not be more costly than alternative services that are at least as likely to produce equivalent therapeutic and diagnostic results.

Preauthorization is required by Cigna and UHC for the following services:

- Applied Behavioral Analysis (ABA) Therapy
- All inpatient admissions, which must be made at least five business days prior to a scheduled admission or within 48 hours following an emergency admission
- BRCA testing (breast cancer susceptibility)
- Cardiology services:
  - Inpatient: Electrophysiology implants
  - Outpatient: Cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators, echocardiograms and stress echocardiograms
- Cochlear implant
- Congenital heart disease services
- Dental services
- Dialysis services
- Durable medical equipment:
  - Cigna: All durable medical equipment
  - UHC: Durable medical equipment with a cost greater than $1,000
- Electro-convulsive treatment
- Extended mental health and substance abuse outpatient treatment visits over 45-50 minutes
- External prosthetic appliances
  - Cigna: All prosthetic devices
  - UHC: Prosthetic devices with a cost greater than $1,000
- Home health care—Includes home infusion therapy
- Hospice
- Hospital stays for newborns, only if stay is longer than 48 hours for infants born through vaginal delivery or 96 hours for infants born through Caesarean section
- Injectable drugs (other than self-injectable)
- Maternity admission, only if the stay is longer than 48 hours for vaginal delivery or 96 hours for Caesarean section
- Mental health and substance abuse intensive outpatient programs
- Organ and tissue transplants
- Physical therapy/occupational therapy (PT/OT)[1]
- Proton-beam therapy
- Psychological testing
- Radiation therapy
- Outpatient radiology services, including CT, PET, MRI, MRA and nuclear medicine
- Reconstructive or cosmetic procedures
- Septoplasty/rhinoplasty
- Skilled nursing
- Sleep-disorder tests and treatments
- Speech therapy
- Surgery, inpatient or outpatient
- Outpatient therapeutics (dialysis, intensity-modulated radiation therapy, MR-guided focused ultrasound)
- Temporomandibular joint (TMJ) treatment
- Vein procedures

Cigna also requires preauthorization for:

- Biofeedback
- Certain outpatient surgical procedures
- Chiropractic services
- Home oxygen
- Nuclear cardiology
- Private-duty nursing

[1] Prior authorization is required after 30 visits for UHC.

UHC also requires preauthorization for:

- Chemotherapy (in-network only)
- Nonemergency ambulance

Please note that these lists are subject to change at any time, as determined by Cigna or UHC. If you have any questions about whether a service requires preauthorization, check with Cigna or UHC by calling the number on the back of your ID card.

Failure to receive preauthorization for any service requiring it **will result in the service not being covered**, even if the service is determined to be medically necessary. Amounts you pay for services that are required to be preauthorized but are not will not be applied to your annual deductible or coinsurance limit, even if they are otherwise Eligible Expenses.

Schedule of Benefits for the Medical Plan—National Coverage Options

Listed below is a general summary of covered services under the Medical Plan administered by Cigna and UHC. For the "Schedule of Benefits" for regional options, please visit the Benefit Center website or contact the plan administrator directly.

PLAN FEATURES	OPTION A (CIGNA OR UHC)		OPTION B (CIGNA OR UHC)		OPTION C (CIGNA OR UHC)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Deductible, Out-of-Pocket and Lifetime Maximums						
Annual Deductible[1, 2, 3]	$600 per person; $1,250 family maximum	$1,200 per person; $2,500 family maximum	$1,200 per person; $2,500 family maximum	$2,400 per person; $5,000 family maximum	$2,300 per person; $4,600 family maximum (true family deductible), combined Medical and Prescription	$4,600 per person; $9,200 family maximum (true family deductible), combined Medical and Prescription
Annual Out-of-Pocket Maximum[4]	$2,000 per person; $5,000 family maximum	$4,000 per person; $10,000 family maximum	$3,000 per person; $7,500 family maximum	$6,000 per person; $15,000 family maximum	$5,500 per person; $11,000 family maximum, combined Medical and Prescription	$11,000 per person; $20,000 family maximum, combined Medical and Prescription
Lifetime Benefit Maximum	None, except Fertility (see the row on page 40)	None, except Fertility (see the row on page 40)	None, except Fertility (see the row on page 40)	None, except Fertility (see the row on page 40)	None, except Fertility (see the row on page 40)	None, except Fertility (see the row on page 40)
Professional Services						
Office Visits **Preventive Care** See the "Preventive/Wellness Care" row on page 44.	100%; no annual deductible	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%; no annual deductible	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%; no annual deductible	100% up to $250, then 60% of Eligible Expenses; no annual deductible
PCP/Specialist/Nonspecialist	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Allergy Testing and Treatment	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible

[1] Amounts paid to out-of-network providers count toward both the in-network and out-of-network deductible. The out-of-pocket maximum includes the deductible.
[2] Amounts paid for preventive drugs in Option C will count toward the out-of-pocket maximum and not be applied to the deductible.
[3] If you elect family coverage under Option C, your family must reach the in-network deductible of $4,600 or the $9,200 out-of-network deductible before the Plan will begin paying for any member of the family.
[4] Annual out-of-pocket maximum includes the annual deductible.

Schedule of Benefits for the Medical Plan—National Coverage Options (continued)

PLAN FEATURES	OPTION A (CIGNA OR UHC)		OPTION B (CIGNA OR UHC)		OPTION C (CIGNA OR UHC)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Professional Services (continued)						
Anesthesia	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Cochlear Implant Specific criteria apply; contact your Medical Plan for more information.	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Dental[1, 2] .	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Expanded Women's Preventive Care Services:[3] • Breastfeeding support, supplies and counseling[4] • Contraception methods and counseling • Domestic violence screening • Gestational diabetes screening • HIV screening and counseling • Human papillomavirus screening (beginning at age 30 and every three years thereafter) • Sexually transmitted infections counseling • Well-woman visits	100% covered, no deductible	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100% covered, no deductible	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100% covered, no deductible	100% up to $250, then 60% of Eligible Expenses; no annual deductible

[1] Preauthorization is required and you must meet the standards for medical necessity. Failure to preauthorize will result in reimbursement of services being denied.
[2] Eligible services include only those required to sound, natural teeth if rendered within six months of an accidental injury or due to congenital anomaly; limit extended to 12 months if medically necessary. TMJ treatment is also covered (nonsurgical TMJ treatment may be covered under the Dental Plan; check with your dental carrier for details). Note: A congenital anomaly is a physical developmental defect that is present at the time of birth, and that is identified within the first 12 months following birth. Examples include cleft defect, Pierre-Robin sequence, hemifacial microsomia, and Treacher Collins syndrome.

[3] In- and out-of-network services are combined when applying all visit, day and dollar maximums.
[4] Limited to one manual or standard breast pump per birth, as ordered or prescribed by a physician.

Schedule of Benefits for the Medical Plan—National Coverage Options (continued)

PLAN FEATURES	OPTION A (CIGNA OR UHC)		OPTION B (CIGNA OR UHC)		OPTION C (CIGNA OR UHC)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Professional Services (continued)						
Fertility[1, 2, 3] (Includes Cryopreservation, Artificial Insemination, IVF, GIFT, ZIFT) Subject to combined $30,000 medical services and Prescription Drug lifetime maximums. Maximums apply across all Plan options. See the "UHC Fertility Solutions Program" on page 51.	Cigna: 80% after annual deductible; UHC: Must be enrolled in the UHC Fertility Solutions Program. Treatment must be received at one of UHC's Centers of Excellence; 80% after annual deductible	Cigna: 60% of Eligible Expenses after annual deductible; UHC: No coverage	Cigna: 80% after annual deductible; UHC: Must be enrolled in the UHC Fertility Solutions Program. Treatment must be received at one of UHC's Centers of Excellence; 80% after annual deductible	Cigna: 60% of Eligible Expenses after annual deductible; UHC: No coverage	Cigna: 80% after annual deductible; UHC: Must be enrolled in the UHC Fertility Solutions Program. Treatment must be received at one of UHC's Centers of Excellence; 80% after annual deductible	Cigna: 60% of Eligible Expenses after annual deductible; UHC: No coverage
Radiologist,[2] Anesthesiologist, Pathologist, Laboratory	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Surgeon and Assistant Surgeon	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Bariatric Surgery[2] See "Surgery Exclusions" on page 68.	Cigna: 100% at Cigna Certified Hospitals for Bariatric Surgery; 80% after annual deductible at other in-network facilities	Cigna: 60% of Eligible Expenses after annual deductible; UHC: No coverage	Cigna: 100% at Cigna Certified Hospitals for Bariatric Surgery; 80% after annual deductible at other in-network facilities	Cigna: 60% of Eligible Expenses after annual deductible; UHC: No coverage	Cigna: 100% covered after deductible is met at Cigna Certified Hospitals for Bariatric Surgery; 80% after annual deductible at other in-network facilities	Cigna: 60% of Eligible Expenses after annual deductible; UHC: No coverage

1 In- and out-of-network services are combined when applying all visit, day and dollar maximums.
2 Includes services related to a diagnosis and treatment of infertility once a condition of infertility has been diagnosed and services related to enabling conception regardless of an infertility diagnosis.
3 Cryopreservation storage is limited to a 12-month period. UHC members must be enrolled in UHC Fertility Solutions and use a Center of Excellence.

Schedule of Benefits for the Medical Plan—National Coverage Options (continued)

PLAN FEATURES	OPTION A (CIGNA OR UHC)		OPTION B (CIGNA OR UHC)		OPTION C (CIGNA OR UHC)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Professional Services (continued)						
Bariatric Surgery[1] (continued) See the "UHC Bariatric Resource Services Program" on page 53.	UHC: Must enroll in the UHC Bariatric Resource Services Program. Surgery must be received at one of UHC's Centers of Excellence; 100% covered, no deductible; 80% covered after deductible for all other services		UHC: Must enroll in the UHC Bariatric Resource Services Program. Surgery must be received at one of UHC's Centers of Excellence; 100% covered, no deductible; 80% covered after deductible for all other services		UHC: Must enroll in the UHC Bariatric Resource Services Program. Surgery must be received at one of UHC's Centers of Excellence; 100% covered after deductible is met; 80% covered after deductible for all other services	
Surgeries for Gender Reassignment1 See "Surgery Exclusions" on page 68.	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Surgeries for General Disorders[1] See "Surgery Exclusions" on page 68.	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Second Surgical Opinion	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Multiple Surgical Procedures on the Same Day[1]	Plan coverage levels vary for subsequent procedures when more than one surgical procedure is performed on the same day. Contact your health plan administrator for more information.					
Voluntary Sterilization	100% for women; 80% covered for men after annual deductible	100% up to $250, then 60% of Eligible Expenses; no annual deductible for women; 60% of Eligible Expenses for men after annual deductible	100% for women; 80% covered for men after annual deductible	100% up to $250, then 60% of Eligible Expenses; no annual deductible for women; 60% of Eligible Expenses for men after annual deductible	100% for women; 80% covered for men after annual deductible	100% up to $250, then 60% of Eligible Expenses; no annual deductible for women; 60% of Eligible Expenses for men after annual deductible

[1] Preauthorization is required and you must meet the standards for medical necessity. Failure to preauthorize will result in reimbursement of services being denied.

Schedule of Benefits for the Medical Plan—National Coverage Options (continued)

PLAN FEATURES	OPTION A (CIGNA OR UHC)		OPTION B (CIGNA OR UHC)		OPTION C (CIGNA OR UHC)	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Professional Services (continued)						
Abortion	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Birthing Center	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Hospice[1] (Including Bereavement Counseling)	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Hospital Room Charge[1]; Accidental Injury; Maternity/Well Newborn[2]; Medical Rehabilitation; Semiprivate Room Accommodations (Private Room Paid at Semiprivate Rate)	80% after annual deductible; deductible waived for well newborn	60% of Eligible Expenses after annual deductible; deductible waived for well newborn	80% after annual deductible; deductible waived for well newborn	60% of Eligible Expenses after annual deductible; deductible waived for well newborn	80% after annual deductible	60% of Eligible Expenses after annual deductible
Hospital Services[1]; Inpatient Surgery	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Skilled Nursing Facility[1, 3] Cigna is limited to 150 days annually (combined in- and out-of-network). UHC is limited to 120 days annually (combined in- and out-of-network).	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Emergency Care						
Air- and Ground-Ambulance Service; Nonemergency Air and Ground Ambulance Services[1]	80% after annual deductible	80% after annual deductible	80% after annual deductible	80% after annual deductible	80% after annual deductible	80% after annual deductible
Hospital Emergency Room	80% after annual deductible	80% after annual deductible	80% after annual deductible	80% after annual deductible	80% after annual deductible	80% after annual deductible
Urgent Care Center	80% after annual deductible	80% of Eligible Expenses after annual deductible	80% after annual deductible	80% of Eligible Expenses after annual deductible	80% after annual deductible	80% of Eligible Expenses after annual deductible

[1] Preauthorization is required and you must meet the standards for medical necessity. Failure to preauthorize will result in reimbursement of services being denied.
[2] Hospital stays longer than 48 hours for a vaginal delivery or 96 hours for a Caesarean section require preauthorization.
[3] In- and out-of-network services are combined when applying all visit, day and dollar maximums.

Schedule of Benefits for the Medical Plan—National Coverage Options (continued)

PLAN FEATURES	OPTION A (CIGNA OR UHC)		OPTION B (CIGNA OR UHC)		OPTION C (CIGNA OR UHC)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Outpatient Care						
Acupuncture[1, 2] Limited to 20 visits per calendar year. Must be performed by an MD or certified acupuncturist, ***and may only be covered for certain conditions***.	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Chemotherapy/ Radiation and Blood Therapy[3]	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Chiropractic Care[1, 2, 3] Limited to 30 visits per calendar year.	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Diagnostic X-Rays, Lab Tests and Procedures[3] **(Nonpreventive)**	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Nutritional Counseling[1, 4]	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Occupational Therapy[3]	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Applied Behavior Analysis (ABA) Therapy[3]	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Physical Therapy[3]	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Presurgical Testing	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible

[1] In- and out-of-network services are combined when applying all visit, day and dollar maximums.
[2] Visits may be defined as a day or a number of hours in a day; contact your plan administrator for more information.
[3] Preauthorization is required and you must meet the standards for medical necessity. Failure to preauthorize will result in reimbursement of services being denied.
[4] Cigna: Routine visits are limited to three per calendar year; nonroutine visits are limited to 12 per calendar year.
UHC: Limited to three visits per calendar year; limit extended to 12 visits if medically necessary. Must be provided by a registered dietician or MD. Visits are limited to chronic diseases or conditions in which dietary adjustment has a therapeutic role.

Schedule of Benefits for the Medical Plan—National Coverage Options (continued)

PLAN FEATURES	OPTION A (CIGNA OR UHC)		OPTION B (CIGNA OR UHC)		OPTION C (CIGNA OR UHC)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Outpatient Care (continued)						
Respiratory and Cardiac Therapy[1]	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Speech and Hearing Therapy[1]	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Ambulatory or Outpatient Surgery; Clinic and Other Outpatient Services	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Vision Therapy[1]	80% after annual deductible	Cigna: 80% of Eligible Expenses after annual deductible; UHC: 60% of Eligible Expenses after annual deductible	80% after annual deductible	Cigna: 80% of eligible Expenses after annual deductible; UHC: 60% of Eligible Expenses after annual deductible	80% after annual deductible	Cigna: 80% of Eligible Expenses after annual deductible; UHC: 60% of Eligible Expenses after annual deductible
Mental Health/Substance Abuse[1]						
Plan's Network	Cigna: Cigna Behavioral Health UHC: United Behavioral Health					
Inpatient[1, 2]	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Outpatient[1, 2] Preauthorization required for Mental Health and Substance Abuse intensive outpatient programs. Coinsurance waived if treatment received at certain preferred facilities for substance abuse. Contact Cigna or UHC for details.	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Preventive/Wellness Care[3, 4, 5]						
Cholesterol (Hypercholesterolemia) Screening Limited to one per calendar year.	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible

[1] Preauthorization is required and you must meet the standards for medical necessity. Failure to preauthorize will result in reimbursement of services being denied.
[2] Coinsurance is waived if treatment is received at certain preferred facilities for substance abuse. Contact Cigna or UHC for details.
[3] In- and out-of-network services are combined when applying all visit, day and dollar maximums.
[4] Diagnostic screenings are subject to certain frequency limits, based on age. Medically necessary screenings are not subject to limitations.
[5] The Preventive/Wellness Care limits listed are guidelines only. Additional screenings may be approved by your plan administrator.

Schedule of Benefits for the Medical Plan—National Coverage Options (continued)

PLAN FEATURES	OPTION A (CIGNA OR UHC)		OPTION B (CIGNA OR UHC)		OPTION C (CIGNA OR UHC)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Preventive/Wellness Care[1, 2, 3] (continued)						
Colon Cancer Screening Sigmoidoscopy: age 50+; limited to one every five years. Colonoscopy: age 50+; limited to one every 10 years. Frequency limits do not apply for UHC Plans.	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible
Diagnostic X-Rays, Scans and Lab Tests (Preventive)	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible
Preventive Immunizations (Includes Travel Immunizations)	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible
Mammography Cigna: age 40+; limited to one per calendar year. UHC: No age or frequency limits.	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible
Prostate Cancer Screening (PSA) Up to age 40: Limited to one every two calendar years. Age 40+: Limited to one per calendar year.	Cigna: 100%; UHC: 80% after annual deductible	Cigna: 100% up to $250, then 60% of Eligible Expenses; no annual deductible; UHC: 60% of Eligible Expenses after annual deductible	Cigna: 100%; UHC: 80% after annual deductible	Cigna: 100% up to $250, then 60% of Eligible Expenses; no annual deductible; UHC: 60% of Eligible Expenses after annual deductible	Cigna: 100%; UHC: 80% after annual deductible	Cigna: 100% up to $250, then 60% of Eligible Expenses; no annual deductible; UHC: 60% of Eligible Expenses after annual deductible
Routine GYN Exam (Includes Pap Smear) Limited to one per calendar year.	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible

[1] In- and out-of-network services are combined when applying all visit, day and dollar maximums.
[2] Diagnostic screenings are subject to certain frequency limits, based on age. Medically necessary screenings are not subject to limitations.
[3] The Preventive/Wellness Care limits listed are guidelines only. Additional screenings may be approved by your plan administrator.

Schedule of Benefits for the Medical Plan—National Coverage Options (continued)

PLAN FEATURES	OPTION A (CIGNA OR UHC)		OPTION B (CIGNA OR UHC)		OPTION C (CIGNA OR UHC)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Preventive/Wellness Care[1, 2, 3] (continued)						
Routine Physical Exam and Related Lab Tests Age 3+: Limited to one per calendar year. **Routine Electrocardiogram (With 12 Leads)**	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible
Well-Baby Care Birth to 36 months.	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100%	100% up to $250, then 60% of Eligible Expenses; no annual deductible
Routine Vision Exam Limited to one per calendar year.	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Other						
Birth Control (IUDs, Oral Contraceptives, Injections and Diaphragms) If generic is available, will be paid at 100%.	100% covered; no annual deductible	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100% covered; no annual deductible	100% up to $250, then 60% of Eligible Expenses; no annual deductible	100% covered; no annual deductible	100% up to $250, then 60% of Eligible Expenses; no annual deductible
Hearing Aids Up to age 19: $3,000 maximum benefit every 24 months Age 19+: $3,000 maximum benefit every 36 months.	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible

[1] In- and out-of-network services are combined when applying all visit, day and dollar maximums.
[2] Diagnostic screenings are subject to certain frequency limits, based on age. Medically necessary screenings are not subject to limitations.
[3] The Preventive/Wellness Care limits listed are guidelines only. Additional screenings may be approved by your plan administrator.

Schedule of Benefits for the Medical Plan—National Coverage Options (continued)

PLAN FEATURES	OPTION A (CIGNA OR UHC)		OPTION B (CIGNA OR UHC)		OPTION C (CIGNA OR UHC)	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Other (continued)						
Home Health Care/ Private Duty Nursing[1, 2] Limited to 200 days per calendar year.	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Newborn Circumcision (performed in a Hospital as Part of Initial Hospital Stay)	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Prescribed Durable Medical Equipment[2] UHC: Preauthorization is required for rental or purchase of equipment in excess of $1,000, including insulin pumps.	80% after annual deductible	Cigna: 60% of Eligible Expenses after annual deductible; UHC: 60% of Eligible Expenses after annual deductible; $20,000 annual maximum benefit for feedings and supplies	80% after annual deductible	Cigna: 60% of Eligible Expenses after annual deductible; UHC: 60% of Eligible Expenses after annual deductible; $20,000 annual maximum benefit for feedings and supplies	80% after annual deductible	Cigna: 60% of Eligible Expenses after annual deductible; UHC: 60% of Eligible Expenses after annual deductible; $20,000 annual maximum benefit for feedings and supplies
Prescription Drugs (Including Oral Contraceptives)	See the “Prescription Drugs” section on page 64 for complete details.					

[1] In- and out-of-network services are combined when applying all visit, day and dollar maximums.
[2] Preauthorization is required and you must meet the standards for medical necessity. Failure to preauthorize will result in reimbursement of services being denied.

Cigna Cancer Support Program

If you have Medical Plan coverage administered by Cigna and receive a cancer diagnosis, Cigna will extend its Cancer Support Program (CSP) to you to ensure that you have the resources and support you need during this difficult time. In addition to receiving personalized one-on-one support with a highly experienced RN throughout your illness, if you enroll in the CSP within 30 days of your diagnosis and use an in-network provider, you will also receive higher medical coverage benefits, as outlined in the chart below.

Cigna Option A

	COVERED BENEFIT IF ENROLLED IN CANCER SUPPORT PROGRAM		COVERED BENEFIT IF NOT ENROLLED IN CANCER SUPPORT PROGRAM	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
TO RECEIVE THE FINANCIAL BENEFITS OF THE CANCER SUPPORT PROGRAM, PARTICIPANTS MUST ENROLL WITHIN 30 DAYS OF DIAGNOSIS				
Plan Pays	100% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Annual Out-of-Pocket Maximum	$600 per person $1,250 family maximum	$4,000 per person $10,000 family maximum	$2,000 per person $5,000 family maximum	$4,000 per person $10,000 family maximum

Cigna Option B

	COVERED BENEFIT IF ENROLLED IN CANCER SUPPORT PROGRAM		COVERED BENEFIT IF NOT ENROLLED IN CANCER SUPPORT PROGRAM	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
TO RECEIVE THE FINANCIAL BENEFITS OF THE CANCER SUPPORT PROGRAM, PARTICIPANTS MUST ENROLL WITHIN 30 DAYS OF DIAGNOSIS				
Plan Pays	100% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Annual Out-of-Pocket Maximum	$1,200 per person $2,500 family maximum	$6,000 per person $15,000 family maximum	$3,000 per person $7,500 family maximum	$6,000 per person $15,000 family maximum

Cigna Option C

	COVERED BENEFIT IF ENROLLED IN CANCER SUPPORT PROGRAM		COVERED BENEFIT IF NOT ENROLLED IN CANCER SUPPORT PROGRAM	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
TO RECEIVE THE FINANCIAL BENEFITS OF THE CANCER SUPPORT PROGRAM, PARTICIPANTS MUST ENROLL WITHIN 30 DAYS OF DIAGNOSIS				
Plan Pays	100% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Annual Out-of-Pocket Maximum	$2,300 per person $4,600 family maximum	$11,000 per person $20,000 family maximum	$5,500 per person $11,000 family maximum	$11,000 per person $20,000 family maximum

Please note: Treatments of any kind that are considered by the Plan Administrator to be experimental, investigative and educational, or provided primarily for research (see the *Experimental, Investigational or Unproven Services* definition in the Glossary on page 201 for more details) will not be covered. Benefits will not be provided even if the Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition.

UHC Travel and Lodging Guidelines

If you have Medical Plan coverage administered by UHC and are approved for cancer-related treatments, obesity surgery, eligible knee/hip/spine surgeries through the Spine and Joint Solution (SJS) program, or a transplant procedure, coverage is indicated in the table below. For cancer-related treatments, you are eligible for the travel and lodging reimbursement if you use a UHC Designated Facility that is more than 50 miles from your primary residence. For obesity surgery, knee/hip/spine surgeries through SJS, and transplants, you (or your donor, in the case of a transplant) are only eligible for the reimbursement if there is no UHC Designated Facility within 50 miles of where you live.

TOTAL BENEFITS LIMITED TO A $10,000 LIFETIME MAXIMUM, INCLUDING TRANSPLANT DONOR'S TRAVEL AND LODGING; $1,000 BENEFIT PER SJS SURGERY, SEPARATE FROM $10,000 LIFETIME MAXIMUM

Covered Items	
Lodging	• Allowance of $100 per day for two people ($50 for one)
Travel	• 100% covered, up to total lifetime maximum listed above • Air, train and bus fares at coach rates; car rental, including mileage (if charged by car rental agency); gas; parking (excluding valet) and tolls • Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site where the services are given for the purposes of an evaluation, the procedure or other treatment, or necessary post-discharge follow-up
Items Not Covered	
Convenience and Entertainment	• Telephone, fax • Movies, books and video rentals
Groceries	• Alcoholic beverages, paper products, toiletries, personal hygiene products
Miscellaneous	• Laundry service or dry cleaning, laundry detergent • Gratuities of any kind • Cooking utensils, appliances, meals and furniture
Travel	• Personal car mileage, first-class and business-class airfare; U-Hauls
Travel and Lodging Guidelines	• Designated Facilities are defined as Centers of Excellenceb for bariatric, cancer, SJS and transplant services. • For cancer, lodging and travel offered only through UHC's designated Cancer Resource Centers; please contact UHC directly for additional information. • A maximum Benefit of $10,000 per Covered Person applies for all travel and lodging expenses reimbursed under this Plan in connection with all cancer treatments, transplant procedures and obesity surgery services during the entire period that person is covered under this Plan. Excludes Benefit for SJS surgeries. • A maximum Benefit of $25,000 per Covered Person applies for bone marrow transplants, including transplant donor search, during the entire period that person is covered under this Plan. • A maximum Benefit of $1,000 per surgery per Covered Person applies for eligible procedures under the SJS program. • Original and itemized receipts must be submitted to be eligible for reimbursement.

UHC Cancer Support Program

If you have Medical Plan coverage administered by UHC and receive a cancer diagnosis, UHC will extend its Cancer Support Program (CSP) to you to ensure that you have the resources and support you need during this difficult time. In addition to receiving personalized one-on-one support with a highly experienced RN throughout your illness, if you enroll in the CSP within 30 days of your diagnosis and use an in-network provider, you will also receive higher medical coverage benefits, as outlined in the chart below.

UHC Option A

	COVERED BENEFIT IF ENROLLED IN CANCER SUPPORT PROGRAM		COVERED BENEFIT IF NOT ENROLLED IN CANCER SUPPORT PROGRAM	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
TO RECEIVE THE FINANCIAL BENEFITS OF THE CANCER SUPPORT PROGRAM, PARTICIPANTS MUST ENROLL WITHIN 30 DAYS OF DIAGNOSIS				
Plan Pays	100% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Annual Out-of-Pocket Maximum	$600 per person $1,250 family maximum	$4,000 per person $10,000 family maximum	$2,000 per person $5,000 family maximum	$4,000 per person $10,000 family maximum

UHC Option B

	COVERED BENEFIT IF ENROLLED IN CANCER SUPPORT PROGRAM		COVERED BENEFIT IF NOT ENROLLED IN CANCER SUPPORT PROGRAM	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
TO RECEIVE THE FINANCIAL BENEFITS OF THE CANCER SUPPORT PROGRAM, PARTICIPANTS MUST ENROLL WITHIN 30 DAYS OF DIAGNOSIS				
Plan Pays	100% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Annual Out-of-Pocket Maximum	$1,200 per person $2,500 family maximum	$6,000 per person $15,000 family maximum	$3,000 per person $7,500 family maximum	$6,000 per person $15,000 family maximum

UHC Option C

	COVERED BENEFIT IF ENROLLED IN CANCER SUPPORT PROGRAM		COVERED BENEFIT IF NOT ENROLLED IN CANCER SUPPORT PROGRAM	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**
TO RECEIVE THE FINANCIAL BENEFITS OF THE CANCER SUPPORT PROGRAM, PARTICIPANTS MUST ENROLL WITHIN 30 DAYS OF DIAGNOSIS				
Plan Pays	100% after annual deductible	60% of Eligible Expenses after annual deductible	80% after annual deductible	60% of Eligible Expenses after annual deductible
Annual Out-of-Pocket Maximum	$2,300 per person $4,600 family maximum	$11,000 per person $20,000 family maximum	$5,500 per person $11,000 family maximum	$11,000 per person $20,000 family maximum

For more information, call the UHC CSP team at 866-936-6002.

Please note: Treatments of any kind that are considered by the Plan Administrator to be experimental, investigative and educational, or provided primarily for research (see the *Experimental, Investigational or Unproven Services* definition in the Glossary on page 201 for more details) will not be covered. Benefits will not be provided even if the Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition.

UHC Fertility Solutions Program

If you have Medical Plan coverage administered by UHC and wish to undergo fertility treatments, **you must enroll in the Fertility Solutions program and use a fertility Center of Excellence in order to receive coverage**.

United Resource Networks helps patients obtain care through its Centers of Excellence (COE) network, which includes facilities that meet UHC's standards. Criteria include program volumes and clinical outcomes, patient and family-oriented services, and practice of evidence-based medicine. You will also have a designated fertility nurse available to you throughout your treatment, helping to ensure you get the care and support you need. These requirements have been put in place to help you maximize your fertility benefit and select effective treatment options.

There are more than 100 fertility COE facilities available at 240 locations across the U.S. However, if you do not live within a 60-mile radius of a fertility COE facility, you may contact the Fertility Solutions team at 866-774-4626 to identify a network facility from which you may receive treatment or for assistance with negotiating payment with an out-of-network provider. Certain exclusions for fertility treatment may apply.

All fertility treatments, including those related to cryopreservation, are subject to the Plan's $30,000 lifetime limit on fertility benefits.

What Benefits Are Available as Covered Health Services?

Fertility Services

Therapeutic services for the treatment of fertility when provided by or under the direction of a physician. Benefits under this section are limited to the following procedures:

- Assisted Reproductive Technologies (ART)
- Frozen Embryo Transfer cycle including the associated cryopreservation and storage of embryos
- ICSI (intracytoplasmic sperm injection)
- Insemination procedures (artificial insemination [AI] and intrauterine insemination [IUI])
- Embryo transportation-related network disruption
- Ovulation induction (or controlled ovarian stimulation)
- Testicular Sperm Aspiration/Microsurgical Epididymal Sperm Aspiration (TESA/MESA) – male factor associated surgical procedures for retrieval of sperm
- Surgical procedures: laparoscopy, lysis of adhesions, tubotubal anastomosis, fimbrioplasty, salpingostomy, transcervical catheterization, cystoplasty, metroplasty
- Electroejaculation
- Pre-implantation Genetic Diagnosis (PGD) –to determine whether a gene mutation that the genetic parents carry has been transmitted to the embryo

Enhanced Benefit Coverage

Embryo biopsy for Pre-implantation Genetic Screening (PGS) – used to select embryos for transfer in order to increase the chance for conception

Donor Coverage: – The plan will cover associated donor medical expenses, including collection and preparation of ovum and/or sperm, and the medications associated with the collection and preparation of ovum and/or sperm. The plan will not pay for donor charges associated with compensation or administrative services.

Fertility Preservation for Medical Reasons – when planned cancer or other medical treatment is likely to produce Infertility/sterility. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovarian stimulation and retrieval of eggs, oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Additional Benefit Coverage

Fertility Preservation for Nonmedical Reasons – when you would like to delay pregnancy for nonmedical reasons. Coverage is limited to: collection of sperm, cryopreservation of sperm, ovulation induction and retrieval of eggs, oocyte cryopreservation, ovarian tissue cryopreservation, in vitro fertilization, and embryo cryopreservation. Long-term storage costs (anything longer than 12 months) are not covered.

Single female or female without a male partner – Certain Covered Health Services may be available to female Covered Persons without a male partner. The plan will cover treatment of the female factor causing infertility, therapeutic donor insemination and reciprocal in vitro fertilization (Reciprocal IVF or Partner IVF). Coverage is limited to six attempts of insemination for each female Covered Person. The Plan will cover the Reciprocal IVF or Partner IVF transfer of any resulting embryos to the Covered Person from whom the oocytes were NOT derived. See also the *Exclusions and Limitations* for Gestational Carrier or Surrogate.

Single male or male without a female partner – Certain Covered Health Services may be available to male Covered Persons without a female partner. The plan will cover the diagnosis and treatment of the male factor causing infertility, including collection and preparation of sperm, and the medications associated with the collection and preparation of sperm. See also the *Exclusions and Limitations* for Gestational Carrier or Surrogate.

For UHC Choice Plus Option A, B and C Plans: Any combination of Network Benefits and Non-Network Benefits are limited to a $30,000 maximum per Covered Person per lifetime. This limit includes Benefits for Infertility medications provided under your prescription plan. This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services – Sickness and Injury,* below.

For UHC Core Plans: Limited to a $30,000 maximum per Covered Person, per lifetime. This limit includes Benefits for infertility medications provided under your prescription plan. This limit does not include Physician office visits for the treatment of infertility for which Benefits are described under *Physician's Office Services – Sickness and Injury,* below.

Only charges for the following apply toward the fertility lifetime maximum:

- Surgeon
- Assistant surgeon
- Anesthesia
- Lab tests
- Specific injections

You must enroll in the Fertility Solutions program to receive services from a Designated Provider. To enroll, you can call the telephone number on your ID card or you can call the Fertility Solutions program nurse team at 888-936-7246.

UHC Options A, B and C

	COVERED BENEFIT IF ENROLLED IN FERTILITY SOLUTIONS PROGRAM (AND USE A COE)	COVERED BENEFIT IF NOT ENROLLED IN FERTILITY SOLUTIONS PROGRAM (AND USE A COE)
Plan Pays	80% after deductible is met	Not covered

For more information, call the UHC Fertility Solutions team at 866-774-4626.

UHC Bariatric Resource Services Program

If you have Medical Plan coverage administered by UHC and wish to undergo bariatric surgery, **you must enroll in the Bariatric Resource Services (BRS) program and receive the surgery at a UHC Center of Excellence in order to receive coverage**. BRS is a surgical weight loss solution for individuals who qualify clinically for bariatric surgery. Specialized nurses provide support through all stages of the weight loss surgery process, including decision support in preparation for surgery, information and education around selecting a bariatric surgery program, and post-surgery and lifestyle management. Nurses can provide information on the nation's leading obesity surgery centers, known as BRS Centers of Excellence (COE).

All authorization information and enrollment for bariatric surgery for UHC members must be initiated through the BRS Program. Participants seeking coverage for bariatric surgery should notify UHC as soon as the possibility of a bariatric surgery procedure arises (and before a pre-surgical evaluation is performed).

There are more than 250 BRS COE across the U.S. However, if you do not live within a 50- mile radius of a BRS facility, you may contact the BRS team to identify a network facility from which you may receive treatment, to determine your eligibility for a travel and lodging benefit if you wish to travel to a COE, or to get assistance with negotiating payment with an out-of-network provider.

For more information and to enroll in the program, call the UHC BRS team at **888-936-7246**.

UHC Options A and B

	COVERED BENEFIT IF ENROLLED IN THE BRS PROGRAM	COVERED BENEFIT IF NOT ENROLLED IN THE BRS PROGRAM
Plan Pays	100% covered, no deductible	No coverage

UHC Option C

	COVERED BENEFIT IF ENROLLED IN THE BRS PROGRAM	COVERED BENEFIT IF NOT ENROLLED IN THE BRS PROGRAM
Plan Pays	100% covered after deductible is met	No coverage

UHC Spine and Joint Solution (SJS) Program

The Spine and Joint Solution program is a surgical program that provides access to top-performing, regional surgical centers, called Centers of Excellence (COE), for individuals who meet the criteria for certain inpatient surgeries. Eligible surgeries include: total hip replacements, total knee replacements, spinal fusion surgery and spine disc surgery. Contact your Plan Administrator for more details.

Through the program, you will have access to a specialized nurse team that will provide assistance with finding a COE, answering questions about your treatment plan and helping you understand what to expect throughout your surgery and hospital stay. The SJS nurse will also connect you with 2nd MD, Morgan Stanley's expert medical second opinion vendor, to provide a consultation on your diagnosis and treatment plan.

If you enroll in the SJS program prior to your surgery, use a COE facility and surgeon, and complete a 2nd MD consultation, you will receive higher medical benefits, as outlined in the chart below. (Note that both the facility and surgeon must be part of UHC's COE network).

To enroll in SJS: You or your doctor may call the toll-free number on the back of your UHC ID Card.

UHC Options A, B and C

	COVERED BENEFIT IF ENROLLED IN SJS, USE A COE, AND COMPLETE A 2ND MD CONSULTATION	COVERED BENEFIT IF NOT ENROLLED IN SJS AND USE AN IN-NETWORK PROVIDER	COVERED BENEFIT IF NOT ENROLLED IN SJS AND USE AN OUT-OF-NETWORK PROVIDER
Plan Pays	100% after deductible is met	80% after deductible is met	60% after deductible is met

Medical Plan – National Coverage Options Exclusions

Listed below are services, supplies, medical care and/or treatment options that are excluded under Medical Plan coverage administered by Cigna and UHC. Contact your Plan Administrator directly for information about any additional exclusions that may apply. For regional options exclusions, please visit the Benefit Center website or contact the Plan Administrator directly.

CATEGORY	EXCLUSIONS
Act of War	• Any loss caused or contributed to by any declared or undeclared act of war, riots or insurrection or by an illness or injury sustained while in the armed forces of any country
Acupuncture	• Services not performed by an MD or a certified acupunturist • Services provided by an Oriental Medical Doctor (OMD)
Cryopreservation	• Subject to Plan fertility lifetime maximum amount of $30,000 and limited to 12 months of storage. UHC members must be enrolled in the Fertility Solutions program and use a fertility Center of Excellence. • Certain exclusions and limitations apply. Contact Plan Administrator for details.
Custodial/Convalescent Care	• The following services for confinement for custodial or convalescent care, rest cures or long-term custodial health care: – Nonhealth-related services such as daily living assistance (including, but not limited to, feeding, dressing, bathing, transferring, ambulating) – Health-related services that do not seek to cure or that are provided when the patient's medical condition is not changing – Health-related services that do not require continued administration by trained medical personnel to be delivered safely and effectively – Other custodial services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care
Dental Services	• Any dental services, other than those required as a result of an accidental injury to sound, natural teeth if service is provided within six months of injury (or within 12 months if medically necessary), or due to a congenital syndrome or teeth lost due to cancer treatment. Doctor's services for X-ray examinations in conjunction with mouth conditions due to a periodontal or periapical disease, or any condition (other than a malignant tumor) involving teeth, surrounding tissue or structure, the alveolar process or the gingival tissue • Care of or treatment to the teeth, gums or supporting structures, including, but not limited to, periodontal treatment, endodontic services, extractions, implants or any treatment to improve the ability to chew or speak, with the exception of services related to treatment of temporomandibular joint (TMJ) disorders • Oral appliances or orthotic splints, even if related to the treatment of TMJ • Surgical correction or other treatment of malocclusion • Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums, including: – Transplant preparation (Cigna only) – Extraction, restoration and replacement of teeth – Medical or surgical treatments of dental conditions – Services to improve dental clinical outcomes

Medical Plan – National Coverage Options Exclusions (continued)

CATEGORY	EXCLUSIONS
Dental Services (continued)	• Dental implants where a clinically acceptable alternative is available • Dental braces • Dental X-rays, supplies and appliances, and all associated expenses, including hospitalizations **NOTE:** The following procedures and treatments may be covered, as determined by the Plan Administrator as noted below: • Transplant preparation (UHC only) • Initiation of immune suppressives • The direct treatment of acute traumatic injury, cancer or cleft palate • Anesthesia and any related facility charges for dental procedures, limited to the following: – Individual who is age 7 years or younger – Individual who is severely psychologically impaired or developmentally disabled – Individual who has one or more significant medical disorders or diseases that preclude the use of other local anesthesia or conscious sedation or for which careful monitoring is required during and immediately following the planned procedure
Eligibility	• Charges for treatment or supplies received (a) before coverage under the Plan begins, or (b) after it is terminated, including health services for medical conditions beginning before the date your coverage under the Plan starts • Expenses incurred by a dependent if they are covered as an employee for the same services under the Plan
Experimental/Investigative	• Treatments of any kind that are considered by the Plan Administrator to be experimental, investigative and educational or provided primarily for research (see *Experimental, Investigational or Unproven Services* definition in the Glossary, starting on page 201). Benefits will not be provided even if the Experimental, Investigational or Unproven Service, treatment, device or pharmacological regimen is the only available treatment for a particular condition
Fertility	• For UHC members, services not received at a fertility Center of Excellence • The following services related to Gestational Carrier or Surrogate: – Fees for the use of a Gestational Carrier or Surrogate – Insemination costs of Surrogate or transfer of embryo to Gestational Carrier except as provided under Additional Benefit Coverage for Reciprocal IVF or Partner IVF – Pregnancy services for a Gestational Carrier or Surrogate who is not a Covered Person – The reversal of voluntary sterilization – Fees or direct payment to a donor for sperm or ovum donations – Long-term storage (longer than one year) of reproductive materials such as sperm, eggs, embryos, ovarian tissue and testicular tissue. Monthly fees for maintenance and/or storage of frozen embryos after 12 months are not covered under the Plan – Health services associated with the use of nonsurgical or drug-induced pregnancy termination – Any experimental, investigational or unproven fertility procedures or therapies, as determined by the Plan Administrator – Donor services and nonmedical costs of oocyte or sperm donation, such as donor agency fees – Ovulation predictor kits – Artificial reproductive treatments done for nongenetic disorder sex selection or eugenic (selective breeding) purposes – Fertility treatment with voluntary sterilization currently in place (vasectomy, bilateral tubal ligation) – Fertility treatment following the reversal of voluntary sterilization (tubal reversal/ reanastomosis; vasectomy reversal/ vasovasostomy or vasoepididymostomy)

Medical Plan – National Coverage Options Exclusions (continued)

CATEGORY	EXCLUSIONS
Fitness	• Membership fees or costs for health clubs, weight loss clinics and similar programs • Physical conditioning programs such as athletic training, bodybuilding, exercise, fitness, flexibility and/or general motivation • Personal trainers
Foot Care	• Routine foot care, including care of, paring and removing of corns, bunions, calluses, toenails, flat feet, fallen arches, weak feet and chronic foot strain, except to treat severe systemic disease • Foot care related to diabetes and peripheral vascular disease is covered • Symptomatic complaints of the feet, except capsular or bone surgery related to bunions and hammertoes • Shoe orthotics, except for custom-molded shoe inserts prescribed to treat a disease or illness of the foot • Hygienic and preventive maintenance foot care, including: – Cleaning and soaking the feet – Applying skin creams in order to maintain skin tone – Other services that are performed when there is not a localized illness, injury or symptom involving the foot • Treatment of subluxation of the foot
Government Agency/Laws/Plans	• Services or supplies furnished by or reimbursable through a government-sponsored agency or program (except as provided under the Medicare secondary payer rules) • Services for care provided in any government hospital or facility when the individual is eligible for government benefits • Services or supplies (a) furnished by or for any government, unless payment is legally required, or (b) to the extent that such services or supplies are provided by any governmental program or law under which the individual is, or could be, covered – Item (b) does not apply to Medicaid or to any law or plan when its benefits are in addition to a private plan or program • Services covered under Workers' Compensation, no-fault automobile insurance or similar statutory programs • Services furnished by governmental plans • Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you • Health services while on active military duty
Hearing	• Hearing aids, in excess of $3,000 Plan maximum every 36 months for persons age 19 and over and every 24 months for children up to age 19
Hospital Charges	• Charges made by a hospital for confinement in a special area of the hospital that provides nonacute care, including, but not limited to, the type of care given by the facilities listed below. If that type of facility is otherwise covered under this Plan option, then benefits for that covered facility which is part of a hospital are payable at the coverage level for that facility, not at the coverage level for a hospital – Adult or child day care center – Birth center (birth centers are paid at the same as the hospital benefit) – Halfway house – Hospice – Skilled nursing facility – Treatment center – Vocational rehabilitation center • Any other area of a hospital that renders services on an inpatient basis for care other than the acute care of sick, injured or pregnant persons

Medical Plan – National Coverage Options Exclusions (continued)

CATEGORY	EXCLUSIONS
Medical Supplies and Appliances	• Devices used specifically as safety items or to affect performance in sports-related activities • Prescribed or nonprescribed supplies and disposable supplies such as elastic stockings, ace bandages, other bandages, skin preparations, test strips, gauze and dressings (ostomy supplies and catheters are covered; UHC also covers lymphedema stockings) • Tubings, nasal cannulas, connectors and masks are not covered except when used with durable medical equipment
Medications	• Services for prescription and nonprescription medications, unless administered while in a hospital or emergency room (may be covered by prescription drug benefits) • Prescription drug products for outpatient use that are filled by a prescription order or refill (may be covered by prescription drug benefits) • Self-injectable medications (may be covered under prescription drug benefits) • Noninjectable medications given in a physician's office, except as required in an emergency
Mental Health/Substance Abuse	• Any court-ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under the Plan • Treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain • Developmental disorders, including, but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders • Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association • Services for mental health/substance abuse that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention • Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other mental illnesses that are not expected to substantially improve beyond the current level of functioning, or that are not expected to be subject to favorable modification or management according to prevailing national standards of clinical practice, as determined by the Plan Administrator or its mental health/substance abuse vendor • Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Plan Administrator or its mental health /substance abuse vendor • Services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance abuse disorders that, in the reasonable judgment of the Plan Administrator or its mental health/substance abuse vendor, are any of the following: – Not consistent with prevailing national standards of clinical practice for the treatment of such conditions – Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome – Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost-effective – Not consistent with the Plan Administrator's or its mental health/substance abuse vendor's guidelines or best practices as modified from time to time – The Plan Administrator or its mental health/substance abuse vendor may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria • Nonroutine and routine use of psychological testing without preauthorization

Medical Plan – National Coverage Options Exclusions (continued)

CATEGORY	EXCLUSIONS
Miscellaneous	• Lamaze classes • Ecological or environmental medicine, diagnosis and/or treatment • Herbal medicine or holistic or homeopathic care, including drugs • Acupressure, aromatherapy, hypnotism, Rolfing and other forms of alternative medicine as defined by the Office of Alternative Medicine of the National Institutes of Health • Chelation therapy, except to treat heavy metal poisoning • Circumcision not performed in a hospital as part of initial hospital stay • Naturopaths and naturalists • Massage therapy • Enteral feedings and other nutritional and electrolyte formulas, including infant formula, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low-fat, low-cholesterol), oral vitamins and oral minerals, except when a certain enteral formula is needed as the sole source of nutrition or for the treatment of inborn errors of metabolism • Feedings provided through a feeding tube necessary to treat a metabolic condition or to treat and control symptoms and progressions of an illness or disease (if covered by your Medical Plan option) require preauthorization. If services are not preauthorized, coverage will be denied (exclusion under UHC only; not an exclusion under Cigna). • Vitamins, minerals, megavitamin and nutrition-based therapy • Services payable by another plan or insurer under the Coordination of Benefits provisions of the Medical Plan • Travel or transportation expenses, even though prescribed by a physician, unless provided under the Travel and Lodging provision • If an out-of-network provider waives copays and/or the annual deductible for a particular health service, no benefits are provided for the health service for which the copays and/or annual deductible are waived. • Respite care • Psychosurgery • Stem cell maintenance and storage • Treatment of benign gynecomastia (abnormal breast enlargement in males) unless determined to be medically necessary by the Plan Administrator • Medical and surgical treatment of excessive sweating (hyperhidrosis) (exclusion under UHC only; not an exclusion under Cigna) • Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea • Appliances for snoring

Medical Plan – National Coverage Options Exclusions (continued)

CATEGORY	EXCLUSIONS
Miscellaneous (continued)	• Any charges for room or facility reservations or record processing • Any charges higher than the actual charge. The actual charge is defined as the provider's lowest routine charge for the service, supply or equipment • Any charge for services, supplies or equipment advertised by the provider as free • Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency • Any charges prohibited by federal anti-kickback or self-referral statutes • Any charges by a resident in a teaching hospital where a faculty physician did not supervise services • Treatment consisting of routine, long-term or nonmedically necessary care provided to prevent recurrences or to maintain the patient's current status • Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness such as asthma or allergies • Services performed by Christian Science practitioners • Craniosacral/cranial therapy • Dance and movement therapy • Applied kinesiology • Prolotherapy • Extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions • Nonmedical counseling or ancillary services, including, but not limited to, custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back-to-school and return-to-work services, work hardening programs, driving safety, and services, training, educational therapy or other nonmedical ancillary services for learning disabilities, autism or mental retardation • Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to, routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected • Blood administration for the purpose of general improvement in physical condition
Preventive Care	• Services not categorized as preventive under the Plan • Vision perception training
Smoking Cessation Programs	• Transdermal patches/nicotine gum • Treatment provided in connection with tobacco dependency, except Tobacco Cessation programs provided by the Plan Administrator. Once you have registered with the online program, you may choose over-the-counter nicotine replacement therapy, either patches or gum, at no cost to you. The over-the-counter therapy is available once per participant, per calendar year.

Medical Plan – National Coverage Options Exclusions (continued)

CATEGORY	EXCLUSIONS
Special Charges/Services	• Any services, treatments or supplies administered by a facility that is not licensed under state law • Fees or charges made by an individual, agency or facility operating beyond the scope of its license • Any services, treatments or supplies that are not medically necessary for the prevention, diagnosis or treatment of an illness, injury or pregnancy, as determined by the Plan Administrator • Health services and supplies that do not meet the definition of *Covered Health Services*, as defined in the Glossary • Physical, psychiatric or psychological exams, testing, vaccinations, immunizations (except travel immunizations) or treatments that are otherwise covered under the Medical Plan when: – Required solely for purposes of career, education, sports or camp, travel,[1] employment, insurance, marriage or adoption – Related to judicial or administrative proceedings or orders – Conducted for purposes of medical research – Required to obtain or maintain a license of any type • Services for hospital confinement primarily for diagnostic studies • Education, training, and bed and board while confined in an institution that is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home • Services, supplies, medical care or treatment given by one of the following members of the employee's immediate family: – The employee's spouse or domestic partner – The child, brother, sister, parent or grandparent of either the employee or the employee's spouse or domestic partner • Services performed by a provider with your same legal residence • Charges in excess of the Eligible Expenses fee, other than for out-of-network emergency room services or emergency transportation • Services and supplies for which no charge is made or for which you or a dependent have no legal obligation • Services given by volunteers or persons who do not normally charge for their services • Services for telephone consultations (excluding telemedicine), charges for failure to keep a scheduled visit, charges for completion of a claim form or charges for giving information concerning a claim • Charges for any confinement or treatment given in connection with a service or supply that is not covered under the Plan

[1] Physical, psychiatric or psychological exams, testing, vaccinations, immunizations (except travel immunizations) or treatments for travel are covered under UHC.

Medical Plan – National Coverage Options Exclusions (continued)

CATEGORY	EXCLUSIONS
Special Charges/Services (continued)	• Separate charges by interns, residents, house physicians or other health care professionals who are employed by the covered facility • Services provided at a freestanding or hospital-based diagnostic facility without an order written by a physician or other provider. Services that are self-directed to a freestanding or hospital-based diagnostic facility. Services ordered by a physician or other provider who is an employee or representative of a freestanding or hospital-based diagnostic facility, when that physician or other provider (a) has not been actively involved in your medical care prior to ordering the service, or (b) is not actively involved in your medical care after the service is received. This exclusion does not apply to mammography testing. • Standby services required by a physician • Services given by a pastoral counselor • Expenses you would not be required to pay for if there were no health coverage • Personal convenience or comfort items including TVs, telephones, first-aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs • Devices and computers to assist in communication and speech, except when there is no other ability, verbally or otherwise, to communicate. Before purchasing one of these devices, there is a mandatory three-month rental period. Home remodeling to accommodate a health need (such as ramps and swimming pools) is excluded. • Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that are, at the time of determination: – Not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, and not identified in the American Hospital Formulary Service or the U.S. Pharmacopoeia Dispensing Information as appropriate for the proposed use – Subject to review and approval by any institutional review board for the proposed use – The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial as set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight, or not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed • Speech therapy related to articulation disorders, unless determined to be medically necessary by the Plan Administrator and as required for treatment of a speech impediment or speech dysfunction that results from injury, illness, cancer, stroke, autism spectrum disorders, a congenital anomaly, or is needed following the placement of a cochlear implant; and except for developmental delay in children under 18 for UHC; no age limit for Cigna • Nonrestorative therapies

Medical Plan – National Coverage Options Exclusions (continued)

CATEGORY	EXCLUSIONS
Surgery	• Services for cosmetic procedures, which are defined as procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Plan Administrator, except for reconstructive surgery following a mastectomy. Examples include: – Pharmacological regimens, nutritional procedures or treatments – Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures) – Skin abrasion procedures performed as a treatment for acne • Reconstructive procedures are covered. Services are considered reconstructive procedures when a physical impairment exists and the primary purpose of the procedure is to improve or restore physiologic function for an organ or body part. By "improving or restoring physiologic function," it is meant that the target organ or body part is made to work better. Benefits for reconstructive procedures include breast reconstruction following a mastectomy and reconstruction of the nonaffected breast to achieve symmetry, as mandated by the Women's Health and Cancer Rights Act of 1998. • Reversal of vasectomy or tubal ligation • Upper and lower jawbone surgery is not covered, except as required for direct treatment of acute traumatic injury or cancer or TMJ. • Orthognathic surgery and jaw alignment, except as for the treatment of temporomandibular joint disorders(TMJ) or, except as treatment for obstructive sleep apnea or to repair or correct a severe facial deformity or disfigurement that orthodontics alone cannot correct, provided that the deformity or disfigurement is accompanied by a documented, clinically significant functional impairment and there is reasonable expectation that the procedure will result in meaningful functional improvement; or the orthognathic surgery is medically necessary as a result of tumor, trauma or disease; or the orthognathic surgery is performed prior to age 19 and is required as a result of a severe congenital facial deformity or congenital condition. Repeat or subsequent orthognathic surgeries for the same condition are covered only when the previous orthognathic surgery met the above requirements and there is a high probability of significant additional improvement as determined by the utilization review. Preauthorization is required. • Surgery is considered cosmetic (and excluded) when used to improve the gender-specific appearance of a patient who has undergone or is planning to undergo gender-reassignment surgery, including, but not limited to: reduction thyroid chondroplasty, liposuction, rhinoplasty, facial bone reconstruction, face lift, blepharoplasty, voice modification surgery, hair removal/hairplasty, and breast augmentation. **Note:** Covered gender reassignment services may include any of the following male-to-female procedures: orchiectomy, penectomy, vaginoplasty, clitoroplasty, labiaplasty; and, the following female-to-male procedures: hysterectomy, salpingo-oophorectomy, vaginectomy, metoidioplasty, scrotoplasty, urethroplasty, placement of testicular prostheses, phalloplasty. Preauthorization for covered gender reassignment surgeries and treatments is required.
Telemedicine	• Behavioral Health,[2] lactation services, services requiring a test, complex conditions, chronic conditions, visits outside the U.S., sprained or broken bones requiring bandaging, services requiring a hands-on exam and services not related to acute episodic care
Temporomandibular Joint Disorders (TMJ)	• Oral appliances or orthotic splints, even if related to treatment of TMJ

[1] Telemedicine not available in states where prohibited by law.
[2]. Cigna members: For behavioral health-covered services, visit cignabehavioral.com or UHC members call 888-332-8891.

Medical Plan – National Coverage Options Exclussions (continued)

CATEGORY	EXCLUSIONS
Transplant Services	• Health services for transplants involving mechanical or animal organs • Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person • Health services for organ and tissue transplants that are not listed below. Any multiple-organ transplant not listed below, unless determined by the Plan Administrator to be a proven procedure for the involved diagnoses: – Heart transplants – Heart/lung transplants – Lung transplants – Kidney transplants – Kidney/pancreas transplants – Liver transplants – Liver/small bowel transplants – Pancreas transplants – Small bowel transplants – Some bone marrow transplants; contact your Plan Administrator for information
Vision Care	• Eyeglasses or contact lenses unless required due to accidental injury or cataract surgery (eyeglasses and contact lenses limited to the first pair of contact lenses or first pair of eyeglasses following keratoconus or cataract surgery only) • Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism, including procedures such as radial keratotomy, laser and other refractive eye surgery
Weight-Related[1]	• Weight loss programs, whether or not they are under medical supervision Weight loss programs for medical reasons are also excluded. • Nonsurgical treatment of obesity, including morbid obesity • Surgical treatment of obesity is excluded unless severe morbid obesity (defined as BMI greater than 40, or BMI of 35 with additional diseases or disorders); covered only with preauthorization • Abdominoplasty • Panniculectomy • Liposuction
Wigs/Toupees	• Wigs or toupees, unless the cause of hair loss is cancer, alopecia, dermatophytosis of scalp, leukemia, lupus erythematosus, diseases that cause hair loss, burns or injuries that cause hair loss or prevent hair regrowth, and drugs that cause hair loss, including radiation or chemotherapy. For these purposes, there is a limit of one wig/toupee ($500 maximum) per calendar year. • Excludes hair transplants, hair weaving or any drug if it is used in connection with baldness or to promote hair growth. No additional allowance is payable for liquid adhesive, adhesive remover, wipes/solvents and tape.

[1] The Medical Plan offers weight loss tools and resources to support your good health. Please visit your plan administrator's website for information about available weight loss programs.

Prescription Drugs

The Morgan Stanley Medical Plan includes prescription drug coverage. If you elect Option A, B or C administered by UHC or Cigna, your prescription drug coverage is administered by Express Scripts.

If you participate in one of the regional coverage options, prescription drug coverage is administered through your regional Plan Administrator. Please contact the Plan Administratoror visit its website for information about prescription drug copays, preferred drug or formulary lists and managed drug programs.

Your prescription drug coverage includes a Tier 1 Generic, Tier 2 Preferred Brand-Name Formulary and Tier 3 Nonpreferred Brand-Name Formulary and Specialty Medications

Some prescription drugs have two names: the chemical or **generic** name, and the trademark or **brand** name. By law, both generic and brand- name drugs must contain the same active ingredients and meet the same standards for safety, strength and quality. Inactive ingredients, such as dyes, fillers and preservatives, may vary.

Generic drugs are often medications for which a patent has expired. That means that competing companies can produce the same drug since it is no longer protected by a patent. Generic drugs are usually less costly than brand-name medications. Generic drugs, except for specialty generic medications, are listed under Tier 1. Preferred drugs, also referred to as “formulary” drugs, are brand-name drugs placed on Tier 2 at a lower coinsurance than brand-name drugs not on the preferred list. Nonpreferred drugs and specialty drugs are listed under Tier 3 formulary.

The prescription drug program offers the option to fill your prescriptions at a retail pharmacy or through a mail service program.

Options A and B: When you have a prescription filled at a retail pharmacy, such as a drug store, you must first meet your annual prescription drug deductible before the Plan provides any payment. Prescription drug copays and coinsurance count toward your annual prescription drug out-of-pocket maximums and deductibles (but will not count toward your annual medical out-of-pocket maximums or deductibles).

- Mail service allows you to receive up to a 90-day supply of your prescription and usually reduces your out-of-pocket expenses.
- **Option C:** Your prescription drug deductible and out-of-pocket maximum are combined with your medical deductible. Copays and coinsurance will apply toward your deductible and out-of-pocket maximum for nonpreventive drugs. Copays and coinsurance for any preventive drugs will apply only toward your out-of-pocket maximum amounts.

Out-of-Network Coverage

If you fill a prescription at a retail pharmacy that is not in Express Scripts’ network:

- You will be reimbursed based upon the in-network cost of the drug, and will be responsible for any coinsurance due, according to the schedule on the following pages, and
- You will be responsible for the difference in the total cost of the drug between the out-of-network pharmacy and an in-network pharmacy,
- You will need to pay the entire cost up front and submit a claim form to Express Scripts with your receipt in order to be reimbursed.

For example, if you have already met your annual deductible and the total cost of a Preferred Brand Name Drug is $120 at an out-of-network pharmacy and $100 at an in-network pharmacy:

- You are responsible for the difference between $120-$100 ($20), and
- Since you would be reimbursed for only the in-network cost of $100, based upon the schedule above, you would also be responsible for 30% coinsurance ($30).
- You would pay $120 upfront and be reimbursed $70.

As a result of the Affordable Care Act, certain over-the-counter drugs (such as aspirin, contraceptives, folic acid, etc.) may not require a copay or deductible if you have a prescription.

Maintenance Medications Through Express Scripts

If you use maintenance medications for an ongoing condition such as high blood pressure or diabetes, you are required to fill your maintenance drug prescriptions at a 90-day supply through the Express Scripts network. This network includes the CVS Smart 90 program, Capsule Pharmacy or the Express Scripts Pharmacy (home delivery).

You will be provided three 30-day grace fills at a retail pharmacy. If you do not fill your medication at one of the Express Script, CVS Smart 90 or Capsule network pharmacies starting at the fourth fill, you will pay 100% of the drug cost. This means you will have to pay the full cost out of your own pocket, and the payment will not count toward your plan's deductible or out-of-pocket maximum.

Members continue to have access to their current 30-day pharmacy network to fill prescriptions for acute medications.

Express Scripts Pharmacy

Express Scripts Pharmacy is Express Script's mail-order option. To start using Express Scripts Pharmacy, you can choose between these easy options:

- Call Express Scripts at the toll-free number on the back of your member ID card and let Express Scripts do all the work. For most medications, Express Scripts will be able to contact your doctor for you and arrange for your first mail-order supply.
- Visit www.express-scripts.com/StartHD. After logging in, select "Transfer your retail prescriptions" to get started. The Express Scripts Pharmacy will contact your doctor for you to obtain a 90-day prescription.
- Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to one year (if appropriate). Then, ask your doctor to electronically send the prescription to the Express Scripts Pharmacy.

To transfer any remaining maintenance medication refills from a retail pharmacy to home delivery, log in or register at www.express-scripts.com and look for "Transfer to home delivery" on the home page. Select the medications you'd like to transfer, click "Add to Cart" and checkout. Express Scripts does the rest.

Capsule Pharmacy

Capsule Pharmacy delivers your medications the same day for free – including 90-day maintenance medications.[1] You'll also enjoy a 10% discount on over-the-counter drugs. Capsule currently services select major cities and their suburbs, with plans to grow nationally. To learn more and see if Capsule services your area, go to http://www.capsule.com/morganstanley.

Filling Prescriptions Abroad

If you have a prescription filled while traveling outside of the U.S., you will be required to pay the cost of the prescription and submit a claim form for reimbursement. Please submit the prescription drug receipt with a claim form to Express Scripts for processing. Prescriptions will be reimbursed based on the Express Scripts discounted rate, less any applicable copays, coinsurance and deductibles, but there must also be a corresponding U.S.-equivalent medication.

Accredo, Express Scripts Specialty Pharmacy Program

You are required to obtain your specialty medications through Express Scripts' specialty pharmacy, Accredo, which provides many vital services not available through retail pharmacies. For non-urgent specialty medications, it is optimal to initiate filling at Accredo with the first fill, at the point when you are in greatest need of specialized pharmacy support and therapy education. For medications that may require an immediate start, one courtesy fill at a retail pharmacy is allowed. After this courtesy fill is exhausted, you must pay the full cost of the prescription if you have not transitioned your maintenance medications to Accredo.

[1] Delivery timing will ultimately depend on when the medication is ordered and on available delivery windows in your area. Same-day delivery is not guaranteed.

Managing Prescription Drug Costs With the Step Therapy Program

To help manage the continued escalation in health care costs, the Step Therapy Program was implemented to identify different medications that treat the same illnesses or conditions and recommend less expensive alternatives. Drugs included in the Step Therapy Program are grouped into categories, based on cost:

- **Front-Line Drugs** – Generic medications that are lower-cost alternatives than brand-name drugs. The Step Therapy Program is designed to encourage you and your physician to try or consider Front-Line Drugs first, because they often provide the same health benefit as more expensive drugs at a fraction of the cost.
- **Step 2 Drugs** – Typically, brand-name drugs considered to be lower-cost alternatives to other brand-name drugs, and which provide effective treatment. Because they are not generic, Step 2 Drugs typically cost more than Front-Line Drugs. You and your physician are encouraged to try Step 2 Drugs before higher-cost Step 3 Drugs (described below).
- **Step 3 Drugs** – Brand-name drugs that are more expensive than Front-Line Drugs and Step 2 Drugs. To reduce your prescription drug costs, it is recommended that you and your physician consider Front-Line or Step 2 Drugs before Step 3 Drugs.

As part of this program, certain drugs are designated as subject to the Step Therapy Program. When you submit a prescription for a drug included in the Step Therapy Program to a retail pharmacy or through the Mail Service program, and it is not for a drug included in the lowest available category, your pharmacist will let you know. (Sometimes there may be alternatives in only two of the three categories described.) Your pharmacist will then give you the option of paying the full cost of the drug or speaking to your physician about a suitable alternative medication.

Only your physician can approve and change your prescription to a Front-Line or Step 2 Drug. You or your physician may call Express Scripts at 800-753-2851 to learn what alternative drugs are available for your condition or to find out whether a particular drug is part of the Step Therapy Program.

Express Scripts may contact your physician to discuss the appropriate course of treatment and request consideration of a preferred drug or generic equivalent. This consultation may result in your physician prescribing a different dosage or brand-name product or generic drug in place of your original prescription. Express Scripts will not change your prescription without written consent from your physician.

Prior Authorization

Prior Authorization helps ensure that prescribed medications are being used for their approved indications and prevents expensive medications from being used unnecessarily.

Certain covered drugs are only allowed with Prior Authorization from Express Scripts, including Step 2 or Step 3 drugs in the Step Therapy Program.

If you have any questions about whether a drug or a drug class requires Prior Authorization, contact Express Scripts by calling the number on the back of your medical or prescription ID card.

If you submit a prescription for a drug that requires Prior Authorization to a retail pharmacy or through the Mail Service program and you have not obtained Prior Authorization, your pharmacist should let you know. Your pharmacist should give you the option of paying the full cost of the drug or following up with your physician. If your pharmacist tells you that your prescription needs Prior Authorization, it means that more information is needed. Only your physician can provide this information and request Prior Authorization.

To obtain Prior Authorization, your physician may call Express Scripts at 800-753-2851. Prior Authorization is granted or denied by Express Scripts at its discretion. If your physician obtains Prior Authorization for a drug that requires it, your prescription can be filled at a cost that is equivalent to the Tier 2 Preferred Brand-Name or Tier 3 Nonpreferred Brand-Name formulary drug costs, depending on the drug. This copay structure will also apply to Step 2 or Step 3 drugs that have received Prior Authorization. **If your physician does not obtain Prior Authorization for a drug that requires it, you may fill your prescription as written, but you will pay the full cost of the drug and receive no Prescription Drug Plan benefits.**

Express Scripts may contact your physician to discuss the appropriate course of treatment and request consideration of a preferred drug or generic equivalent. This may result in your physician prescribing a different dosage or brand-name product or generic drug in place of your original prescription. Express Scripts will not change your prescription without written consent from your physician. It is always up to you and your physician to determine the most appropriate drug for you.

Prescription Drug Coverage Benefits at a Glance

If you have Medical Plan coverage administered by Cigna or UHC, you will receive prescription drug coverage from Express Scripts. If you participate in the Grandfathered Morgan Stanley Retiree Medical Plan ("Core"), please refer to that section for the schedule of benefits. For a complete list of covered prescription drugs, visit www.express-scripts.com.

EXPRESS SCRIPTS FEATURES	RETAIL PHARMACY PROGRAM	MAIL SERVICE PROGRAM
Annual Deductible for Option A and Option B	$50 per person $150 family maximum	No annual deductible **Maintenance Drugs:** Maintenance medications must be purchased through a CVS, Capsule or Express Scripts pharmacy (home delivery.). Participant will be provided three lifetime 30-day grace fills per medication at a retail pharmacy. At the fourth retail fill, participant pays the full cost of the drug if not purchased through a CVS, Capsule or Express Scripts pharmacy (home delivery).. The cost for the drug will not apply toward the participant's annual deductible or out-of-pocket maximum amounts, if any. **Diabetic supplies and medications (excluding durable medical equipment):** Participant's annual deductible, if any, will be waived and a $0 copay will apply at mail-order and in-network retail pharmacies for 30-day and 90-day fills.
Annual Deductible for Option C	Combined medical and prescription drug (applies to both retail and mail) $2,300 individual/$4,600 family (true family deductible) **Preventive drugs:** Deductible does not apply **Nonpreventive drugs:** Deductible applies before Plan pays benefits	**Maintenance Drugs:** Maintenance medications must be purchased through a CVS, Capsule or Express Scripts pharmacy (home delivery) Participant will be provided three lifetime 30-day grace fills per medication at a retail pharmacy. At the fourth retail fill, participant pays the full cost of the drug if not purchased through mail-order or participating Smart 90 pharmacy. The cost for the drug will not apply toward participant's annual deductible or out-of-pocket maximum amounts, if any. Additional three 30-day grace fills will be provided if the dosage or medication is changed. **Diabetic supplies and medications (excluding durable medical equipment):** The participant's annual deductible, if any, will be waived and a $0 copay will apply at mail-order and in-network retail pharmacies for 30-day and 90-day fills.
Annual Out-of-Pocket Maximum for Option A and Option B	$2,450 per person $6,125 family maximum Applies to retail and mail	
Annual Out-of-Pocket Maximum for Option C	**In-Network** $5,500 per person (combined medical and prescription drugs) $11,000 family maximum (combined medical and prescription drugs) **Out-of-Network** $11,000 per person (combined medical and prescription drugs) $20,000 family maximum (combined medical and prescription drugs)	

EXPRESS SCRIPTS FEATURES	RETAIL PHARMACY PROGRAM	MAIL SERVICE PROGRAM
Tier 1 Generic Drugs[1]	$10 copay for up to a 30-day supply	$20 copay for up to a 90-day supply
Tier 2 Preferred Brand-Name Drugs	30% member coinsurance for up to a 30-day supply $25 minimum/$75 maximum	30% member coinsurance for up to a 90-day supply $65 minimum/$150 maximum
Tier 3 Nonpreferred Brand-Name Drugs (Includes all specialty drugs)	40% member coinsurance for up to a 30-day supply $50 minimum/$150 maximum for nonspecialty; $200 maximum for specialty	40% member coinsurance for up to a 90-day supply $125 minimum/$300 maximum for nonspecialty; $400 maximum for specialty
Brand-Name Drugs, where generics are available	**Member pays the brand copay plus the difference in cost between the brand name and the generic**; this cost will not apply to your annual deductible, or your out-of-pocket maximum.	

[1] If the brand-name drug is requested when a generic alternative is available and the prescription does not indicate Dispense as Written ("DAW"), the member will pay the generic copay plus the difference in cost between the brand-name drug and generic. *The surcharge will not apply to the member's deductible but will apply toward the out-of-pocket maximum.*

Prescription Drug Exclusions and Limitations

The following list of exclusions and limitations are applicable only if you are enrolled in the Medical Plan administered by Cigna or UHC and receive prescription drug coverage through Express Scripts.

MEDICATION	EXCLUSION OR LIMITATION
Most over-the-counter medications (any medication not requiring a prescription) and prescription drugs that have an over-the-counter equivalent	Generally excluded, except for certain preventive drugs as mandated by the Affordable Care Act with a doctor's prescription
Devices for respiratory therapy, ostomy supplies or other pharmacy devices	Excluded
Hair loss prescriptions (for example, Propecia)	Excluded
Renova	Excluded
Erectile dysfunction prescriptions (for example, Viagra)	Limited to 10 units per 30-day supply
Vitamins (for purposes other than prenatal), minerals and food supplements	Generally excluded but contact Express Scripts to confirm coverage. Select prescription-only vitamins are covered.
Infant formula or nutritional supplements	Generally excluded, but contact Express Scripts to confirm coverage
Prior Authorization fertility drugs	Excluded when it exceeds the combined $30,000 medical and prescription drug lifetime maximum plan benefit per covered person; the lifetime maximum applies across plan options
Specialty medications (including those for growth-deficiency disorders, psoriasis, hepatitis C, severe allergic asthma and rheumatoid arthritis, cystic fibrosis, multiple sclerosis, pulmonary hypertension, cholesterol, corticotrophins, hemophilia, Synagis, inflammatory conditions, fertility and new-to-market therapies)	Diagnosis and Prior Authorization are required
Prescription drugs used for cosmetic treatment	Excluded
Drug classes requiring Prior Authorization	Prior Authorization is required. See page 66. If your physician does not obtain Prior Authorization for a drug that requires it, you may fill your prescription as written, but you will pay the full cost of the drug and receive no Prescription Drug Plan benefits. The Prior Authorization list is subject to change and may not reflect all drugs which require prior authorization. Contact your Plan Administrator with any questions.
Insulin Pumps	Excluded
Zolgensma	Excluded
Medical Foods	Excluded
Blood and Blood Plasma Products	Excluded
Allergy Sera	Excluded
Gene Therapies (covered under medical)	Excluded

Right to Reimbursement (Subrogation Agreement)

The Medical Plan has the right to receive reimbursement for any recovery from a third party due to an injury or other condition for which the Plan provided benefits. This right is called "subrogation." The Prescription Drug feature is a part of the Medical Plan and, therefore, the Medical Plan's subrogation provisions apply. See the section called *Right to Reimbursement* (Subrogation Agreement) on page 17 for more information.

Medical Plan – Regional Coverage Options

HMSA Medical Plan

Available to residents of Hawaii, the HMSA Medical Plan option is administered (and insured) by Hawaii Medical Service Association (HMSA), a Blue Cross Blue Shield company. HMSA offers a Preferred Provider Organization (PPO) plan, giving you the flexibility to use both in- and out-of-network services.

Reimbursements for out-of-network services are based on the Eligible Expenses as determined by HMSA after you meet the annual deductible. You are responsible for charges over Eligible Expenses as determined by HMSA.

Kaiser Permanente HMO Options

Available to residents of Hawaii, and Northern and Southern California, the Kaiser HMO options provide benefits when you use the Kaiser Permanente network of doctors, hospitals and other health care providers. Kaiser Permanente features a broad network of providers, giving you choice and flexibility. You are encouraged to designate a PCP to coordinate your care and serve as your personal physician.

Women may choose an OB/GYN as their PCP and parents may choose a pediatrician as their child's PCP. In addition, women do not need a referral or authorization to seek care from an in-network OB/GYN specialist. No coverage is provided for services received outside of the Kaiser network, other than out-of-area urgent and emergency care.

Cigna Global Health Medical Plan

The Cigna Global Health Medical Plan option is available to certain U.S. expatriates and international employees that are U.S. benefits-eligible. While overseas, you may use any hospital, doctor or other health care provider you choose. It is administered (and insured) by Cigna Global Health.

If you require medical care while in the U.S., you may also see any provider you choose. Any inpatient hospital admission in the U.S. requires prenotification by contacting Cigna Global Health's management team at least five days prior to your scheduled admission or within 48 hours after an emergency admission.

Note: If you are eligible to enroll in the Cigna Global Health Medical Plan, you are also eligible to enroll in dental coverage through the *Cigna Global Health Dental Plan*. See page 87 for more information.

Medical Plan – Regional Options Benefits at a Glance

This chart provides a high-level overview of some features of the HMSA, Kaiser Permanente and Cigna Global Health Medical Plans. For questions, contact the Plan Administrator directly.

MEDICAL PLAN FEATURES	HMSA (HAWAII)		KAISER HMO (HAWAII)	KAISER HMO (SO. CA)	KAISER HMO (NO. CA)	CIGNA GLOBAL HEALTH INTERNATIONAL AND U.S.		
	In-Network	Out-of-Network	In-Network Only	In-Network Only	In-Network Only	International (Outside the U.S.)	U.S. In-Network	U.S. Out-of-Network
Office Visits	$12 copay	70% of Eligible Expenses, after annual deductible	$15 copay	$20 copay	$20 copay	80% after annual deductible	80% after annual deductible	60% of Eligible Expenses, after annual deductible[1]
Most Preventive Care	100%	70% of Eligible Expenses, after annual deductible	100%	100%	100%	100%	100% of Eligible Expenses	100% of Eligible Expenses
Preventive X-Ray and Lab Work	100% if preventive 90% inpatient 80% outpatient if diagnostic	70% of Eligible Expenses, after annual deductible	100% if preventive $15 copay basic labs and X-ray 20% coinsurance complex labs, imaging and testing	100% if preventive $10 copay per service	100% if preventive $10 copay per service	100% if preventive	100% if preventive	100% of Eligible Expenses if preventive
Annual Deductible	None	$100 per person $300 family maximum	None	None	$500 per person $1,000 family maximum	$500 per person $1,500 family maximum	$500 per person $1,500 family maximum	$1,500 per person $4,500 family maximum
Annual Out-of-Pocket Maximum	$2,500 per person $7,500 family maximum Prescription Coverage: $3,600 per person $4,200 family maximum		$2,500 per person $7,500 family maximum	$1,500 per person $3,00 family maximum	$3,000 per person $6,000 family maximum		$4,000 per person $10,000 family maximum	
Lifetime Benefits Maximum	None, except for infertility		None, except for infertility	None	None	None	None	
Hospital Stay	90%	70% of Eligible Expenses, after annual deductible	90%	$250 copay	90%	80%, after annual deductible	80%, after annual deductible	60% of Eligible Expenses, after annual deductible

[1] U.S. out-of-network service

Medical Plan – Regional Options Benefits at a Glance (continued)

MEDICAL PLAN FEATURES	HMSA (HAWAII)		KAISER HMO (HAWAII)	KAISER HMO (SO. CA)	KAISER HMO (NO. CA)	CIGNA GLOBAL HEALTH INTERNATIONAL AND U.S.		
	In-Network	Out-of-Network	In-Network Only	In-Network Only	In-Network Only	International (Outside the U.S.)	U.S. In-Network	U.S. Out-of-Network
Outpatient Surgery	80% (Non-Cutting Surgery) 90% (Cutting Surgery) 90% (Ambulatory Surgical Center)	70% of Eligible Expenses, after annual deductible	90%	$20 copay	90%	80%, after annual deductible	80%, after annual deductible	60% of Eligible Expenses, after annual deductible
Emergency Room	80%	80%	$100 copay	$50 copay	90%	80%, after annual deductible	80%, after annual deductible	80% of Eligible Expenses, after annual deductible (Except if not a true emergency, then 60% of Eligible Expenses, after annual deductible)

PHARMACY PLAN FEATURES		HMSA (HAWAII)	KAISER HMO (HAWAII)	KAISER HMO (SO.CA)	KAISER HMO (NO. CA)	CIGNA GLOBAL HEALTH INTERNATIONAL AND U.S.	
		PARTICIPATING PHARMACY[1]	PARTICIPATING PHARMACY	PARTICIPATING PHARMACY	PARTICIPATING PHARMACY	OUTSIDE THE U.S.	INSIDE THE U.S.
Generic	30-Day Retail	$7 copay	Maintenance: $3 copay Other: $15 copay	$15 copay	$10 copay	All drugs covered at 20%	30-day Retail: 20% coinsurance at participating pharmacy; 40% coinsurance at nonparticipating pharmacy 90-Day Mail Order: 20% coinsurance at participating pharmacy; not covered at nonparticipating pharmacy
	90-Day Mail Order	$11 copay	Maintenance: $6 copay Other: $30 copay	$30 copay	$20 copay		
Brand Name	30- Day Retail	Preferred: $30 copay Nonpreferred: $75 copay	$50 copay	$30 copay	$30 copay		
	90-Day Mail Order	Preferred: $65 copay Nonpreferred: $200 copay	$100 copay	$60 copay	$60 copay		
Specialty	30-Day Retail	Preferred: $100 copay Nonpreferred: $200 copay	$200 copay	30% coinsurance, $150 max	20% coinsurance, $150 max		
	90-Day Mail Order	Not Covered	Not Covered	Not Covered	Not Covered		
Out-of-Pocket Maximum		$3,600 Individual $4,200 Family	Counts toward the plan's out-of-pocket maximum				

[1] Nonparticipating mail-order pharmacies not covered. Nonparticipating pharmacies for specialty drugs not covered. If using a nonparticipating retail pharmacy, you will be charged the copay, plus 20% of the remaining eligible charge.

Retiree Medical Coverage

Morgan Stanley offers retiree medical coverage to help offset the expenses of medical costs for you and your family in retirement.

Upon retirement from Morgan Stanley, you may be eligible to elect retiree medical coverage for yourself and your eligible dependents.

IF YOU ARE:	YOUR COVERAGE OPTION:	COVERAGE OPTION FOR SPOUSE/ DOMESTIC PARTNER/ DEPENDENTS:	PRESCRIPTION DRUG COVERAGE:	COMMENTS:
At least age 55 At least five years of service Covered by Morgan Stanley Medical Plan at retirement OR Age + Service = at least 70 At least five years of service Covered by Morgan Stanley Medical Plan at retirement OR At least five years of service Age 54, or age + service = 68 Released	Until age 65/Medicare eligibility, the Morgan Stanley Medical Plan After age 65/Medicare eligibility, UHC Connector Model	Until age 65/Medicare eligibility, the Morgan Stanley Medical Plan After age 65/Medicare eligibility, UHC Connector Model Note that spouse/domestic partner and dependent coverage is only available while you are enrolled; dependent coverage generally expires at age 26.	Until age 65/Medicare eligibility, the Morgan Stanley Medical Plan After age 65/Medicare eligibility, Medicare Part D. Morgan Stanley drug coverage is "creditable" so you may enroll within 63 days of becoming eligible with no Medicare penalties.	Be sure to enroll in Medicare Parts B and D as soon as you are eligible. If you do not, you may not enroll in UHC Connector Model, and you will not have prescription drug coverage. You may incur penalties if you enroll in Medicare late.
Age 55 10 years of service before Jan 1, 1989 Covered as an active employee of a qualifying business at retirement[1] OR Member of the Morgan Stanley Operating Committee with three or more years of service at retirement	The Core Plan	The Core Plan Note that spouse/domestic partner and dependent coverage is only available while you are enrolled; dependent coverage generally expires at age 26.	As a part of the Core Plan through Express Scripts Morgan Stanley drug coverage is considered "creditable" so you may not need to enroll in Part D.	
None of the above	No retiree medical coverage is available. COBRA coverage may be available for a limited period of time.	No retiree medical coverage is available. COBRA coverage may be available for a limited period of time.	No prescription drug coverage is available. If COBRA coverage is elected for medical, it will include prescription drug coverage.	Be sure to enroll in Medicare as soon as you are eligible. If you do not, you will not have any retiree medical or prescription drug coverage and you may incur penalties if you enroll late.

[1] Qualifying businesses are Institutional Securities, Institutional Investment Management, Van Kampen Investments, an infrastructure group supporting any of the foregoing. Morgan Stanley's payroll records control for purposes of determining whether you were considered an active employee of a qualifying business, regardless of your actual duties. Special rules apply to employees hired in connection with the acquisition by Morgan Stanley of a business. Call HR Services for details.

Eligibility

Eligible Retirees

You are eligible to enroll in retiree medical coverage if you are participating in the Morgan Stanley Medical Plan as an active employee on the day before your retirement date and you meet the following requirements:

- You have a minimum of five years of service and are at least age 55, or
- You have a minimum of five years of service and your age plus years of service is at least 70.

Most service in a U.S. benefits-eligible position (including service in a non-U.S. location, as a full-time or hourly employee who became eligible for benefits as of January 1, 2020, part-time employee scheduled to work 50% or more of the full-time work week) counts toward determining eligibility for retiree medical coverage. Your service will count regardless of the length of any breaks in service. If your break in service is less than 12 months, you are considered to be continuously employed, and your years of service will not reflect a break in service.

If you are a Morgan Stanley employee participating in a non-U.S. medical program on the day before your retirement date but were previously covered by the U.S. Medical Plan for a minimum of five years, you may be eligible for retiree medical coverage. Please contact HR Services for more information.

If you transferred directly from Citigroup in connection with the creation of Morgan Stanley Smith Barney (now known as Morgan Stanley Wealth Management) and you do not meet the eligibility requirements stated above on your retirement date, you may be eligible for retiree medical coverage if you met the following eligibility for Citigroup's retiree medical coverage on the date of your transfer:

- You were age 50 with a minimum of five years of service, and
- Your age plus service was equal to at least 60.

If you worked at a company that was acquired by Morgan Stanley, special rules may apply in determining the number of years of service used to determine your eligibility. Please contact HR Services for more information.

Members of the Morgan Stanley Operating Committee with three or more years of service at the time of retirement will also be eligible for retiree medical coverage under the UHC Retiree Medical Plan (the "Core Plan"). For purposes of determining years of service for eligibility to participate in the Core Plan, service at certain legacy entities, as determined in the Plan Administrator's sole discretion, including service with E*TRADE Financial Corporation, E*TRADE Financial LLC, and E*TRADE Financial Holdings, LLC and each of their respective business units, shall count toward calculation of the three or more years of service requirement.

Reduction in Hours or Change in Status

If you lose eligibility for medical benefits due to a reduction in hours worked or change in status, you may be eligible to elect retiree medical coverage if the eligibility requirements were met on or prior to the effective date of the status change or reduction in hours. Please contact HR Services for more information.

Dependent Eligibility

If your spouse or domestic partner is covered as an eligible dependent in the Morgan Stanley Medical Plan on the day before your retirement date or if they later enroll within 31 days of a Qualified Life Event (QLE), they are eligible for retiree medical coverage.[1] Subject to the other terms of the Plan, they remain eligible for coverage until the date of their death or the date you drop coverage or die, as long as they remain an eligible dependent.

If your eligible dependent children are covered by the Morgan Stanley Medical Plan on the day before your retirement date or if they are later enrolled within 31 days of a QLE,[1] they are eligible for retiree medical coverage until the earliest of:

- The date they reach the applicable age limit,
- The date they no longer qualify as eligible dependents for any reason,

[1] Your dependents may be able to enroll up to 90 days after their QLE. However, if they enroll more than 31 days after their QLE, coverage will be prospective only, from the date of enrollment.

- The date you drop coverage,
- The date you die, or
- The date both you and your spouse or domestic partner (if applicable) are no longer eligible for coverage for any reason.

Special Eligibility Rules for Release

If your employment terminates due to Release, as defined in the *Glossary*, you have a minimum of five years of service and either (1) are within one year of becoming eligible for retiree medical coverage, or (2) your age plus service equal at least 68 on your Release date, you may be eligible for retiree medical coverage. You do not have to be enrolled in the Medical Plan on the day before your Release to be eligible for retiree medical coverage; however, you may enroll only yourself in coverage at that time.

Retiree Medical Coverage Options

Your retiree medical coverage options depend on the date of and your age at retirement, and whether you are eligible for grandfathered coverage.

Retirees and their covered dependents fall into three categories:

- **Pre-Medicare Eligible** – You are not yet eligible for Medicare.
- **Medicare Eligible** – You are eligible for Medicare.
- **Grandfathered Coverage** – You are grandfathered based on your most recent hire date and when you first met eligibility requirements for Morgan Stanley retiree medical.[1]

Information about the coverage categories and options available is included below.

Pre-Medicare Eligible

If you are not yet eligible for Medicare, your medical coverage options are the same as those available to active employees. Based on your home ZIP code, you may have a choice of the following medical plans:

- Option A (administered by Cigna or UHC)
- Option B (administered by Cigna or UHC)
- Option C (administered by Cigna or UHC)
- HMSA Medical Plan—Hawaii
- Kaiser Permanente HMO—Hawaii, Northern and Southern California (in-network coverage only)
- Cigna Global Health Medical Plan (International locations)

Note: Morgan Stanley may change the retiree medical options available at its discretion at any time.

For details about each of the available options, please see the *Medical Plan—National Coverage Options* section on page 33.

Retired on or Prior to January 1, 2003

If you retired on or before January 1, 2003 and are not yet eligible for Medicare, your retiree medical benefits will differ from those included in the *Grandfathered Coverage* on page 76. Specifically, your deductibles and coinsurance limits are as follows:

- Annual deductibles:
  - In-network deductible is $150 per person or $450 family maximum.
  - Out-of-network deductible is $400 per person or $1,200 family maximum.
- Annual coinsurance limit (regardless of the number of covered dependents):
  - In-network coinsurance limit is $3,000.
  - Out-of-network coinsurance limit is $6,000.

Medicare Eligible

If you are not eligible for Grandfathered Coverage and you become or are eligible for Medicare, whether at retirement or while already participating in the retiree medical coverage, you will not be eligible for pre-Medicare coverage and you will instead be eligible for one or more of the following retiree medical options:

- UHC Connector Model (through the UHC private exchange)

[1] Special rules apply to employees hired in connection with the acquisition by Morgan Stanley of a business. Call HR Services for details.

- Cigna Global Health Medical (if living outside the U.S.)

UHC Connector Model (through the UHC Private Exchange)

If you are a retiree who is eligible for Medicare, you will be offered the opportunity to select a variety of Medicare products and supplements so that you can find the right coverage to meet your individual health needs, including medical and prescription drug coverage. UHC Connector Model through the UHC private exchange is available to all Medicare-eligible retirees and covered dependents over age 65, unless living outside the U.S. in retirement or if eligible for Grandfathered Coverage in the Core Plan.

You will be sent enrollment information directly by UHC but will NOT be automatically enrolled when you become Medicare-eligible. If you do not enroll in UHC Connector Model coverage, you will NOT have medical or prescription drug coverage past your Medicare eligibility, and you may incur penalties if you enroll in Medicare at a later date.

However, if you remained enrolled in the Cigna Global Health Plan when you become eligible for Medicare, you will continue to remain enrolled in that plan and are not required to enroll in UHC Connector Model in order to continue your retiree medical coverage.

Additionally, if you are enrolled in post-Medicare coverage with Kaiser Permanente HMO as of December 31, 2014, you will remain eligible to be covered under the Kaiser Permanente HMO Plan and are not required to enroll in UHC Connector Model in order to have coverage.

Note: Covered dependents under age 65 cannot enroll in UHC Connector Model. Your covered dependents under age 65 may be covered under the pre-Medicare coverage described above if eligibility requirements are met, if you are covered under a Morgan Stanley retiree medical option and if you so elect. If you are over the age 65, you must remain continuously enrolled in the UHC Connector Model post-Medicare coverage in order to continue coverage for your dependents enrolled in the Morgan Stanley Pre-Medicare Retiree Medical Plan.

For more information about Cigna Global Health Plan and Kaiser Permanente HMO Plan, please see the *Medical Plan – Regional Coverage Options* section on page 70.

Grandfathered Coverage

Based on your most recent hire date (or date of acquisition or company merger) and date you first met the eligibility requirements for Morgan Stanley retiree medical coverage, you may be able to participate in the UHC Retiree Medical Plan ("Core Plan").

You are eligible to participate in the Core Plan if you were covered as an active employee of:

- Institutional Securities,
- Institutional Investment Management,
- Van Kampen Investments,
- Infrastructure, or
- Any associated company:
  - on the day before your retirement date, and
  - on or before January 1, 1989, you were age 55 or older with at least 10 years of service.

Additionally, members of the Morgan Stanley Operating Committee with three or more years of service at retirement are eligible to participate in the Core Plan.

About the Plan

The Core Plan is administered by UHC and provides medical coverage for both pre- and post-Medicare eligible retirees and their eligible dependents.

If you are eligible for Medicare, the Core Plan coordinates with Medicare which means that the Core Plan pays what Medicare does not so that the total payments do not exceed what the Core Plan would pay on its own. Because benefits are coordinated, payments under the Core Plan are computed as though you are enrolled in Medicare Parts A (hospital) and B (medical), even if you are not actually enrolled. To receive maximum medical coverage, it is important that you enroll in Medicare when you first become eligible. **If you enroll at a later date, you may be subject to a late-enrollment penalty from Medicare.**

You may wish to review the *Coordination* of Benefits on page 15 to learn how the Core Plan works in conjunction with Medicare.

Please see the *Schedule of Benefits for the Grandfathered Morgan Stanley Retiree Medical Plan ("Core Plan")* on page 78 for more information about the Core Plan.

The Core Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Please note that under the Core Plan, preventive care is covered at 80% of Eligible Expenses after your annual deductible is met.

Questions regarding which protections apply to a grandfathered health plan and what might cause a plan to lose its grandfathered status can be directed to the Plan Administrator at UnitedHealthcare, 450 Columbus Blvd., Hartford, CT 06103. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Prescription Drug Coverage

Prescription drug coverage through the Core Plan is provided by Express Scripts and is considered "creditable," which means it is at least as good as Medicare prescription drug coverage. You do not need to enroll in a Medicare prescription drug program (Part D) if you are covered under the Core Plan because the Core Plan will be the primary payer of prescription drug benefits. However, if you are enrolled in a Medicare prescription drug plan, the Core Plan will be the secondary payer of prescription drug benefits**. Note that if you are covered under the Core Plan, you will not have to pay a higher premium or a late-enrollment fee if you decide to enroll in Medicare Part D at a later date.**

Please see the *Schedule of Benefits for the Grandfathered Morgan Stanley Retiree Medical Plan ("Core Plan")* section on page 78 for more information.

Schedule of Benefits for the Grandfathered Morgan Stanley Retiree Medical Plan ("Core Plan")

PLAN FEATURES	MORGAN STANLEY CORE PLAN
General Provisions	
Annual Deductible	• $75 per person • $150 per family
Annual Coinsurance Limit	• $1,500 per person • $3,000 per family
Lifetime Benefit Maximum	• None
Office Visits and Preventive Care	
Office Visits	• 80% of Eligible Expenses after annual deductible
Screenings, X-Rays, Scans and Lab Tests	• 80% of Eligible Expenses after annual deductible
Preventive Care/Wellness Schedule (Additional visits may be provided if medically necessary)	• 80% of Eligible Expenses after annual deductible for most services • Routine physical: One per calendar year • Routine GYN exam: One per calendar year • Mammography: – One between the ages of 35 and 39 – One per calendar year for age 40 and over • Colon cancer screening: 80% of Eligible Expenses after annual deductible – Sigmoidoscopy: One every five years after age 50 – Colonoscopy: One every 10 years after age 50 • Prostate cancer screening: – One every two years up to age 40 – One per calendar year for age 40 and over • Well baby care: 12 visits from birth up to 36 months • Preventive immunizations for children
Prescription Drugs —See the Grandfathered Morgan Stanley Retiree Medical Plan ("Core Plan") Prescription Drug Benefits section on page 80 for more information.	

Schedule of Benefits for the Core Plan [(continued)]

PLAN FEATURES	MORGAN STANLEY CORE PLAN
Hospital and Surgical	
Emergency Room	• 80% of Eligible Expenses after annual deductible
Inpatient Hospital Services	• 100% of Eligible Expenses after annual deductible • Member services must be notified at least five days in advance of scheduled admission or within 48 hours of an emergency admission (waived if Medicare eligible). If notification is not received, only 80% of Eligible Expenses will be covered after annual deductible
Outpatient Surgery Services	• 80% of Eligible Expenses after annual deductible
Mental Health and Substance Abuse	
Outpatient (Administered by United Behavioral Health)	• 80% of Eligible Expenses after annual deductible
Inpatient (Administered by United Behavioral Health)	• 80% of Eligible Expenses after annual deductible
Other	
Dental	• 80% of Eligible Expenses, limited to services due to an accidental injury to sound, natural teeth and services received within six months of accident or due to congenital anomaly. TMJ is also covered.
Vision	• 80% of Eligible Expenses, limited to treatment of disease or injury and cataract surgery
Hearing Aids	• 80% of Eligible Expenses after annual deductible – Up to $3,000 benefit maximum every 24 months for a child up to age 19 – Up to $3,000 benefit maximum every 36 months for adults
Alternative Care Facility (Noncustodial Home Health Care, Hospice, Skilled Nursing Facility)	• 80% of Eligible Expenses after annual deductible, subject to plan limits
Outpatient Therapy (Occupational, Physical, Speech, Vision, Respiratory, Cardiac)	• 80% of Eligible Expenses after annual deductible • 30-visit maximum per calendar year, per therapy (medical review necessary after 30 visits)
Alternative Treatments (Chiropractic, Acupuncture, Massage Therapy)	• Chiropractic care: 80% of Eligible Expenses after annual deductible, 30-visit maximum per person per calendar year • Acupuncture care: 80% of Eligible Expenses after annual deductible, 20-visit maximum per person per calendar year – Acupuncture only covered if performed by a physician or certified acupuncturist • Massage therapy not covered
Foot Care	• 80% of Eligible Expenses after annual deductible – Up to $1,000 annual benefit maximum per person
Diabetic Equipment	• Administered by Express Scripts

Grandfathered Morgan Stanley Retiree Medical Plan ("Core Plan") Prescription Drug Benefits

If you participate in the Core Plan, you will receive prescription drug coverage from Express Scripts. For information about the prescription drug coverage, see the *Prescription Drugs* section on page 64. However, note that Core Plan participants are not required to enroll in the Express Scripts Smart90 program; any network retail pharmacy can be used for maintenance medications. For a complete list of prescription drugs covered through Express Scripts, visit its website at www.express-scripts.com.

EXPRESS SCRIPTS FEATURES	RETAIL PHARMACY PROGRAM	MAIL SERVICE PROGRAM
Annual Deductible	$50 per person/$150 family maximum	No deductible
Tier 1 Generic Drugs	$5 copay for up to a 30-day supply	$10 copay for up to a 90-day supply
Tier 2 Preferred Brand-Name Drugs[1]	25% member coinsurance for up to a 30-day supply $25 minimum/$50 maximum	$60 copay for up to a 90-day supply
Tier 3 Nonpreferred Brand-Name Drugs	35% member coinsurance for up to a 30-day supply $50 minimum/$50 maximum	$120 copay for up to a 90-day supply
Brand-Name Drugs, where generics are available[2]	You pay the amount applicable for the generic, plus the difference between what the plan would have paid for the generic and the cost of the brand-name drug; the difference will not apply to your Annual Deductible.	
Specialty Drugs	$60 for up to a 30-day supply. There is a one-time retail fill and then must be filled through the Mail Service program	$60 copay for up to a 30-day supply ($180 copay for up to a 90-day supply)
Compound Drugs	Up to a 30-day supply	Up to a 30-day supply

Out-of-Network Coverage

If you fill a prescription at a retail pharmacy that is not in Express Scripts' network:

- You will be responsible for the difference in the total cost of the drug between the out-of-network pharmacy and an in-network pharmacy.
- You will be reimbursed based upon the in-network cost of the drug, according to the schedule above.
- You will need to pay the entire cost upfront and submit a claim form to Express Script with your receipt in order to be reimbursed.

Retiree Medical Contributions

Your retiree medical contribution is made on an after-tax basis, and the amount depends on your coverage level and whether you (or a covered dependent) are eligible for Medicare and/or a Firm-provided subsidy. **If you are not eligible for a Firm-provided subsidy, you must pay the full cost of coverage.** Prescription drug benefits are part of your Medical Plan coverage. Your retiree contributions are subject to change and will likely increase on January 1 of each year. Please contact HR Services for information about your contribution amounts.

Eligibility for a Firm-Provided Subsidy

The amount of the subsidy varies based on:

- Your most recent date of hire (or date of acquisition or company merger),
- When you met retiree medical eligibility requirements, **and**
- Your years of service at retirement.

[1] A preferred brand-name drug is one that is part of the Express Scripts formulary list. These medications will be listed as Tier 2 on the formulary list. Preferred brand-name drugs generally cost less than nonpreferred brand-name drugs. Nonpreferred drugs will be listed as Tier 3 on the formulary list.
[2] Drugs that are approved under the Step Therapy Program or that receive Prior Authorization are excluded.

There is a two-part requirement for eligibility for a Firm-provided subsidy.

- You will be eligible for a Firm-provided subsidy only if, **as of December 31, 2010, you met all of the age and service requirements below:**
  - You were at least age 50 with a minimum of five years of service, or you were at least age 45 with a minimum of five years of service, **and** met the rule of 65 in which your age plus years of service is equal to 65 or greater.
  - You were employed in a U.S. benefits-eligible position as of December 31, 2007.
  - Any break in service was less than 12 months.
  - You were covered under the Morgan Stanley Medical Plan as an active employee.
- In order to be eligible for a Firm-provided subsidy, you must also meet the age and service requirements of your business unit listed below on the date of your retirement.

Age and Service Requirements for Global Wealth Management (formerly Morgan Stanley Smith Barney), Individual Asset Management, or Infrastructure or Company

If you are an employee of Global Wealth Management, Individual Asset Management, or Infrastructure or a supporting Company, who was employed in a U.S. benefits-eligible position on or before December 31, 2007, you meet the business unit's age and service requirements for a Firm-provided subsidy toward the cost of retiree medical coverage if at retirement:

- You are covered under the Morgan Stanley Medical Plan as an active employee on the day before retirement, **and either**
  - You are age 55 or older with a minimum of 20 years of continuous service and are not yet Medicare eligible, **or**
  - You are age 60 or older with a minimum of 15 years of continuous service and are not yet Medicare eligible.

Continuous service is defined as the period that starts on your most recent date of hire, unless there was a break in service of less than 12 months from your previous date of termination, in which case pre-break service is bridged.

The Firm-provided subsidy applies only to the cost of your pre-Medicare coverage and only to the cost of your spouse or domestic partner's pre-Medicare coverage until the earliest of:

- The date you become eligible for Medicare, **and**
- The date they become eligible for Medicare, **or**
- The date you die.

Age and service requirements for Institutional Securities, Institutional Investment Management, or Infrastructure or Company

If you are an employee of Institutional Securities, Institutional Investment Management, Van Kampen Investments, or Infrastructure or a supporting company, who was employed in a U.S. benefits-eligible position on or before December 31, 2007, you meet the business unit's age and service requirements for a Firm-provided subsidy toward the cost of retiree medical coverage if at retirement:

- You are covered under the Morgan Stanley Medical Plan as an active employee on the day before your retirement date, **and**
  - You are age 55 or older with a minimum of five years of service, **and**
  - Your age plus service is at least 65 with a minimum of five years of service.

Most service in a U.S. benefits-eligible position as a full-time or part-time employee scheduled to work 50% or more of the full-time work week counts, regardless of the length of any break in service. Special rules may apply to service at an acquired company. Special rules may also apply to employees rehired after December 31, 2007, or due to an acquisition. Please contact HR Services for details.

Your eligibility for, or amount of, a Firm-provided subsidy does not change if your employment terminates due to Release, as defined in the Glossary on page 201.

For more information about eligibility for Retiree Medical coverage and a Firm-provided subsidy, please see the chart on the following page.

General Eligibility Rules for Retiree Medical Coverage and Subsidies

ELIGIBILITY FOR COVERAGE

(ELIGIBILITY FOR COVERAGE DOES NOT IMPLY ELIGIBILITY FOR A FIRM-PROVIDED SUBSIDY)

General Rules	On last day of employment: • Must be covered under the Morgan Stanley Medical Plan AND • Must meet the following minimum requirements: – Age 55 with five years of service (YOS), **OR** – Age plus YOS at least 70 with five YOS At initial enrollment, can cover eligible dependents only if they are covered on last day of employment.
Special Rules for Transfers From Citigroup to the MSWM Joint Venture	• On last day of employment at Morgan Stanley, must be covered under the Morgan Stanley Medical Plan **AND** • On last day of employment at Citigroup, must meet the General Rules above OR the following minimum requirements: – Age 50, **AND** – Age plus YOS at least 60 with five YOS
Special Rules for Termination Due to Release	Must meet the General Rules above **OR** the special rules for MSWM JV transfers above **OR** the following minimum requirements on last day of employment: • Age 54 with five YOS, **OR** • Age plus YOS at least 68 with five YOS. Do not have to be covered under the Morgan Stanley Medical Plan on last day of employment. Can cover eligible dependents if added within 31 days after Release.

ELIGIBILITY FOR SUBSIDY[1] (LEGACY MORGAN STANLEY EMPLOYEES[2] ONLY)

	Legacy Morgan Stanley MSWM Employees and Support Staff	**Legacy (ISG and MSIM) Employees and Support Staff Including Administration**
General Rules	• Must be eligible for Morgan Stanley retiree medical coverage *under the General Rules above* and first employed full-time (or part-time, scheduled to work at least 50%) on or before December 31, 2007, **AND** • Cannot have a break in service of greater than 12 months after December 31, 2007 (unless covered under Morgan Stanley subsidized retiree medical coverage the day before rehire), **AND** • Must satisfy Business Rules below, **AND** • Must meet the following requirements *as of December 31, 2010*: – Age 50 with five years of service (YOS), **OR** – Age 45 with five YOS **AND** age plus YOS equal to at least 65	
Business Rules	• Must meet the following minimum requirements on last day of employment: – Age 55 with 20 years of continuous service (YOCS[3]), **OR** – Age 60 with 15 YOCS • Subsidy ends when retiree becomes eligible for Medicare (typically, age 65)	Must meet the following minimum requirements on last day of employment: • Age 55 with five YOS, **AND** • Age plus YOS is at least 65

[1] Separate rules apply to determine the amount of subsidy. Contact HR Services for details.
[2] Legacy Morgan Stanley employees include all employees who were benefits-eligible as of December 31, 2007. Former Citigroup employees who transferred in connection with the creation of Morgan Stanley Smith Barney in 2009 are not considered Legacy Morgan Stanley employees, even if previously employed (before 2009) by Morgan Stanley. Prior service at Citigroup and its affiliates does not count when determining eligibility for subsidy. Whether prior service at other acquired companies counts depends on the terms of those acquisitions. Contact HR Services for details.
[3] Continuous service is based on most recent hire date, excluding breaks in service less than 12 months.

Important Retiree Medical Information

Changing Your Coverage

Your pre-Medicare retiree medical coverage election is generally irrevocable. However, you may make changes to your coverage in limited circumstances, such as QLEs. QLEs are events that affect your or your spouse's legal marital or domestic partner status, number of dependents, employment status, and certain Plan costs or coverage changes. **If you waive coverage or cancel your coverage at any time, you may not re-enroll in the retiree medical coverage.** You have 90 days from the date of the QLE to make a prospective change to your pre-Medicare retiree medical election. See the Qualified Life Events section on page 18 for details.

You may also be able to make changes to your pre-Medicare retiree medical coverage during annual enrollment, if offered. **Please be advised that there is no guarantee that an annual enrollment period will be offered to retirees in any given year.** Additionally, unlike active employees, you cannot add dependents during annual enrollment; you may add dependents to coverage only as a result of, and consistent with, a QLE.

Retirees Age 65 and Older

If you are eligible for retiree medical coverage through the Firm, eligible for Medicare and over age 65, you will have the opportunity to enroll in UHC Connector Model for coverage. If you have dependents under age 65 and wish to retain their coverage under the Morgan Stanley Medical Plan, you must remain continuously enrolled with UHC Connector Model.

Medicare

Medicare is the federal health insurance program for people age 65 or older, and for people who have certain disabilities or end-stage renal disease. Generally, you are eligible for Medicare on the first day of the month in which you attain age 65, or 24 months after you first receive disability benefits from Social Security. Medicare contains several parts which cover different services including:

- **Medicare Part A (Hospital Insurance)—** helps cover your inpatient care in hospitals and limited nursing home care if you meet certain conditions.

  If you receive benefits from Social Security, you will automatically receive Medicare Part A. You generally do not pay a premium for Part A if you or your spouse paid Medicare taxes while working.

  However, if you are not receiving benefits from Social Security (for instance, if you are still working), you will need to sign up for Part A by contacting the Social Security Administration three months before you turn age 65.

  An Initial Enrollment Package containing information about Medicare Part A, including your Medicare card, is usually sent to you automatically. However, if you do not receive a notice, you must contact the Social Security Administration to apply for Medicare Part A three months before you turn age 65 to take full advantage of your Initial Enrollment Period (IEP).
- **Medicare Part B (Medical Insurance)—**primarily covers medically necessary services such as doctors' fees, most outpatient hospital services and certain related services. Medicare Part B also covers some preventive services. You pay a monthly premium for Medicare Part B.

  Generally, if you receive benefits from Social Security, you will automatically receive Medicare Part B when you become eligible. If you are not automatically enrolled for any reason, once you become eligible for Medicare, you should enroll in Medicare Part B during your IEP. Your IEP is the first seven months you are eligible to enroll in Medicare because of age or disability and includes the three months before your month of eligibility, the month you become eligible, and the three months following your month of eligibility.

  If you choose to decline Part B during your IEP and choose to enroll at a later time, you may only enroll at the beginning of each year during the annual general enrollment period. If you do not enroll in Part B during your IEP, you will generally be charged a late-enrollment penalty.

The penalty is for life, and you will always pay more for your Part B coverage than you would have had you enrolled when first eligible.

Note: If you are actively employed, not receiving LTD benefits and are eligible for Medicare Part B or if you are covered by an employer's group health plan and are eligible for Medicare Part B, you may not need Part B until you are no longer covered under that plan. If you sign up for Part B within eight months after your employer group health plan benefits end, you will not be penalized for late enrollment.

Retiree medical coverage under the Morgan Stanley Medical Plan always coordinates with Medicare, with Medicare Parts A and B deemed to be paying primary, regardless of whether or not you are actually enrolled in Medicare.

- **Medicare Prescription Drug Coverage (Part D)—**helps cover prescription drug costs. Medicare Part D is available to everyone with Medicare through Medicare prescription drug programs and Medicare Advantage plans that offer prescription drug coverage. All Medicare prescription drug programs provide at least the level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

  If you are currently or are about to become eligible for Medicare, you will have a seven-month IEP for Medicare Part D regardless of how you qualify for Medicare. If you do not enroll in a Medicare drug plan during your initial IEP, you may only enroll at the end of each year. Your benefits will not start until the beginning of the following year, and you will be charged a late-enrollment penalty.

  If you already have prescription drug coverage, such as through your or your spouse's or domestic partner's employer group health plan, including retiree medical coverage, you may be able to delay your enrollment in Medicare Part D without being charged a late-enrollment penalty. To delay enrollment without being charged a penalty, the plan must be creditable, meaning it is as good as or better than the Medicare prescription drug benefit.

  If at some point you lose your source of creditable coverage (for example, you lose your employer or retiree medical benefits), you may enroll in a Medicare drug plan without penalty or a delay in benefits as long as you join that plan within 63 days after your current coverage ends.

  Note: The prescription drug coverage provided through the Core Plan and the UHC Medicare Coordination Plans is considered creditable coverage.

- **Disability—**Medicare coverage is also available to disabled persons who are approved for Social Security Disability Insurance (SSDI). To receive maximum medical coverage, it is important to enroll in Medicare Parts A and B once you are approved for Medicare because your benefits under the Medical Plan will be computed as though you have received Medicare benefits, even if you have not enrolled in this coverage. **If you decide to enroll in Medicare at a date later than your initial Medicare eligibility date, you may be subject to a late-enrollment penalty from Medicare.**

Medicare is generally the secondary payer for domestic partners when the domestic partner can get Medicare because of age and has group health plan coverage through their current employer.

Medicare is generally the primary payer for domestic partners with group health insurance coverage if the domestic partner is Medicare eligible due to their age or disability and has group health plan coverage through their partner's Morgan Stanley coverage.

For questions about Medicare or SSDI, contact the Social Security Administration at 800-772-1213 or log on to www.ssa.gov or www.medicare.gov.

Morgan Stanley does not advise you as to your rights and responsibilities under Medicare. You are solely responsible for your decision whether and when to enroll in Medicare; Morgan Stanley does not monitor enrollment in Medicare and therefore will not advise you when you should enroll in Medicare.

COBRA

If you are eligible to receive retiree medical coverage when you retire, you may choose to defer it temporarily and elect continuation of active coverage under COBRA for a period of time. This may save you money. After continuation coverage under COBRA expires, you will be *automatically enrolled* in retiree medical coverage under the Morgan Stanley Medical Plan. You may make changes to your retiree medical coverage no later than 90 days after your COBRA coverage ends; however, your medical coverage must be continuous.

If you drop retiree medical coverage or waive it at any time (other than electing COBRA coverage), you will not be able to enroll in retiree medical coverage at a later date.

Right to Reimbursement (Subrogation Agreement)

The Core Plan has the right to receive reimbursement for any recovery from a third party due to an injury or other condition for which the Plan provided benefits. This right is called "subrogation." The Core Plan is subject to the same subrogation provisions as the Medical Plan. See the *Right to Reimbursement (Subrogation Agreement)* section on page 17 for more information.

Employee Assistance Plan (Lyra Mental Health Benefit)

The Employee Assistance Plan provides a mental health benefit, inclusive of therapy, coaching and self-care tools. The benefit includes access to a web-based platform to search for and, where applicable, schedule an appointment for services to support your mental, behavioral, and emotional health. The benefit is provided by Lyra Healh ("Lyra"). Through Lyra's online platform, or by contacting a Lyra representative, you may receive suggestions for licensed behavioral health care professionals ("Provider"), professionals trained in Lyra's Coaching Program ("Coach") and/or other programs available through Lyra's partners, including Lyra Clinical Associates P.C. ("LCA"), a professional medical corporation. In cases where the requested Provider or Coach has a calendar integrated with Lyra's online platform, you may also be able to book an appointment through the online platform. Additionally, onsite counseling is available within the Health Center at 1585 Broadway.

Lyra, along with LCA, provides short-term, outpatient behavioral health services with LCA's group of top Providers and Coaches in your area for up to 16 sessions, at no cost to employees and dependents. Behavioral health services can be delivered through in-person sessions, video sessions, and/or by phone, and include assessment of psychological disorders, individual psychotherapy, marital and couples counseling, family therapy, group therapy, support through Lyra's Coaching Program and/or other services as appropriate, or other clinical programs offered by LCA. Lyra's Coaching Program provides up to six (6) one-to-one, personalized support sessions via live video or phone with a Coach, or as applicable, additional follow-up sessions ("Coaching Sessions") and is available to individuals who do not have complex or clinical issues, such as anxiety, depression or trauma. The Coaching Sessions shall be counted against the 16 sessions available to a user annually. Self-care applications are also available through partners to support emotional or behavioral health needs through a mobile app or website.

Behavioral health services under the Plan are only available through Lyra's group of Providers and Coaches.

Lyra does not guarantee successful clinical outcomes for users based on its suggestions for Clinical Services, Coaching Program Services or any other Services.

You can access Plan benefits by going to the Lyra online portal at www.lyrahealth.com/morganstanley or by contacting the Lyra care team at [844-926-2648]. You must register with Lyra first (by phone or online) before you can access the benefits of the Plan.

This Plan does not cover (and Lyra does not provide) inpatient, residential treatment, partial hospitalization, intensive outpatient treatment, long-term care or counseling, prescription medication, psychiatric services, disability assessments, autism spectrum disorder care, services for remedial education, non-evidence-based behavioral health care, or emergency care. This Plan does not cover (and Lyra does not provide) any benefits that are not clinically indicated.

Program Eligibility

The Lyra benefit is available to all U.S. benefits-eligible Morgan Stanley employees, spouses and domestic partners, and dependents (up to age 26), with the exception of any individuals living abroad:

- All Morgan Stanley U.S. employees and their eligible dependents can access up to 16 free sessions per member, per year. Members do not have to be enrolled in the health plan to access Lyra's services.
- Dependents under age 18 will not have access to the Lyra website. It is recommended their parent call Lyra to initiate use for the dependent.
- Because federal laws govern minors' use of the internet and the ability to collect certain types of information without parental permission, Lyra restricts access to the care platform for those under the age of 18. Lyra collects individuals' date of birth at registration to determine appropriate use.
- Minors' access to mental health care is dependent on state laws. Some states require parental consent while others do not. To comply with state laws, Lyra recommends minors contact the care team to determine their eligibility to access care. The care team, when legally appropriate, can help members find and start care.
- Individuals living abroad will not have access to Lyra due to provider licensing/data privacy regulations.

Effective April 1, 2021, the Lyra benefit is available to U.S. employees (and their spouses or domestic partners, and dependents) that are employed by an E*TRADE entity as determined in the Plan Administrator's sole discretion.

Dependent Eligibility

The program also covers your benefits-eligible dependents.

Coverage will terminate if you no longer meet the eligibility requirements. Coverage for your spouse and dependents stops when your coverage stops, or when they are no longer eligible under the requirements listed above. However, you may be entitled to COBRA continuation coverage, as explained later in this SPD.

Program Cost

Lyra covers short-term, evidence-based outpatient mental health services, at no cost to you — up to 16 visits per person per year. There are no copays, no deductibles and no prior authorizations or referrals needed to begin care.

If you reach your 16-session limit for the year, you may elect to continue working with your Lyra provider, but any future sessions will require out-of-pocket payment. You may be able to submit claims to your medical plan to cover part of the cost of care if your plan includes partial reimbursement for out-of-network providers. Alternatively, you may opt to find a provider who is in-network with your medical plan. Contact your medical plan provider for further details.

Cancellation Policy

Most providers require 24 to 48 hours notice for cancellations. Please refer to your provider for questions about their cancellation policy and fees. Morgan Stanley will cover the cost of up to two last-minute cancellations or no-shows. Beyond this, if you do not cancel on time or miss an appointment without canceling, for any reason, you will be required to reimburse your provider for the missed session.

Any missed or late sessions will count against the 16 sessions you get per calendar year.

Work Life Services

Work Life services offered by Lyra include:

- Legal advice, consisting of a 30-minute, free consultation with an attorney, ongoing discounts, legal forms
- Financial advice, consisting of a 30-minute, free consultation, including tax support and ongoing discounts
- ID theft support, consisting of a 60-minute, free consultation with a fraud support specialist and credit assistance

You may continue the engagement after the initial consultation at a discounted rate at your own cost.

Dental Plan

The Morgan Stanley Dental Plan is designed to help you maintain good dental health and manage the cost of your dental care.

Morgan Stanley offers U.S. employees a choice of three dental coverage options:

- MetLife Dental Option A
- MetLife Dental Option B
- Delta Dental

Morgan Stanley shares in the cost of your dental care premiums. You may enroll in the Dental Plan even if you do not enroll in the Morgan Stanley Medical Plan. The Dental Plan's coverage categories are the same as the Medical Plan's coverage categories.

- **MetLife Dental Option A:** This dental option offers you the ability to receive benefits within MetLife's Preferred Dentist Program (PDP) network or to use out-of-network providers. MetLife Dental Option A features a greater level of benefits than MetLife Dental Option B when using participating PDP network providers and offers greater out-of-network benefits, in addition to higher annual limits and orthodontic benefits for adults. However, your semimonthly premiums are higher with this dental plan option than with MetLife Dental Option B.
- **MetLife Dental Option B:** This dental option also offers you the ability to receive benefits within MetLife's (PDP) network or to use out-of-network providers. Rates within the PDP network have been discounted, reducing your dental costs when you use participating providers. This may be a good option if you like to keep your semimonthly dental premiums low.
- **Delta Dental:** This dental option features Delta Dental PPO participating network providers, Delta Dental Premier participating network providers, and out-of-network providers. Delta Dental dentists offer you greater opportunities to save on your out-of-pocket costs. Under this option, you'll likely save **most** with a dentist in the Delta Dental PPO network, save **some** with a dentist in the Delta Dental Premier network, and save the **least** with a dentist who does not participate or contract with Delta Dental.
- **Cigna Global Health Option:** The Cigna Global Health Dental Plan is available to U.S. benefits-eligible international employees and U.S. expatriates only. This option gives you the freedom to select any dentist at any time, and Cigna Global Health pays a portion of your cost. It provides similar coverage to MetLife Dental Option A and Delta Dental's non-PDP benefits.

MetLife Dental Options

The nationwide network features more than 317,000 dentists. All PDP dentists must meet MetLife's standards for licensing, education, practice history and emergency coverage to be accepted into the network.

When you receive services from a PDP dentist, you do not need to meet an annual deductible, your out-of-pocket expenses are reduced to prenegotiated rates and your annual benefit maximum is greater than if you use a non-PDP dentist. You may obtain a complete list of PDP dental charges from MetLife or the Benefit Center website.

MetLife Dental Option A

The MetLife Dental Option A offers the same in-network services as MetLife Dental Option B when using the PDP network of providers, but features a higher annual maximum and increased orthodontic benefits. When using out-of-network or non-PDP providers, Option A offers greater benefits than Option B, including orthodontic benefits for adults.

In-Network PDP Features

- Diagnostic and preventive care is covered at 100%.
- Restorative care is covered at 80% of the discounted fee.
- Prosthodontics, inlays, onlays, crowns and implants are covered every seven years per tooth at 50% of the discounted fee.
- Orthodontics are covered at 50% of the discounted fee for children to age 26 and adults, up to a $3,000 lifetime benefit maximum per person. **NOTE**: An in-network dentist providing Invisalign services can charge their normal fee but you will only be covered based on the in-network PDP fee schedule. The in-network dentist has to inform you of the cost difference

and you must agree to be responsible for any cost difference between the PDP network fee and the dentist's charge for the Invisalign treatment. You will be responsible for any cost difference.

- There is no annual deductible.
- Your annual benefit maximum is $3,000 per person (excluding orthodontia).
- You are eligible to receive a discounted rate from a MetLife PDP provider for noncovered services, such as bleaching. To receive the discounted rate, you must notify your provider that you participate in the MetLife PDP program.

Out-of-Network Non-PDP Features

- Diagnostic and preventive care is covered at 80% of reasonable and customary charges ("Eligible Expenses").
- Restorative care is covered at 75% of Eligible Expenses after the deductible.
- Prosthodontics, inlays, onlays, crowns and implants are covered every seven years per tooth at 50% of Eligible Expenses after the deductible.
- Orthodontics are covered at 50% of Eligible Expenses for both children to age 26 and adults, up to a $3,000 lifetime benefit maximum per person. No deductible.
- Your annual deductible is:
  - $50 per person
  - $150 family maximum
- Your annual benefit maximum is $2,000 per person.

MetLife Dental Option B

With MetLife Dental Option B, you will pay a percentage of the cost of services or coinsurance. You may reduce your dental costs by using providers in the MetLife PDP Network.

When you receive services from a non-PDP dentist, you must meet an annual deductible before MetLife Dental Option B pays benefits. The deductible is waived for diagnostic and preventive services (see the *Covered Dental Expenses* chart on page 92). For all other services, MetLife Dental Option B pays a portion of the Eligible Expenses after you meet the annual deductible.

In-Network PDP Features

- Diagnostic and preventive care is covered at 100%.
- Restorative care is covered at 80% of the discounted fee.
- Prosthodontics are covered at 50 percent of the discounted fee.
- Orthodontics are covered at 50 percent of the discounted fee for children to the age of 19, up to a $2,000 lifetime benefit maximum per person.
- There is no annual deductible.
- Your annual benefit maximum is $2,000 per person (excluding orthodontia).

Out-of-Network Non-PDP Features

- Diagnostic and preventive care is covered at 50% of Eligible Expenses.
- Restorative care is covered at 40% of Eligible Expenses after the annual deductible.
- Prosthodontics, inlays, onlays and crowns are covered at 25% of Eligible Expenses after the annual deductible.
- Orthodontics are not covered.
- Your annual deductible is:
  - $100 per person
  - $300 family maximum
- Your annual benefit maximum is $1,000 per person.

If you choose to participate in a MetLife Dental option, log on to www.metlife.com/mybenefits to review your available benefits, see detailed plan information, download a claim form and track your claim status and history.

Delta Dental

Delta Dental Option

The Delta Dental option offers you three choices for obtaining dental care:

1. **Delta Dental PPO In-Network Providers:** You may obtain services from any of Delta Dental's 283,600 PPO network provider locations nationwide. With this option, the cost of services has been negotiated and provides you with significant savings.
2. **Delta Dental Premier Network Providers:** You may obtain services from the Delta Dental

Premier network which is composed of approximately 359,000 dental offices. Dentists participating in the Premier network have contracted their service fees directly with Delta Dental.

3. **Out-of-Network:** You may obtain services from any out-of-network provider of your choice.

Delta Dental In-Network Dentists

When you receive services from a Delta Dental PPO in-network dentist, you do not need to meet an annual deductible, and your out-of-pocket costs are reduced to the Delta Dental PPO Maximum Plan Allowance (MPA), or the dentist's actual fee, whichever is less (the "Allowed Amount"). In addition to reducing your out-of-pocket costs, using PPO in-network dentists provides you with a greater annual benefit maximum per person.

Delta Dental Premier Dentists

When you receive services from a Delta Dental Premier dentist, you must meet an annual deductible before the Delta Dental Plan option pays benefits. The annual deductible is waived for diagnostic, preventive and periodontal maintenance services (see the *Covered Dental Expenses* chart on page 92.) Once you meet the annual deductible, your out-of-pocket costs are reduced to the Delta Dental Premier MPA or the dentist's actual fee, whichever is less (the "Allowed Amount"). Services provided by a Delta Dental Premier dentist are benefited at the out-of-network level of benefits.

Out-of-Network Dentists

When you receive services from a dentist who does not participate in Delta Dental's networks, you must meet an annual deductible before the Plan pays benefits. The deductible is waived for diagnostic, preventive, periodontal maintenance and orthodontic services (see the *Covered Dental Expenses* chart on page 92). After you meet your annual deductible, payment for services performed by a nonparticipating dentist is calculated by Delta Dental using a maximum allowance as determined by the Plan. Delta Dental makes all payments directly to you, and you are responsible for paying your dentist's total fee, which may include amounts and services not covered by the plan.

PPO In-Network Features

- Diagnostic and preventive care is covered at 100% of the applicable Allowed Amount.
- Restorative care is covered at 80% of the applicable Allowed Amount.
- Prosthodontics, inlays, onlays, crowns and implants are covered every seven years per tooth at 50% of the applicable Allowed Amount.
- Orthodontics are covered at 50 percent of the applicable Allowed Amount for both children and adults, up to a $3,000 lifetime benefit maximum per person.
- There is no annual deductible.
- Your annual benefit maximum is $3,000 per person (excluding orthodontia).

Premier Network and Out-of-Network Features

- Diagnostic and preventive care is covered at:
  - 85% of the applicable Allowed Amount for the Premier network
  - 80% of the applicable Allowed Amount when using out-of-network providers
- Restorative care is covered at 75% of the applicable Allowed Amount after the annual deductible.
- Prosthodontics, inlays, onlays, crowns and implants are covered every seven years per tooth at 50% of the applicable Allowed Amount after the annual deductible.
- Orthodontics are covered at 50% of the applicable Allowed Amount for both children and adults, up to a $3,000 lifetime benefit maximum per person. No deductible.
- Your annual deductible is:
  - $50 per person
  - $150 family maximum
- Your annual benefit maximum is $2,000 per person (excluding orthodontia).

If you choose to participate in the Delta Dental option, you may find a PPO in-network or participating Premier dentist in your area by visiting the online dentist directory at www.deltadentalins.com or by calling Delta Dental at 800-932-0783.

Cigna Global Health Dental Plan Features

- Diagnostic and preventive care is covered at 100% of Eligible Expenses.
- Restorative care is covered at 80% of Eligible Expenses after the deductible.
- Prosthodontics, inlays, onlays and crowns are covered at 50% of Eligible Expenses after the deductible.
- Orthodontics are covered at 50% of Eligible Expenses, after a separate $50 deductible, for children to age 26, up to a $3,000 lifetime benefit maximum per person.
- Your annual deductible is:
  - $50 per person
  - $150 family maximum
- Your annual benefit maximum is $2,000 per person (excluding orthodontia).

Note: If you participate in a health care FSA or LPFSA, automatic reimbursement is available. For any additional eligible dental expenses that may be reimbursed through a health care FSA or LPFSA, you must submit a manual claim form and itemized receipt to UHC or YSA for reimbursement.

See the *Submitting a Claim Form* section on page 108 for additional information.

Dental Plan Reimbursement Schedule

This chart describes covered services under each Dental Plan coverage option.

PLAN FEATURES	METLIFE DENTAL OPTION A AND DELTA DENTAL[1]		METLIFE DENTAL OPTION B		CIGNA GLOBAL HEALTH DENTAL
	In-Network/ PDP & PPO Services	**Out-of-Network/ Non-PDP/Premier Services**	**In-Network/ PDP Services**	**Out-of-Network/Non-PDP Services**	**In- and Out-of-Network**
Annual Deductible[2] (Applies to all salary levels)	No annual deductible	$50 per person $150 family maximum	No annual deductible	$100 per person $300 family maximum	$50 per person $150 family maximum
Diagnostic and Preventive Care	100% of discounted fee	Delta Dental Premier: 85% of Allowed Amount MetLife and Delta Dental Out-of-Network: 80% of Eligible Expenses	100% of discounted fee	50% of Eligible Expenses	100% of Eligible Expenses
Restorative Services	80% of discounted fee	75% of Eligible Expenses or Allowed Amount (Delta Premier), after annual deductible	80% of discounted fee	40% of Eligible Expenses, after annual deductible	80% of Eligible Expenses, after annual deductible
Prosthodontics, Inlays, Onlays and Crowns Covered every seven years per tooth	50% of discounted fee	50% of Eligible Expenses or Allowed Amount (Delta Premier), after annual deductible	50% of discounted fee	25% of Eligible Expenses, after annual deductible	50% of Eligible Expenses, after annual deductible
Orthodontics[3] Lifetime benefit maximum is applied across plan options No deductible applied except for Cigna Global Health Dental Plan	50% of discounted fee, up to a $3,000 lifetime benefit maximum per person (MetLife: children to age 26 and adults; Delta: children to age 26 and adults)	50% of Eligible Expenses or Allowed Amount (Delta Premier), up to a $3,000 lifetime benefit maximum per person (MetLife: children to age 26 and adults; Delta: children to age 26 and adults)	50% of discounted fee, up to a $2,000 lifetime Benefit Maximum per person (children to age 19)	Not covered	50% of Eligible Expenses after separate $50 deductible, up to a $3,000 lifetime maximum per person (children to age 26)
Annual Benefit Maximum[3] Per Person	$3,000	$2,000	$2,000	$1,000	$2,000

[1] For the Delta Dental Plan option, the reimbursement percentage is based on Delta Dental's applicable Maximum Plan Allowance or the dentist's fee, whichever is less (the Allowed Amount).
[2] The deductible is waived for diagnostic, preventive care and orthodontic services except for orthodontic services under the Cigna Global Health Dental Plan.
[3] No person may receive more than the annual benefit maximum during a calendar year (excluding orthodontics) even if provided by an in-network or PDP dentist.

Covered Dental Expenses

Each of the Morgan Stanley Dental Plan options covers the dental expenses listed in the chart below. Refer to the *Dental Plan Exclusions and Limitations* on page 94 for more information.

TYPE A EXPENSES DIAGNOSTIC/PREVENTIVE SERVICES	TYPE B EXPENSES MINOR RESTORATIVE SERVICES	TYPE C EXPENSES PROSTHODONTIC SERVICES
Oral exams twice per calendar year; during pregnancy you may receive an additional oral exam in a calendar year	Fillings ("silver" or "white")	Crowns (replacement limitation—not more than once every seven years)
Prophylaxis (scaling and cleaning of teeth) twice per calendar year; during pregnancy: choice of one additional prophylaxis in a calendar year or one additional periodontal maintenance procedure in a calendar year **Periodontal Prophylaxis** (deep-tissue cleanings) four times per calendar year but reduced by the number of routine preventive prophylaxes so that the total number of prophylaxes does not exceed four times per calendar year	Extractions **Scaling and Root Planing** once per unique area every 24 months	Repair of crowns and bridgework (restoration limitation—not more than once every three years)
Space maintainers for eligible individuals under age 19	Oral surgery	Initial installation of fixed bridgework
Fluoride treatments for eligible individuals under age 19 (once per calendar year)	Periodontal services (surgical and non-surgical)—supporting tissues of the teeth Periodontal surgery, including gingivectomy, gingival curettage and osseous surgery, but no more than one surgical procedure per quadrant in any 36-month period	Initial installation of partial or full removable dentures (including adjustment after six months) from initial placement
Sealants on permanent molars for eligible individuals under age 19 (one application per 60 months)	General anesthesia administered during covered dental services	Replacement of, or addition to, dentures or bridgework to replace teeth extracted or accidentally lost, to change temporary denture with a permanent one if done within 12 months of the installation of the temporary denture, or to replace an appliance that is more than seven years old and cannot be made serviceable
Full-mouth X-rays (not more than one series in 60 consecutive months)	Endodontics: Root canal therapy	Gold fillings, inlays and onlays when other restorative materials cannot be used (replacement limitation—not more than once every seven years) Covered benefit percentage amount may vary based on the Dental Plan option
Bitewing X-rays Dependent children to age 19 (two sets per calendar year) Adult bitewings, age 19 and over (one set per calendar year)	Injection of antibiotic drugs	Dental Implants—reconstruction of missing teeth and their supporting structures with natural or synthetic (alloplastic, allogenic or autogenous) substitutes (replacement limitation—not more than once every seven years)
Emergency treatment to alleviate pain	Recement inlays/onlays	Bruxism (grinding the teeth), including bite guards

Important Information About the Dental Plan Options

Predetermination of Benefits

If you need dental care beyond a routine checkup or cleaning, you should discuss the services and cost of treatment with your dentist before having the procedure performed. If treatment is expected to cost $300 or more, your dentist may complete a pretreatment estimate, which can be found on the dental claim form. The pretreatment estimate describes the services and charges proposed by your dentist.

You or your dentist may send the completed form to your Dental plan administrator (Delta Dental, MetLife or Cigna Global Health) for review. Your Dental plan administrator will then advise you how much the Dental Plan will pay for these services before work begins. If the procedure for which you receive a pretreatment estimate is not followed or if the verifying information required by the Dental plan administrator is incomplete, the benefits paid will be based on the information submitted. This could result in a smaller benefit than would otherwise be paid. If you choose not to submit a pretreatment estimate, your procedure may be reimbursed at a lower rate than you expect.

Alternate Courses of Treatment

Dental procedures can vary greatly in expense. To help manage dental costs, dental consultants may review pretreatment estimates and claim forms to determine whether alternate courses of treatment that meet generally accepted standards of care would provide a satisfactory result at a lower cost. If there is more than one suitable procedure for your particular situation, the Dental Plan will pay benefits for the less expensive procedure. If you and your dentist elect to use a more expensive procedure or material, you will be required to pay the difference between the costs of the procedure provided and that which is approved by the Dental plan administrator.

Exclusions and Limitations[1]

On the following pages is a chart that outlines those services and supplies that are not covered under the Dental Plan. To find out whether other types of services are covered, contact your Dental plan administrator. Please note the following additional exclusions or limitations:

- Charges in excess of Eligible Expenses amounts, Allowed Amounts; charges that satisfy the annual deductible or exceed annual maximums.
- Benefits will not be payable for treatment received before your coverage under the Plan begins. However, if previously initiated treatment is completed after the effective date of Plan coverage, a portion of the cost may be covered.

[1] Reminder: Be sure to review the restrictions contained in the discussion of "**When must I file a claim?**" including limitations on your ability to bring a lawsuit to recover benefits under the Plan.

Dental Plan Exclusions and Limitations

Below is a list of services and supplies that are excluded from coverage. For more, please call your Dental plan administrator.

CATEGORY	EXCLUSION OR LIMITATION
General Services	• Missed appointments • Treatment by a provider other than a dentist or licensed dental hygienist under the supervision of a dentist • Oral-hygiene instruction, plaque-control programs and dietary instructions • Services or supplies that are normally provided free of charge • Services or supplies not recommended and approved by the attending dentist or physician • Services or supplies not dentally necessary • Services or supplies that do not meet generally accepted standards of dental care, as determined by the Dental Plan administrator • Any dental services or supplies included as covered expenses under another Morgan Stanley benefit plan • Experimental procedures • Fabrication of athletic mouth guards • Periodontal splinting • Prescription drug premedications, relative analgesia • Replace tooth structure by attrition • Equilibration • Gianthological recordings • Charges for hospitalization, including hospital visits
Dentures, Crowns and Inlays	• Elaborate attachments or features for dentures, bridgework or other dental appliances • Replacement of a lost, missing or stolen prosthetic device or appliance • Any duplicate prosthetic device or appliance • Dentures, crowns, inlays, onlays and bridgework or other appliances or services to increase vertical dimension • Veneers on crowns or pontics on the molar teeth • Supplies that are temporary (for example, a temporary bridge)
Treatment of Conditions	• Procedures to correct congenital or developmental malformations, except for covered dependent children and newborn children eligible at birth • Treatment for temporomandibular joint (TMJ) disorder or other craniomandibular disorders except for the following: – Delta Dental: ▪ TMJ arthrogram, including injection, and temporomandibular joint films are covered both in- and out-of-network, Type A expense. – MetLife: ▪ TMJ appliance is covered under the MetLife Dental Option A, both in- and out-of-network, Type C expense; and MetLife Dental Option B, in-network only, Type C expense. • Treatment of any jaw disorder
Cosmetic	• Cosmetic services and supplies, such as bleaching

Right to Reimbursement (Subrogation Agreement)

The Dental Plan has the right to receive reimbursement for any recovery from a third party due to an injury or other condition for which the Plan provided benefits. This right is called "subrogation." The Medical Plan's subrogation rules apply to the Dental Plan. See the *Right to Reimbursement (Subrogation Agreement)* on page 17.

Vision Plan

The Morgan Stanley Vision Plan encourages you to receive regular vision exams and manages the cost of vision care.

The Morgan Stanley Vision Plan is administered by VSP.

Morgan Stanley offers U.S. employees a choice of two vision coverage options:

- Option A
- Option B

The primary differences between Options A and B are that Option A includes a higher allowance for frames and contact lenses, covers the purchase of frames every year instead of every two years and has higher out-of-network benefits.

You may enroll in the Vision Plan in the same coverage categories as the Medical and Dental Plans. However, unlike those plans, Morgan Stanley does not share in the cost of your vision care premiums.

VSP Vision Plan

The Vision Plan gives you the freedom to receive vision care services from within the VSP Signature Network of participating providers or from any out-of-network vision care provider you choose. Both options will cover some portion of the costs of eye examinations, prescription eyeglass lenses and frames, or contact lenses. Please be aware that whether using in-network or out-of-network services, VSP makes a distinction between elective and necessary contact lenses. If you can wear prescription eyeglass lenses and frames but choose to wear contact lenses instead, you will receive a lower benefit. VSP must determine that the lenses are medically necessary to receive the maximum benefit under the in- and out-of-network plan features.

In-Network Benefits

The VSP Signature Network is composed of more than 35,000 vision care providers at over 75,000 locations nationwide and includes independent optometrists, ophthalmologists and Participating Retail Chains. All VSP Signature Network doctors must meet VSP's standards for licensing, education, practice history and providing services to be accepted into the VSP Signature Network.

For both Vision Plan Options services, such as eye exams, eyeglass lenses and frames (up to the allowance) are covered at 100 percent after a $20 copay. Additionally, the Vision Plan offers an average 15% reduction or 5% off the promotional price for laser vision correction surgery when services are received within the VSP Signature Network. You may also receive discounted vision care benefits of up to 30 percent on additional prescription glasses and sunglasses.[1]

A list of VSP Signature Network doctors is available on the VSP website at www.vsp.com or by calling VSP customer service at 800-877-7195. Log into the VSP website with your user ID and password, and click on "Find a VSP Doctor." You may also search for a doctor from the Benefit Center website.

When using a VSP Signature Network doctor, you do not need an ID card to obtain services and there are no claim forms to submit; however, you may log into vsp.com with your user ID and password to obtain an online member vision card. When making an appointment with a VSP Signature Network doctor, identify yourself as a participant in the Vision Plan and provide the office with the employee's first and last name and date of birth.

Participating Retail Chains

Participating Retail Chains are providers of covered services and materials who are not contracted as VSP Signature Network Providers, but who have agreed to bill VSP directly. Some Participating Retail Chains may be unable to provide all VSP benefits. Services from a Participating Retail Chain are in lieu of services

[1] Prices and discounts may vary by provider.

provided by a VSP Signature Network or out-of-network provider. VSP is unable to require Participating Retail Chains to adhere to VSP's quality standards for VSP Signature Network providers. Where Participating Retail Chains are located in a membership-only retail environment, you may be required to purchase a membership with the retailer as a condition to receiving Vision Plan benefits through VSP. Contact VSP for details.

Out-of-Network Benefits

If you prefer, you may choose to use an out-of-network provider. When using this option, you will receive reimbursement for eligible eye care services up to the Plan's reimbursement allowance. You must pay for all services and submit a claim form to VSP. Claims for reimbursement must be submitted to VSP within 12 months of the date the service was received. Or you may ask your provider to contact VSP to confirm your eligibility and reimbursement allowances. The provider may then submit the claim on your behalf. The reimbursement will be sent directly to the provider and the provider will only charge you the difference.

Flexible Spending Account

If you participate in a Health Care FSA or LPFSA, automatic reimbursement is available. For any additional eligible vision expenses that may be reimbursed through a Health Care FSA or LPFSA, you must submit a manual claim form and itemized receipt to UHC or YSA for reimbursement. For more information, see the *Submitting a Claim Form* section on page 108 (for the Health Care FSA) or page 113 (for the LPFSA).

Additional VSP Benefits

Laser Vision Correction Surgery

You and your covered dependents may receive discounts ranging from 10% to 25% (average of 15%) off the cost of laser vision surgery when using VSP's in-network Laser Vision Care providers. If the provider is offering a temporary price reduction, VSP members will receive a 5% discount off the promotional price if it is less than the usual discounted price. To receive the laser vision correction surgery discount, you must use a participating VSP Laser Vision Care doctor.

The maximum fee you will pay for laser vision surgery with a participating provider is:

- $1,500 per eye for PRK
- $1,800 per eye for LASIK
- $2,300 per eye for Custom LASIK

You are responsible for paying all fees directly to the provider.

To find a VSP Laser Vision Care doctor near you, visit www.vsp.com or call VSP's member services at 800-877-7195.

Low Vision

Low vision is a significant loss of vision but not total blindness, as determined by VSP. If you or a participating family member suffers from low vision, you may receive low-vision services from a VSP Signature Network doctor or out-of-network provider. Ophthalmologists and optometrists specializing in low-vision care can evaluate and prescribe optical devices, and provide training and instruction to maximize the remaining vision.

VSP's covered low-vision services include:

- Supplemental low-vision testing every two years, which includes evaluation, diagnosis and prescription of vision aids, when needed
  - Testing is covered in full from a VSP Signature Network doctor.
  - You may be reimbursed up to $125 when testing is performed by an out-of-network doctor.
- If low-vision aids are approved, VSP will cover 75% of the approved fee, up to a maximum of $1,000 every two years (less any amount paid for the supplemental testing), from either a VSP Signature Network doctor or out-of-network provider. You are responsible for the remaining 25%, plus any amount over the approved fee. Please refer to the chart on page 98.

Not all Participating Retail Chains provide low-vision services. Contact VSP for details.

Vision Plan Schedule of Benefits

The chart below compares the cost of Vision Plan services received in-network vs. out-of-network for Plan Options A and B.

	OPTION A		OPTION B	
SERVICE	**VSP IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**	**VSP IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
Exam includes dilation (when necessary), once per calendar year	100%, after $20 copay	Up to $50 reimbursement, after $20 copay	100%, after $20 copay	Up to $40 reimbursement, after $20 copay
Retinal screening (as an enhancement to Exam, for eligible members with diabetes)	Up to $39 copay	Not available	Up to $39 copay	Not available
Eyeglass Lenses—Available once every calendar year				
Single	100%, after $20 copay[1]	Up to $50 reimbursement, after $20 copay	100%, after $20 copay[2]	Up to $40 reimbursement, after $20 copay
Bifocal	100%, after $20 copay[1]	Up to $75 reimbursement, after $20 copay	100%, after $20 copay[3]	Up to $60 reimbursement, after $20 copay
Trifocal	100%, after $20 copay[1]	Up to $100 reimbursement, after $20 copay	100%, after $20 copay[2]	Up to $75 reimbursement, after $20 copay
Lenticular	100%, after $20 copay[1]	Up to $125 reimbursement, after $20 copay	100%, after $20 copay[2]	Up to $80 reimbursement, after $20 copay
Optional Lens Types and Treatments—Available once every calendar year				
All typical lens options are covered[4]	100%	Not available; except for Tints: up to $5	100%	Not available; except for Tints: up to $5
Frames[5]—Available once every two calendar years				
Includes the frame of your choice	Up to $250[6] every calendar year, after $20 copay (total for both lenses and frames); 20% discount on cost exceeding $250	Up to $70 reimbursement, every calendar year after $20 copay	Up to $150[7] every other calendar year, after $20 copay (total for both lenses and frames); 20% discount on cost exceeding $150	Up to $60 reimbursement every other calendar year, after $20 copay

[1] Copay applies to both eyeglass lenses and/or frames.
[2] Copay applies to both eyeglass lenses and/or frames.
[3] Copay applies to both eyeglass lenses and/or frames.
[4] Including progressive lenses, photochromic lenses, scratch-resistant coating, anti-reflective coating, hi-index lenses, polarized lenses, polycarbonate lenses, ultraviolet coating, blended segment lenses, rimless lenses, oversized lenses, laminated lenses and edge treatments.
[5] If you are enrolled in Option A and received frames or contact lenses during the year, and then elect to change from the Option A to Option B during the annual enrollment period, you will not be eligible for new frames or contact lenses until the second year of enrollment in Option B.
[6] The frame allowance for Costco, Wal-Mart and Sam's Club is $135.
[7] The frame allowance for Costco, Wal-Mart and Sam's Club is $80.

Vision Plan Schedule of Benefits (continued)

	OPTION A		OPTION B	
SERVICE	**VSP IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**	**VSP IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
Contact Lenses—Available once every calendar year (in lieu of lenses and frames)				
Elective Contact Lenses (In lieu of eyeglass lenses and frames.) When choosing contact lenses instead of glasses, your allowance applies toward the cost of the contact lenses and contact lens exam (fitting and evaluation). The contact lens exam is a separate service for the purpose of fitting for contact lenses.	Up to $250 allowance Up to $60 copay for contact lens fitting and exam 15% discount on contact lens exam (fitting and evaluation), as long as the services are obtained within 12 months of your last eye exam	Up to $105 reimbursement (contacts and exam)	Up to $150 allowance Up to $60 copay for contact lens fitting and exam 15% discount on contact lens exam (fitting and evaluation), as long as the services are obtained within 12 months of your last eye exam	Up to $100 reimbursement (contacts and exam)
Medically Necessary Lenses Approval by VSP is required	100%, after $20 copay	Up to $210 reimbursement, after $20 copay	100%, after $20 copay	Up to $210 reimbursement, after $20 copay
Diabetic Eyecare Plus[1]	$20 copay for additional eye care services for members with diabetic eye disease, glaucoma or age-related macular degeneration (AMD)	Not Available	$20 copay for additional eye care services for members with diabetic eye disease, glaucoma or age-related macular degeneration (AMD)	Not Available
Laser Vision Correction Surgery[2]				
PRK, LASIK and Custom LASIK using wavefront technology only, at a discounted fee from a contracted facility	Discounts range from 10% to 25% (average 15%) (depending upon location) or 5% off any advertised discounted fee, whichever is lower	Not Available	Discounts range from 10% to 25% (average 15%, depending on location), or 5% off any advertised discounted fee, whichever is lower	Not Available
Additional Laser Vision Care Benefit				
After surgery, use any eligible frame benefit for nonprescription sunglasses from any VSP Signature Network doctor	Once every year, up to $250, after $20 copay (total for both lenses and frames), plus 20% discount on costs exceeding $250	Not Available	Once every other year, up to $150, after $20 copay (total for both lenses and frames); 20% discount on cost exceeding $150	Not Available
Low Vision—Available once every two calendar years				
Supplemental Testing (includes evaluation, diagnosis and prescription aids where indicated)	100%	Up to $125 reimbursement	100%	Up to $125 reimbursement

[1] Approval by VSP is required.
[2] The maximum fee a member will pay with an in-network center is $1,500 per eye for PRK, $1,800 per eye for LASIK and $2,300 per eye for Custom LASIK.

Vision Plan Schedule of Benefits (continued)

	OPTION A		OPTION B	
SERVICE	**VSP IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**	**VSP IN-NETWORK PROVIDER**	**OUT-OF-NETWORK PROVIDER**
Supplemental Aids Up to $1,000 every two years (combined in- and out-of-network, including the cost of Supplemental Testing)	75% of approved fee	75% of approved fee	75% of approved fee	75% reimbursement of approved fees
Other				
Additional Prescription Glasses and Prescription or Non-Prescription Sunglasses	Savings of 30% off the retail cost when purchased from the same VSP Signature Network doctor on the same day as your eye exam OR Savings of 20% off the retail cost when purchased from any VSP Signature Network doctor within 12 months of your last covered eye exam	Not Available	Savings of 30% off the retail cost when purchased from the VSP Signature Network doctor on the same day as your eye exam OR Savings of 20% off the retail cost when purchased from any VSP Signature Network doctor within 12 months of your last covered eye exam	Not Available

Vision Plan Exclusions and Limitations

Below is a list of services and supplies that are excluded from coverage under the Vision Plan.

CATEGORY	EXCLUSION OR LIMITATION
General Services	• Lenses that do not provide vision correction except for nonprescription sunglasses obtained in-network in conjunction with Laser Vision Correction Surgery • Charges for the replacement of lost or stolen lenses or frames • Orthoptics or vision training and any associated supplemental testing • Plano lenses (i.e., when a patient's refractive error is less than a +/-50 diopter power) • Two pairs of glasses instead of bifocals • Medical or surgical treatment of the eyes (other than Laser Vision Correction Surgery) • Replacement of lenses and frames except at the stated intervals when services are available • Certain limitations on low vision care • Any eye examination or any corrective eyewear required by an employer as a condition of employment
Contact Lenses	• Corneal Refractive Therapy (CRT) or Orthokeratology • Replacement of lost or damaged lenses • Insurance policies or service agreements • Plano lenses (i.e., when a patient's refractive error is less than a +/-50 diopter power) • Plano lenses to change eye color cosmetically • Artistically painted lenses • Additional office visits associated with contact lens pathology • Contact lens modification, polishing or cleaning
Cosmetic	• Cosmetic services and supplies

Right to Reimbursement (Subrogation Agreement)

The Vision Plan has the right to receive reimbursement for any recovery from a third party due to an injury or other condition for which the Plan provided benefits.

This right is called "subrogation." The Medical Plan's subrogation rules apply to the Vision Plan. See the *Right to Reimbursement (Subrogation Agreement)* section on page 17.

Health Savings Account (HSA)

If you enroll in Option C of the Medical Plan, you may be eligible to contribute to a Health Savings Account (HSA). An HSA allows you to pay current or future health care expenses tax-free. Depending on your health care needs, you can use your HSA to pay for Eligible Expenses now, or let the account grow with tax-free earnings to use for health care costs in the future, even during your retirement. The HSA is administered by Your Spending Account (YSA) with UMB Bank.

To open an HSA you must:

- be enrolled in Option C of the Medical Plan
- not be enrolled in Medicare
- not be claimed as a dependent on another person's tax return

You are only eligible to open an HSA if you are enrolled in Option C of the Medical Plan. Even if you have other consumer-driven health plan coverage, you are not eligible for an HSA through Morgan Stanley.[1]

Note that your nontax-qualified domestic partner must open his or her own HSA, if eligible.

Note: If you enroll in Option C, you may not contribute to a Health Care Flexible Spending Account (HCFSA). However, you may enroll in a Limited Purpose Flexible Spending Account (LPFSA) to reimburse yourself for eligible dental and vision expenses. For more information on an LPFSA, see the *Flexible* Spending Accounts (FSA) for Health Care and Dependent Day Care section on page 104.

Tax Advantages

You can contribute to an HSA with before-tax money, which will lower your current taxable income. In addition, you don't pay taxes on:

- Contributions to an HSA
- Interest and investment earnings on your HSA balance
- Withdrawals used to pay for eligible health care expenses
- Your pretax contributions to your HSA are not subject to employment taxes or withholding, including Social Security, Medicare and FUTA taxes. As a result, your Social Security income may be affected. Please consult your tax advisor regarding tax implications.
- Funds in an HSA, including investment earnings, roll over from year to year. This means you do not have to "use" the full amount you contribute or "lose" it.

Contribution Rules

Once you have enrolled and established your HSA, you may elect to make before-tax contributions to your account. For 2021, the maximum amount that can be contributed to an HSA is $3,600 for single coverage and $7,200 for family coverage. Your nontax qualified dependent and his or her dependents are not considered your family for this purpose.

If you are age 55 or older, you are eligible to make an additional catch-up contribution of $1,000 each year until you become eligible for Medicare.

If you elect to contribute to your HSA, before-tax contributions are automatically deducted from your paycheck in equal amounts throughout the year.

Or you may elect to contribute on an after-tax basis directly to your HSA by a check or online personal bank account.

You may make changes to your contribution election at any time during the year. Changes generally will take effect during the next available Payroll period following your election change. You must elect to contribute to your HSA each year.

Prior year's HSA contribution elections will not roll over.

[1] If you are enrolled in a high-deductible health plan outside of Morgan Stanley, you may still be eligible to establish an HSA outside of Morgan Stanley. Consult your tax and financial advisor for more information.

How to Use Your Account

When you or your eligible dependent has a health care expense that is not covered by your Plan, you can pay for the expense using the funds in your HSA, up to the amount currently available in the account. Unlike a Health Care Flexible Spending Account (HCFSA), your HSA is not prefunded. The amount available for reimbursement is the amount available in your HSA at the time of the reimbursement request.

Your HSA offers three convenient ways to receive reimbursement:

1. HSA Debit Card

For expenses such as prescriptions and over-the-counter items, you no longer have to use cash, personal check or credit card. Upon enrollment, you will receive an HSA (Your Spending Account or "YSA") debit card in the mail to your address on file. If the provider accepts the YSA debit card, the amount will automatically be deducted from your HSA. If you are also contributing to a Limited Purpose Account (LPFSA), you may use your debit card to pay for dental and vision expenses until you have exhausted the LPFSA balance.

2. HSA Online Bill

For other expenses, such as doctor visits or hospitalizations, you can elect to pay the portion of the bill after you receive your Explanation of Benefits (EOB) from your plan administrator. Your plan administrator will be sent a check directly from your HSA. Check reimbursement costs $15 per check.

3. HSA Online Reimbursement

If you use another form of payment for your out-of-pocket eligible health care expenses, such as a personal credit card or check, you can reimburse yourself by using the HSA's online banking feature by clicking "Get Reimbursed." Based upon your direction, YSA will transfer funds from your HSA to your checking account.

It is important to monitor your HSA account balance; banking charges will apply if your HSA is overdrawn. Review your HSA information carefully to understand all potential banking charges.

You should complete an HSA Beneficiary Designation form naming your HSA beneficiary in the event of your death. You can designate your beneficiary through the Your Spending Account website or by requesting a form from YSA. Note that only a spouse beneficiary will be able to continue the tax-savings nature of your HSA. On your death, your nonspouse beneficiary is taxed on the fair value of the HSA.

Eligible Expenses

Generally, expenses permitted by Section 213(d) of the Internal Revenue Code or otherwise allowed under IRS rules are considered qualified for HSA use. Covered expenses include medical copayments and coinsurance, and dental or vision expenses. You may also use your account to pay for the following insurance premiums:

- COBRA
- Qualified long-term care insurance
- Medicare Part A and B

To view all eligible health care expenses, go to www.irs.gov to review IRS Publication 502.

It is your responsibility to determine which expenses are eligible once you open your account.

Coronavirus Update

Beginning January 1, 2020, you may use your HSA to buy certain over-the-counter medical products, such as drugs and surgical masks, without a prescription from a physician, and for certain menstrual care products, such as tampons and pads, as eligible medical expenses.Given the evolving nature of the pandemic and related legislation, the benefits enhancements may be temporary and are subject to change at any time and without notice or your consent.

Investing Your HSA

When your HSA reaches a balance of $500, you can choose to invest amounts over $500 in one or more available investment funds. The HSA investment options consist of open-ended mutual funds selected and monitored by the bank that holds your account, UMB. The investment options cross a variety of asset classes, giving you the ability to diversify your investments to meet your needs.

Any earnings on the funds in your HSA are distributed tax-free if used to cover eligible health

care expenses now or at any time in the future. Note that investment funds may fluctuate in value with market conditions and that past performance is no indication of future results. It is possible that the market value of your HSA will decrease.

Taxes

If you use your HSA for an ineligible expense, the distribution will be subject to income taxes and a federal excise tax.

YSA is required to report HSA activity to you and the IRS. By the end of January 2022, you will receive a Form 1099-SA reporting your 2021 HSA distributions. You will also receive a Form 5498-SA reporting your 2021 HSA contributions.

Note: Contributions made after January are reported in May. For more information on HSA tax reporting, contact your tax advisor.

Reminder: Be sure to save copies of all your receipts. Documentation for reimbursement is required. For additional questions regarding your HSA, please contact Morgan Stanley HR Services.

Flexible Spending Accounts (FSA) for Health Care and Dependent Day Care

Flexible Spending Accounts allow you to reduce your taxable income and save money by setting aside money on a before-tax basis to pay for eligible health care and dependent day care expenses.

Morgan Stanley offers three types of Flexible Spending Accounts:

1. The **Health Care Flexible Spending Account** (HCFSA) allows you to set aside money on a before-tax basis to pay for eligible health-related expenses.
2. The **Dependent Day Care Flexible Spending Account** (DDCFSA) allows you to set aside money on a before-tax basis to pay for eligible dependent care and elder care expenses that allow you and your spouse to work or attend school on a full-time basis.
3. **The Limited Purpose Flexible Spending Account** (LPFSA) allows participants enrolled in Medical Plan Option C to set aside money on a before-tax basis to pay for eligible dental and vision expenses.

Depending on your needs, you may decide to participate in one or more accounts. When you participate in an HCFSA or DDCFSA, you contribute before-tax dollars to an account maintained by UHC, the HCFSA and DDCFSA administrator. When you participate in an LPFSA, you contribute before-tax dollars to an account maintained by YSA, the LPFSA administrator. Your annual election is credited to your account through Payroll deductions. You may obtain reimbursement as you incur Eligible Expenses throughout the year. Since your total FSA contribution is taken from your pay before federal income taxes are deducted, your taxable income is reduced by the amount of your contribution. You do not need to participate in Morgan Stanley's Medical, Dental or Vision Plan to participate in a HCFSA or DDCFSA. You must be enrolled in Option C of the Medical Plan to participate in an LPFSA.

Please note that you must be paid from a U.S. dollar-based Payroll to be eligible to participate in an FSA.

Participating in the FSAs

To participate in an FSA, you must elect a before-tax contribution amount for the calendar year.

- You may contribute between $100 and $2,750 to the HCFSA each year.
- You may contribute between $100 and $5,000 to the DDCFSA each year if you are single or married and file a joint tax return. If you are married and file a separate return, you may contribute between $100 and $2,500 annually to the DDCFSA. Certain highly compensated employees may have their DDCFSA contribution reduced to comply with IRS "nondiscrimination" rules.
- You may contribute between $100 and $2,750 to the LPFSA each year you are enrolled in Medical Plan Option C.
- Once you make your elections, your contributions will continue for the entire calendar year unless:
  - You terminate employment with Morgan Stanley,
  - You become ineligible to participate in the FSA,
  - Your earnings are reduced to an amount less than your annual FSA election,
  - Your contribution is reduced based on IRS nondiscrimination requirements, or
  - You change your election due to a QLE (see the *Qualified Life Events* section on page 18).

Participation in an FSA may reduce your contributions to Social Security, depending on your pay and the amount of your contribution. This may reduce any Social Security benefits to which you may become entitled in the future.

Your contributions to an FSA will not affect any salary-related Morgan Stanley plans, such as the 401(k) Plan.

About HCFSAs

The HCFSA is designed for anyone who pays out-of-pocket health care costs. Eligible health care expenses include annual deductibles, coinsurance, copays and most other Medical, Dental and Vision expenses that are not fully covered by any benefit plan.

To be eligible, the expenses must be:

- Of a type that would be tax deductible (without regard to any cumulative thresholds to claim a deduction)
- Incurred by December 31 of the calendar year
- Incurred while you are an active participant in the HCFSA
- Not reimbursed under any group health plan

Eligible Health Care Expenses

Examples of out-of-pocket health care expenses that qualify for reimbursement through the HCFSA include:

- Medical, Dental or Vision Plan deductibles, coinsurance and copays
- Routine physician office visits not covered by the Medical Plan
- Annual physical examinations not covered by the Medical Plan
- Vision care expenses, including eye exams, prescription eyeglasses and contact lenses not covered by the Medical and Vision Plans
- Hearing care expenses not covered by the Medical Plan
- Amounts in excess of Eligible Expenses limits under the Medical and Dental Plans
- Certain prescribed medical supplies and equipment not covered by the Medical Plan
- Over-the-counter medications with a prescription
- Over-the-counter medical supplies (such as health monitors, support braces and hearing aid batteries) without a prescription. A doctor's note explaining medical necessity may be required.
- Orthodontic expenses not covered by the Dental Plan
- The difference in cost between a hospital's semi-private and private room charge
- Smoking-cessation programs and any related prescribed medications
- Weight-loss programs due to the diagnosis of a disease such as hypertension or obesity
- Transportation expenses incurred for essential medical care

For more information about eligible health care expenses, review *IRS Publication 502*, **Medical and Dental Expenses**, which is available online at www.irs.gov.

Please note that when you receive reimbursement from the HCFSA for an expense, it cannot be claimed as a deduction on your federal income tax return.

Coronavrius Update

Beginning January 1, 2020, you may use your HCFSA to buy over-the-counter medical products, such as drugs and surgical masks, without a prescription from a physician, and to pay for certain menstrual care products, such as tampons and pads, as eligible medical expenses. Given the evolving nature of the pandemic and related legislation, the benefits enhancements may be temporary and are subject to change at any time and without notice or your consent.

Ineligible Health Care Expenses

Over-the-Counter (OTC) nonprescribed medications are not eligible for HCFSA reimbursement. The following are some other expenses that are not eligible for reimbursement from the HCFSA:

- Joint counseling (for example, marriage or family counseling)
- Insurance premiums for any health plan
- Food purchased through weight-loss programs
- Expenses for custodial care in a nursing home
- Cosmetic surgery or treatments such as teeth whitening (unless it is to correct a birth defect or to correct an injury from an accident)

Definition of Eligible Dependents

For the HCFSA, the definition of eligible dependents is different than the definition used for other Morgan Stanley health plans. Under the HCFSA, you may request reimbursement for eligible health care expenses incurred by:

- Yourself
- Your spouse
- Your dependent children
- Any individual you can claim as a dependent for federal income tax purposes, regardless of whether they meet the eligibility requirements of other Morgan Stanley group health plans

Under IRS regulations, the HCFSA may not recognize domestic partners or children of domestic partners as eligible dependents unless they meet the criteria listed above and the relationship is not in violation of local law. Same-sex spouses who are lawfully married under a state or foreign law are recognized.

Your dependents' eligible expenses may be reimbursed through the HCFSA even if they are not enrolled as dependents under Morgan Stanley's Medical, Dental or Vision Plan, provided that you can claim them as dependents on your federal tax form.

HCFSA Reimbursement

When you elect to participate in an HCFSA, your full annual contribution amount will be available to you for reimbursement at the beginning of the year. This means that you may request reimbursement from your account as soon as you or your dependents have an eligible expense, regardless of how much you have contributed toward your account at that point in time. If you have a QLE and increase your contribution election during the year, only expenses incurred on or after the date of the QLE are eligible for reimbursement from the additional amount.

In general, you may receive reimbursement from your HCFSA in three ways—Health Care Spending Debit MasterCard, Automatic Reimbursement or by submitting a claim form.

Health Care Spending Card Debit MasterCard®

You will be provided with a Health Care Spending Card Debit MasterCard® that may be used to pay for certain Eligible Expenses directly from your Healthcare FSA. The Health Care Spending Card Debit MasterCard® allows for direct payment to qualified locations and providers and can be used at any approved location that accepts MasterCard®.

Use of the Health Care Spending Card Debit MasterCard® is voluntary and if elected you may continue to use automatic reimbursement or submit a manual form to request a reimbursement.

Receiving Your Health Care Spending Card Debit MasterCard®.

If you choose to activate the Health Care Spending Card Debit MasterCard® you will need to call the toll-free number indicated on the sticker affixed to the card and follow the voice prompts to activate. The card will be ready to use with funds available in real-time upon activation of the card within effective date of coverage for the Plan year.

You will automatically receive two Health Care Spending Card Debit MasterCards®. Read the terms and conditions found on the card insert and sign the back of your card. You may call the customer service number listed on the back of the Health Care Spending Card Debit MasterCard® to order additional cards.

Qualified Locations and Providers

The Health Care Spending Card Debit MasterCard® may be used at any approved provider or merchant with a Point-of-Service (POS) bankcard terminal that accepts MasterCard®, or your Health Care Spending Card Debit MasterCard® number can be entered online or on an order form, similar to using a credit card number. You can even use your Health Care Spending Card Debit MasterCard® to pay for a bill you receive in the mail if the merchant or provider accepts MasterCard®. Examples of qualified locations and providers include hospitals, physician and dental offices, vision care providers and retail pharmacy counters.

Using the Health Care Spending Card Debit MasterCard®

In order to use the Health Care Spending Card Debit MasterCard®, you will need to enter "credit" on the POS bankcard terminal just as if you were purchasing an item using a credit card. Each time the card is used for payment, you will sign a receipt. Your FSA and card are regulated by the IRS; therefore you should retain all itemized receipts generated from the Health Care Spending Card Debit MasterCard®, because certain

payments must be verified and UnitedHealthcare may request this receipt from you to ensure that payment was made for a qualified health care or dependent care expense. Credit card receipts that do not itemize expenses are not sufficient to verify payment. Amounts paid that cannot be verified may be considered taxable income to you.

Once you swipe the Health Care Spending Card Debit MasterCard® through the POS bankcard terminal, your available benefit balance is verified. The card validates your purchases in real time and automatically debits your FSA account based on the guidelines established by the IRS and your specific plan design as described under the *Health Care Spending Account* and *Dependent Care Spending Account* sections. A claim number is assigned to the transaction.

Your card can be used for certain Eligible Dependent Care Expenses and Eligible Health Care Expenses including prescription copayments or out-of-pocket responsibility, eligible over-the-counter (OTC) supplies, materials, prescribed OTC medicines and copayments, deductibles and coinsurance at locations such as doctor, dentist, eye doctor, clinic, hospital or other care providers associated with Medical, Dental or Vision at UnitedHealthcare in-network providers. Additionally, your card can be used for out-of-network copayments if your copayment is the same as the in-network copayment. While in-network provider transactions can be used for coinsurance and deductibles, the card does not determine patient responsibility or eligible benefits.

Please note

You may be able to use your Health Care Spending Card Debit MasterCard® to pay for prescribed OTC medicines if you take your OTC prescription to a pharmacist to be filled and have a prescription number assigned. Or you may purchase prescribed OTC medicines using another form of payment, such as cash or a personal credit card. If it is an Eligible Expense under your Plan, you can manually submit for reimbursement. Non-prescribed OTC medicines are not an Eligible Expense subject to reimbursement.

Partial Payment Authorization

Partial authorization capability allows you to use your Health Care Spending Card Debit MasterCard® for transactions with amounts greater than the funds available in your HCSA for a portion of the transaction at providers or merchants that accept partial authorization. For example, if you purchase an item that costs $20 and you only have $10 remaining in your HCFSA, the HCFSA balance of $10 will be authorized for the purchase and you are responsible for paying the remaining balance of $10 with another form of payment. **Note:** Not all providers or merchants permit you to do a partial authorization.

Explanation of Benefits (EOBs) will not be issued for card transactions. Instead, you will receive monthly health statements and a FSA yearly statement, which will include your card activity. You will also be able to view card transactions on www.myuhc.com. If you note a discrepancy on the monthly health statement or FSA yearly statement, call the number on the back of your Health Care Spending Card Debit MasterCard® to resolve the issue.

Getting help 24 hours a day is easy.

Simply call our toll-free number at 1-866-755-2648 available 24 hours a day:

- Learn your account balance.
- Report a lost or stolen card.
- Order extra cards and more.

Go onto myuhc.com anytime.

Automatic Reimbursement

Eligible out-of-pocket expenses incurred through the Medical, Dental and Vision Plans may be automatically forwarded to UHC for reimbursement from your HCFSA, and you will not need to submit a claim form. To authorize your health plans to submit your expenses to UHC on your behalf, you must elect the Automatic Reimbursement feature from the Benefit Center website. When enrolling in the HCFSA, you will have the option to elect or waive the Automatic Reimbursement feature. This feature may be turned on or off at any time by contacting HR Services. To update your banking information for Automatic Reimbursement, you

must create an account on the UHC website at www.uhc.com. You will need to reference FSA Group Number 202942 and your Social Security number.

Only eligible out-of-pocket expenses covered by a group health plan will be forwarded for Automatic Reimbursement. Expenses that are not covered by a health plan, such as over-the-counter medications or denied expenses, will not be submitted for Automatic Reimbursement. Instead, you must submit a claim form as described below. Please allow one to two weeks from the date of service for claims to be forwarded to UHC for Automatic Reimbursement.

Automatic Reimbursement is currently not available for employees who cover domestic partners or their eligible dependents. Instead, requests for payment of HCFSA benefits must be made by submitting a claim form. Additionally, expenses incurred through the HMSA Medical Plan or a Kaiser HMO cannot be automatically reimbursed.

If you participate in the Vision Plan, Automatic Reimbursement is available until you reach the maximum allowance for eyeglasses or contact lenses under the Vision Plan. For additional Vision expenses that may be reimbursed through the HCFSA, you must submit a manual claim form and itemized receipt to UHC for reimbursement.

Submitting a Claim Form

You may submit claims for your unreimbursed health care expenses by completing an *FSA Claim Form*. You must also attach itemized bills, receipts and/or the Explanation of Benefits (EOB) from your health plan as proof of the unreimbursed eligible expenses. To be reimbursed for eligible over-the-counter medications, you must include a copy of the prescription from your provider that shows the specific name of the medication and the receipt for payment with your claim form. *FSA Claim Forms* are available on the Benefit Center website or www.myuhc.com.

Deadline to Submit Claims

Expenses incurred between January 1, 2021, and December 31, 2021, must be submitted for reimbursement from your 2021 HCFSA by *April 30, 2022*. According to IRS rules, **any amount in your account that is not reimbursed to you for eligible expenses incurred by the deadline will be forfeited.**

Notwithstanding the foregoing, up to $550 of your unused HCFSA balance for 2020 will be carried over to 2021, assuming you elect to participate in the HCFSA for 2021, enroll in Medical Plan Option A or B, and do not enroll in Option C. If you enroll in Option C under the Medical Plan, **you will not be eligible to have a HCFSA in 2021 and** your unused 2020 HCFSA balance must be forfeited.

You will only receive reimbursement for claims incurred while you are a participant in the HCFSA.

If you terminate employment or become ineligible to participate in the HCFSA due to an employment status change prior to December 31 (excluding transfers to an international status), you may submit claims for reimbursement incurred only through your termination date or the date your status changed. However, if you elect to continue participation in the HCFSA through COBRA (see the *Continuation Coverage Rights Under COBRA* section on page 184), you will still be considered a participant in the HCFSA.

If you transfer to an international status, you may submit claims for expenses incurred by December 31 of the year of your transfer.

Claims Processing

FSA claims are generally processed daily and reimbursement checks are mailed within three business days. There is a minimum reimbursement amount of $50. However, this minimum is waived at the end of the calendar year and through April 30 of the following calendar year when payments for small amounts of eligible expenses are processed, allowing you to use up any remaining account balance. Expenses that are covered by a health plan must first be submitted to the health plan for payment before being submitted to your HCFSA.

If a reimbursement check issued to you remains uncashed for more than six months, UHC will send you a letter stating that the check has not been cashed and asking that you either cash the check or contact UHC if the check was lost or never received. If the check was lost or never received, UHC will place a “stop payment” on the check and will issue a new check to you. For all checks that

remain uncashed for more than 24 months, UHC will automatically place a "stop payment" on the checks, and those checks will not be reissued to you and the money will be forfeited.

Direct Deposit Feature

You may register to have your HCFSA reimbursements deposited directly into your U.S. checking or savings account. To register for direct deposit, go to the UHC website at www.myuhc.com (FSA group number 202942).

You will need your Social Security number to set up your account.

About DDCFSAs

The DDCFSA is designed for dependent day care expenses you pay to have someone take care of your eligible dependents so that you may work or attend school on a full-time basis. If you are married, your spouse must be unable to care for your dependents because he/she works, is a full-time student, or has a physical or mental disability.

The only expenses eligible for reimbursement from the DDCFSA are those incurred for the primary purpose of assuring the well-being and protection of your eligible dependent. If you are married and your spouse is not working, not a full-time student, or not mentally or physically able to care for himself or herself, your dependent care expenses are not eligible. Health care expenses for your dependents are not payable under the DDCFSA, nor are expenses for food or clothing. Federal tax law limits the amount of contributions to a DDCFSA to the lesser of your or your spouse's earned income. It is limited to $5,000 if you are single or file a joint tax return or $2,500 if you are married and filing a separate tax return. If your spouse is not working but is a full-time student or disabled, your spouse's earned income is considered to be $250 a month if you have one eligible dependent or $500 monthly for two or more eligible dependents (see the *Definition of Eligible Dependents* section on page 105).

Eligible Dependent Day Care Expenses

Eligible expenses include the cost of a babysitter (for work- or education-related expenses), day care center or home care center as well as nursery school and day camp programs. Weekend or "evening-out" babysitting expenses, kindergarten expenses and overnight camp expenses are not eligible under the DDCFSA.

Expenses eligible for reimbursement from a DDCFSA include:

- Payments made for services provided in your home. These services may not be provided by someone you also claim as a dependent or by your children who will be under age 19 at the end of the calendar year. Although these services may involve household maintenance, they must include the care of your eligible dependent,
- Payments made for day care services outside your home for a dependent child under age 13 or for other dependents of any age who are disabled or elderly and spend at least eight hours a day in your home, and
- Payments made to a qualified day care center that provides care for at least six people on a regular basis. The day care center must require a fee for care and be in compliance with all applicable state and local laws.

You may wish to consult your tax advisor or view *IRS Publication 503*, **Child and Dependent Care Expenses**, (available at www.irs.gov) to see if a particular type of expense is eligible for reimbursement.

Definition of Eligible Dependents

For purposes of the DDCFSA, an eligible dependent is any person you can claim as a dependent on your federal income tax return who is:

- **A "qualifying child" under age 13 or a "qualifying relative."** See the *Eligibility* section on page 7.

In addition, if you are divorced or legally separated, you may cover a child whom you cannot claim as a dependent provided that:

- You and the other parent together have custody of the child for more than half of the year,
- You and the other parent together provide for more than half of the child's support,
- You have custody of the child for more of the year than the other parent,

- You could claim the child as a dependent but for the fact you signed an agreement to let the other parent do so, and
- The child is under age 13 or is physically or mentally incapable of self-care.

Note: IRS regulations do not recognize domestic partners and children of domestic partners as eligible dependents unless they meet the criteria listed above and the relationship is not in violation of local law.

DDCFSA Reimbursement

Once you start accumulating contributions credited to a DDCFSA, you may request reimbursement from your account for qualified dependent day care expenses. Unlike an HCFSA, DDCFSA reimbursements are limited to your year-to-date contributions minus any reimbursements at the time your claim is submitted.

Submitting a Claim Form

To receive reimbursement from your account, you must submit an FSA Claim Form. You must include a copy of a paid receipt or a copy of the front and back of a cancelled check with your claim form as proof of payment of your day care expenses.

Please be sure to include the Tax Identification Number (TIN) of the day care provider as no request for reimbursement will be paid without a TIN. You must also indicate if the provider is a tax-exempt organization. Forward the completed claim form and necessary attachments to UHC for reimbursement. Always keep copies of your claim forms and supporting documentation for your files.

Deadline to Submit Claims and Claims Processing

Expenses incurred between January 1, 2021, and December 31, 2021, must be submitted for reimbursement from your 2021 DDCFSA by April 30, 2022. According to IRS rules, **any amount in your account that is not reimbursed to you for eligible expenses incurred by the December 31 deadline will be forfeited.**

FSA claims are generally processed daily and reimbursement checks mailed within three business days. There is a minimum reimbursement amount of $50. However, this minimum is waived at the end of the calendar year and through April 30 of the following calendar year, when payments for small amounts of eligible expenses are processed, allowing you to use up any remaining account balance.

If a reimbursement check issued to you remains uncashed for more than six months, UHC will send you a letter stating that the check has not been cashed and asking that you either cash the check or contact UHC if the check was lost or never received. If the check was lost or never received, UHC will place a “stop payment” on the check and will issue a new check to you. For all checks that remain uncashed for more than a year, UHC will automatically place a “stop payment” on the checks, and those checks will not be reissued to you and the money will be forfeited.

You may register to have your DDCFSA reimbursements deposited directly into your U.S. checking or savings account. To register for direct deposit, go to the UHC website at www.myuhc.com (FSA group number 202942).

Your Form W-2 Statement

The amount of your annual DDCFSA contribution will be shown in Box 10 of your Form W-2 statement. Additionally, if you use the **Bright Horizons Back-Up Care Advantage Program**, the fair market value of these services paid by Morgan Stanley on your behalf will also be reflected on your Form W-2 statement. If the total amount of your DDCFSA contribution and Bright Horizon’s services exceeds $5,000, the amount over $5,000 will be considered taxable income and included in Box 1 of your Form W-2 statement.

If you or your spouse contribute to another employer’s DDCFSA and the Morgan Stanley DDCFSA in the same calendar year and the total exceeds $5,000, consult with your tax advisor on how to report the additional taxable income and your dependent day care expenses.

Dependent Care Tax Credit

If you pay someone to care for your eligible dependent, you may be able to claim the Child and Dependent Care Credit on your federal income tax return.

How the Credit Differs from the DDCFSA

When you contribute to a DDCFSA, you fund your account with before-tax contributions, pay your

dependent care providers and then submit your eligible expenses to the FSA for reimbursement. With the Child and Dependent Care Credit, you receive a tax credit on your federal income tax return to offset your dependent care expenses.

The tax credit may be up to 35% of your qualifying expenses, depending on your adjusted gross income. You may count up to $3,000 of expenses paid during the year for one qualifying dependent or $6,000 for two or more qualifying dependents. To calculate the credit, multiply your qualified dependent care expenses (the same type of expenses used for DDCFSA reimbursements) by the applicable percentage specified in the table below.

Dependent Care Tax Credit Chart

ADJUSTED GROSS INCOME (AGI)	TAX CREDIT PERCENTAGE
Up to $15,000	35%
$15,001 - $17,000	34%
$17,001 - $19,000	33%
$19,001 - $21,000	32%
$21,001 - $23,000	31%
$23,001 - $25,000	30%
$25,001 - $27,000	29%
$27,001 - $29,000	28%
$29,001 - $31,000	27%
$31,001 - $33,000	26%
$33,001 - $35,000	25%
$35,001 - $37,000	24%
$37,001 - $39,000	23%
$39,001 - $41,000	22%
$41,001 - $43,000	21%
$43,001 or more	20%

What Does This Mean for You?

Determining whether it is more advantageous to contribute to the DDCFSA, receive the tax credit on your income tax return or possibly both requires some consideration. Be advised that any DDCFSA reimbursements you receive will reduce the expense amount you may claim for the tax credit. However, the maximum amount of the tax credit is higher than the maximum DDCFSA reimbursement if you have two or more qualifying dependents. If you have two or more qualifying dependents and you receive the maximum $5,000 before-tax reimbursement from your DDCFSA, you may also be able to claim qualified expenses over the $5,000 DDCFSA maximum toward the dependent care tax credit.

For example, assume you have an adjusted gross income of $22,000, you incur $6,000 of dependent care expenses in 2021 for your two children and you contribute $5,000 in eligible expenses to your Morgan Stanley DDCFSA. In this scenario, you will have an additional $1,000 in qualified expenses to which you may be able to apply the tax credit. If eligible, you would calculate the tax credit by multiplying the remaining $1,000 of unreimbursed expenses by 31% (based on the tax credit percentage in the table), giving you a tax credit of $310.

For more information on the dependent care tax credit, see *IRS Publication 503*, **Child and Dependent Care Expenses**, at www.irs.gov. You may also wish to consult your tax advisor to determine how to best use the dependent care tax credit and the DDCFSA to their full advantage.

Limited Purpose Flexible Spending Accounts (LPFSAs)

The LPFSA is designed for anyone enrolled in Option C of the Medical Plan who pays out-of-pocket dental and vision costs. Eligible dental and vision expenses include annual deductibles, coinsurance, copays, and most other dental and vision expenses that are not covered by any dental or vision plan.

To be eligible, the expenses must be:

- Of a type that would be tax deductible (without regard to any cumulative thresholds to claim a deduction)
- Incurred by December 31 of the calendar year
- Incurred while you are an active participant in the LPFSA
- Not reimbursed under any group health plan

Eligible Vision and Dental Expenses

Examples of eligible out-of-pocket dental and vision expenses that qualify for reimbursement through the LPFSA:

- Dental or Vision Plan deductibles, coinsurance and copays
- Vision care expenses, including eye exams, prescription eyeglasses and contact lenses not covered by the Medical and Vision Plans
- Amounts in excess of Eligible Expenses limits under the Vision and Dental Plans
- Orthodontic expenses not covered by the Dental Plan

For more information about eligible vision and dental eligible expenses, review *IRS Publication 502,* **Vision and Dental Expenses**, which is available online at www.irs.gov.

Please note that when you receive reimbursement from the LPFSA for an expense, it cannot be claimed as a deduction on your federal income tax return.

Ineligible Vision and Dental Expenses

The following are some other expenses that are **not** eligible for reimbursement from the LPFSA:

- Cosmetic surgery or treatments such as teeth whitening (unless it is to correct a birth defect or to correct an injury from an accident)
- Premiums for the cost of your vision and dental coverage.

Definition of Eligible Dependents

For the LPFSA, the definition of eligible dependents is different than the definition used for other Morgan Stanley health plans. Under the LPFSA, you may request reimbursement for eligible vision and dental expenses incurred by:

- Yourself
- Your spouse
- Your dependent children
- Any individual you can claim as a dependent for federal income tax purposes, regardless of whether they meet the eligibility requirements of other Morgan Stanley group health plans

Under IRS regulations, the LPFSA may not recognize domestic partners or children of domestic partners as eligible dependents unless they meet the criteria listed above and the relationship is not in violation of local law. Same-sex spouses who are lawfully married under a state or foreign law are recognized.

Your dependents' eligible expenses may be reimbursed through the LPFSA even if they are not enrolled as dependents under Morgan Stanley's Dental or Vision Plan, provided that you can claim them as dependents on your federal tax form.

LPFSA Reimbursement

If you are enrolled in Option C and elect to participate in an LPFSA, your full annual contribution amount will be available to you for reimbursement at the beginning of the year. This means that you may request reimbursement from your account as soon as you or your dependents have an eligible expense, regardless of how much you have contributed toward your account at that point in time. If you have a QLE and increase your contribution election during the year, only expenses incurred on or after the date of the QLE are eligible for reimbursement from the additional amount.

In general, you may receive reimbursement from your LPFSA by:

- Utilizing Your Spending Account (YSA) debit card,
- Automatic Reimbursement, or
- Submitting a claim form

Reimbursement Options

Debit Card

You will be issued a debit card from Your Spending Account (YSA) with your annual election amount (minimum $100) for the LPFSA as your available balance. When you visit eligible providers for your vision and dental services, you may present the YSA card for payment for your out-of-pocket expenses. Choose the "credit" option if the transaction prompts you to choose "debit" or "credit." Sign the receipt provided and retain for your records along with a detailed invoice for the services provided in the event the documentation is required to support your claim at a later date. If you choose the "debit card" option, you will be required to enter your personal four-digit Personal

Identification Number (PIN) that you set up when your card is issued. Once the claim has been processed, you will receive notification regarding the status of your claim and if any follow-up documentation is required. Any expenses paid by the card will not be reimbursed by another source. If you forgot or need to change the PIN associated with your card, you can call 1-888-999-0194.

Your YSA debit card will remain active for up to 48 months as long as you remain an active employee and remain eligible for benefits. The card can only be utilized for LPFSA reimbursements for years you have made contributions to your LPFSA. After the end of the year, expenses incurred in the prior plan year can only be submitted through the manual claim process.

While most YSA debit card claims are automatically validated at the point of sale, federal regulations require confirmation that the expense is eligible for reimbursement under your plan.

YSA will attempt to automatically validate your expense before contacting you. Even if you use your card at a dental or vision office, providers may perform some services that are ineligible for reimbursement. Accordingly, **you may be required to provide an itemized receipt to prove that your claims qualify for reimbursement.**

Make sure your itemized receipt(s) or documentation includes:

- Date the service was rendered
- Name and address of the provider or merchant
- Detailed description of the service or product, including recipient
- Amount charged
- Amount covered by insurance

If the documentation submitted is not sufficient, you will be notified and asked to submit additional information. Expenses for which you do not provide adequate documentation are considered ineligible and will be treated as an overpayment. If the overpayment is $100 or greater, your YSA debit card will be suspended until the documentation has been submitted or the overpayment has been recovered. You can repay your overpayment via electronic check at www.morganstanley.com/benefits or by mailing a check to the below address.

Your Spending Account Service Center
P.O. Box 64030
The Woodlands, TX 77387-4030

By fax: 1 (888) 211-9900

Submitting a Claim

If you do not use your YSA debit card, you may submit an online or paper claim for your unreimbursed dental and vision expenses. You are required to provide the itemized bills, receipts and/or the Explanation of Benefits (EOB) from your dental or vision plan as proof of the unreimbursed eligible expenses. If you submit a claim online, you can upload documentation to the website. Alternatively, you can call HR Services to request a claim form and send a hard-copy claim with your receipts.

Expenses that are covered by a vision or dental plan must first be submitted to the plan for payment before being submitted to your LPFSA.

Deadline to Submit Claims

Expenses incurred between January 1, 2021, and December 31, 2021, must be submitted for reimbursement from your 2020 HCFSA by April 30, 2022. According to plan rules, **any amount in your account that is not reimbursed to you for eligible expenses incurred by the December 31 deadline will be forfeited.** You will only receive reimbursement for claims incurred while you are a participant in the LPFSA.

If you terminate employment or become ineligible to participate in the LPFSA due to an employment status change prior to December 31 (excluding transfers to an international status), you may submit claims for reimbursement incurred only through your termination date or the date your status changed. However, if you elect to continue participation in the LPFSA through COBRA (see the *Continuation Coverage Rights Under COBRA* section on page 184), you will still be considered a participant in the LPFSA plan, but you will no longer have access to your debit card and will be required to submit claims online or by mail.

If you transfer to an international status, you may submit claims for expenses incurred by December 31 of the year of your transfer.

If a reimbursement check issued to you remains uncashed for more than 180 days, a stop-payment order will be placed on the check. In the event you have misplaced or lost a check, you will need to contact your Spending Account Administrator directly to have the payment reissued.

Direct Deposit Feature

You may have your LPFSA reimbursements deposited directly into your U.S. checking or savings account. To register for direct deposit, visit the "Your Profile" section on the Your Spending Account website at www.morganstanley.com/benefits.

Important Information About the FSAs Plan Rules

As you consider whether to contribute to one or both of the FSAs, and if so, how much, please consider the following federal tax law restrictions.

- **Use-It-or-Lose-It Rule**. Any unused balances in your HCFSA, LPFSA or DDCFSA at December 31 and unreimbursed by April 30 of the following year are forfeited. However, you may elect to carry over up to $550 in your HCFSA to the following year provided you do not enroll in Medical Plan Option C in the following year and you enroll in Medical Plan Option A or B and elect to contribute to the 2021 HSA.
- **Only eligible expenses incurred while you are a participant will be reimbursed**
- **Only eligible expenses will be reimbursed through the FSAs**
  - A list of eligible health care expenses is available in IRS Publication 502, **Medical and Dental Expenses.**
  - A list of eligible dependent day care expenses is available in IRS Publication 503, **Child and Dependent Care Expenses.**
  - To obtain copies, call 800-TAX-FORM or visit the IRS website at www.irs.gov.
- Once you elect to participate in an FSA, **your election will remain in effect for the entire** calendar year, as long as you remain an eligible employee, unless you have a QLE (see the *Qualified Life Events* section on page 18).
- **You may not transfer money between LPFSA, HCFSA and DDCFSA accounts.**
- **Morgan Stanley is required to perform tests on the FSAs** to ensure they do not favor participants who are considered highly compensated under federal tax law. If the results of these tests do not meet certain standards, the before-tax contributions of higher-paid employees may be reduced. The plan administrator will notify affected employees if a reduction is necessary
- **Before-tax contributions to your DDCFSA are reported** by Morgan Stanley on Box 10—Dependent Care Benefits of your Form W-2 statement.

Life and Accident Insurance

Morgan Stanley offers a number of life insurance and accident programs to help safeguard you and your family against the unexpected.

The Morgan Stanley life and accident programs include the following:

- Life Insurance Plan
- Accidental Death and Dismemberment (AD&D) Insurance Plan
- Business Travel Accident (BTA) Plan
- Executive Equity Life Program (Paragon Program), which covers certain Morgan Stanley employees who purchased policies prior to January 1, 2003

Please note that if you are mistakenly enrolled in an amount of life or accident insurance greater than the amount for which you are eligible, only the amount for which you are eligible will be in force, regardless of the amount of premiums you paid.

Life Insurance Plan

There are several different components of the Life Insurance Plan, including:

- Employee Basic Life
- Employee Supplemental Life/Group Variable Universal Life Insurance (GVUL)
- Spouse/Domestic Partner Life
- Child Life

MetLife is the administrator for the Life Insurance Plan (other than the Paragon Program) and determines benefits payable.

Employee Basic Life

Morgan Stanley provides you with $50,000 of Life Insurance coverage at no cost to you.

Employee Supplemental Life/GVUL

You may elect to purchase additional coverage up to the lesser of 10 times your Benefits Eligible Earnings or $5,000,000. There may be circumstances in which the amount of life insurance you elected in the past may exceed the amount you may currently be eligible to elect, including due to changes in your Benefits Eligible Earnings. In that case, you will be allowed to keep the higher amount of coverage. However, if you choose to reduce your Life Insurance amount, you must reduce coverage to an amount no greater than the maximum amount otherwise permitted at the time of the change and you will not be eligible to later elect an amount of coverage that exceeds your coverage maximum at the time of election.

Generally, Benefits Eligible Earnings are calculated at your hire date and again each fall prior to Annual Enrollment. Your Benefits Eligible Earnings are generally the higher of your: (1) annualized base pay or (2) prior calendar year's Eligible Pay or, for newly hired financial advisors, 40% of your trailing 12 months of earnings. (See the *Benefits Eligible Earnings* section on page 13 for more information.) For example, if BEE is calculated for 2021 Annual Enrollment, prior year's eligible pay is determined with reference to 2019 Eligible Pay. You may be asked to provide Evidence of Insurability before your coverage becomes effective.

If you elect Employee Supplemental Life Insurance coverage and your Benefits Eligible Earnings are greater than $500,000, you wil be automatically enrolled in GVUL. (See the *Eligible Employee* section on page 7 for more information.) GVUL provides life insurance coverage to secure your family's future, combined with an opportunity to invest and accumulate cash value. With GVUL, you can invest in a variety of tax-deferred investment options. (See the *GVUL Optional Tax-Advantaged Investment Feature* section on page 122 for more information)

Spouse/Domestic Partner Life

To elect Spouse/Domestic Partner Life Insurance, you must also elect Employee Supplemental Life Insurance.

You may elect coverage for your spouse or domestic partner up to the amount of employee supplemental life you elect for yourself or $250,000, whichever is less. To review the levels of coverage available to your spouse or domestic partner, visit the Benefit Center website.

You may be asked to provide Evidence of Insurability before your spouse's/domestic partner's coverage becomes effective.

Child Life

You are not required to elect Employee Supplemental Life Insurance to elect Child Life Insurance.

You may elect coverage for each of your eligible dependent children up to age 26 in $5,000 increments, up to a maximum of $20,000. To review the levels of coverage available for your child, you may visit the Benefit Center website.

Evidence of Insurability Requirements

If you elect Employee Supplemental Life Insurance, GVUL or Spouse/Domestic Partner Life Insurance coverage at any time after your initial 31-day enrollment period as a new hire or newly benefits-eligible employee, you will be required to provide Evidence of Insurability (EOI) for yourself and your spouse or domestic partner. EOI is not required for Child Life Insurance.

EOI is also required in the following situations:

- You elect coverage greater than $1,000,000 for yourself (if available),
- You elect coverage greater than $30,000 for your spouse or domestic partner,
- You elect to increase your or your spouse's or domestic partner's coverage by more than one level, or
- At any time, if you previously waived coverage

If EOI is required, you must complete an online EOI form when you make your coverage election. If you are approved at that time, you will be notified immediately by MetLife. If you are not approved online, MetLife will notify you within approximately

seven days that additional information is required. If you are unable to complete the EOI form online, please contact HR Services for assistance.

Elections requiring MetLife's approval will be effective from the date that EOI is approved. Until that time, you or your spouse or domestic partner will receive coverage and pay for the highest level allowed without EOI. It is your responsibility to follow up with MetLife about the status of any EOI.

If you are ill or injured and away from work on the day your coverage or any increase in coverage would become effective, you will be charged the increase in premium from the date of the request for increase. If a claim is incurred prior to the date you return to work for one full day, MetLife will not pay the increased amount of coverage and the increased premium will be refunded to your beneficiary.

If you or your spouse or domestic partner dies within two years of obtaining coverage for which EOI was provided, MetLife has a two-year contestability clause that entitles MetLife to withhold benefits if they determine that any misrepresentation of EOI occurred, even if unintentional.

EOI Requirements for Supplemental Life Insurance

EVENT	EOI REQUIRED
Yourself	
New Hire or Newly Benefits Eligible (within 31 days)	• If coverage higher than $1,000,000 is elected
Annual Enrollment or Qualified Life Event	• If previously eligible, but enrolling for the first time • If increasing coverage more than one level or over $1,000,000
Spouse/Domestic Partner	
New Hire or Newly Benefits Eligible	• If coverage higher than $30,000 is elected
Annual Enrollment or Qualified Life Event	• If previously eligible, but enrolling for the first time • If increasing coverage more than one level or over $30,000
Child	
EOI is never required	

Accelerated Death Benefit

If you or your spouse or domestic partner becomes terminally ill while covered under the Life Insurance Plan, you may request that MetLife pay an Accelerated Death Benefit (ADB).

MetLife will consider you terminally ill if you:

- Suffer from an incurable, progressive and medically recognized disease or condition, and
- Are not expected to survive more than 12 months beyond the date of the request for an ADB based on a reasonable medical probability and generally accepted prognostic protocol

You may request an ADB for up to 80% of the amount of Life Insurance coverage in force for yourself or your spouse or domestic partner.

However, the ADB for an employee may not be for less than $12,500 or more than $500,000 and the ADB for your spouse or domestic partner may not be for less than $5,000 or more than $160,000. You may request an ADB under this Plan only once on your own behalf, and only once on behalf of any one spouse or domestic partner.

To request an ADB, complete the *MetLife Request for Accelerated Death Benefit* form (available from HR Services) and send it to MetLife for review. The request must include:

- A statement from a currently licensed U.S. physician that you or your spouse or domestic partner are terminally ill
- All medical test results
- Laboratory reports
- Any other relevant information, including the generally accepted prognostic protocol used by the physician to determine the person's expected remaining life span
- The amount of the benefit requested

MetLife may require you or your spouse or domestic partner to submit to an independent medical examination at MetLife's expense by a physician of its choosing. MetLife may suspend its review of a request for an ADB until the examination has been completed and the results have been submitted to MetLife.

Upon approval by MetLife, the amount of ADB will be paid to you in a lump sum.

The remaining amount of life insurance available for you or your spouse or domestic partner will be reduced by the amount of the ADB that was paid. If the amount of life insurance is reduced by an ADB, the amount of the ADB will not be available for conversion of life insurance. Additionally, if you request an ADB on behalf of yourself or your spouse or domestic partner, you will not be able to subsequently increase your or your spouse's or domestic partner's coverage. You will only be charged the premium for any remaining employee-paid life insurance still in force.

MetLife may refuse your request for an ADB if:

- The group contract in which you participate terminates
- Prior to the payment of the ADB, the person for whom it is requested ceases to have life insurance coverage
- Prior to payment of the ADB, the person for whom it is requested dies
- MetLife determines that you or your spouse or domestic partner are not eligible for the ADB
- The forms and information needed to file a claim under the GVUL Plan can be obtained by calling GVUL Customer Relations at 1-800-756-0124. A claim packet will be mailed with detailed instructions describing the forms and documentation required to process the claim. Upon receipt of the required forms and documentation, MetLife will process the claim.

Additional Supplemental Life Insurance Benefits[1]

Estate Resolution

MetLife Estate Resolution Services is an additional feature of Supplemental Life Insurance coverage provided at no extra cost. This benefit offers beneficiaries and estate representatives assistance with questions and issues that are raised in the distribution of assets after the death of the covered individual.

Will Preparation

If you elect Supplemental Life Insurance coverage, you may also receive will-preparation services from a MetLife affiliate at no additional cost. The service covers preparation of wills and codicils for you and your spouse or domestic partner, in addition to the creation of any testamentary trust. Tax planning is excluded. For more information, please contact MetLife.

GVUL Optional Tax-Advantaged Investment Feature

In addition to helping satisfy your life insurance needs, the GVUL Policy includes an optional tax-advantaged investment feature. By adding additional premium to your certificate's variable investment portfolios and/or interest-bearing account, you have the opportunity to accumulate cash value.

Your certificate's cash value varies from day to day, depending on the investment performance of the chosen variable portfolios, interest credited to the Fixed Account, charges deducted and any other transactions. The minimum additional contribution for the Investment Feature is $20 per month and the maximum is determined by your age and face amount. The additional premiums can be stopped at any time. The features of this investment component include:

- Tax deferral on investments,
- Tax free transfers between investment choices, and
- Withdrawals from cash value, some of which may be tax free.

Life Insurance Plan Exclusions

There are no exclusions or causes of death for which a benefit would not be paid under the Life Insurance Plan except for the following:

Spouse /Domestic Partner Plan Exclusions

The following apply:

- Must not be serving in the military of any country
- Must not be insured as an employee of the employer under the same plan.

GVUL When Your Coverage Will Lapse

Your certificate will lapse if you stop making premium payments and your cash surrender value is insufficient to cover the monthly deductions required to keep coverage in force. However, you

[1] Neither the Plan nor Morgan Stanley is responsible for any estate resolutions or will preparation services provided to any individuals.

will have a 62-day grace period, during which you can make the necessary payment to keep coverage in force. MetLife will notify you when the grace period is triggered to let you know your coverage is in danger of lapsing.

Accident Plans

Morgan Stanley offers the Accident Plans to provide financial protection if you or a member of your family is in an accident and is seriously injured and suffers dismemberment; paralysis; loss of sight, speech or hearing; or loss of life.

Generally, you may elect coverage for your spouse or domestic partner and unmarried children under age 26.

The Accident Plans are composed of several company-provided and optional programs including:

- Accidental Death and Dismemberment (AD&D) Plan (including Basic and Supplemental AD&D Insurance)
- Business Travel Accident (BTA) Insurance Plan

Under the Accident Plans, all accidents are covered except those outlined in the Exclusions sections for the AD&D (Basic and Supplemental AD&D) and BTA Insurance Plans.

Basic and Supplemental AD&D are insured by MetLife, and BTA is insured by Cigna. MetLife and Cigna determine all benefits payable under the Accident Plans.

Definition of Loss

For the AD&D Plan (including Basic and Supplemental AD&D) and the BTA Insurance Plan, Loss is defined as follows:

- Severance means complete separation from the body.
- Paralysis means loss of use, without severance, of a limb.
- This loss must be determined by a physician to be complete and irreversible.
- Member means hand, foot or eye.
- Limb means entire arm or leg.
- For the hand and foot, it is complete severance through or above the wrist or ankle joint; in South Carolina, loss of four whole fingers of the same hand will be considered the loss of hand.
- For an eye, it is total and irrecoverable loss of sight.
- For speech, it is total inability to communicate audibly in any degree.
- For hearing, it is irrecoverable loss of hearing in both ears that cannot be corrected by any hearing aid or device.
- For the thumb and index finger, it is complete severance of each through or above the metacarpophalangeal joints (the joint between the fingers and hand); in California, loss of at least one whole bone in both the thumb and index finger of the same hand is considered the loss of a thumb and index finger.

If you or your eligible dependents suffer a covered Loss within 365 days of the accident, you will receive benefits as outlined in the following chart.

Schedule of Covered Losses for Accidental Death and Dismemberment Insurance

All amounts listed are stated as percentages of the Full Amount.

AD&D Plan Benefits

EVENT	BENEFIT AMOUNT
Accidental Death or Dismemberment	
Loss of life	Principal Sum
Loss of two or more members	Principal Sum
Loss of speech and hearing (both ears)	Principal Sum
Loss of one member	½ the Principal Sum
Loss of sight (one eye)	½ the Principal Sum
Loss of sight (both eyes)	Principal Sum
Loss of speech	½ the Principal Sum
Loss of hearing (both ears)	½ the Principal Sum
Loss of thumb and index finger of the same hand	¼ the Principal Sum
Paralysis	
Paralysis of two or more limbs	Principal Sum
Paralysis of one arm or leg	½ the Principal Sum

Please note that “Principal Sum” is defined under Supplemental AD&D insurance coverage.

Basic and Supplemental AD&D Insurance Coverage

Morgan Stanley offers both Company-provided and optional AD&D insurance coverage to you and your family, including:

- **Employee Basic AD&D Insurance Coverage:** Morgan Stanley provides you with $50,000 of coverage at no cost to you.
- **Supplemental AD&D Insurance Coverage:**
  - *Coverage for Yourself Only*: You may elect to purchase additional coverage for "Yourself Only" up to the lesser of 10 times your Benefits Eligible Earnings or $5,000,000. Any Supplemental AD&D coverage you elect for yourself is in addition to the $50,000 of Basic AD&D coverage provided by Morgan Stanley. The total of your Basic and Supplemental coverage amount is known as your **Principal Sum.**
  - *Coverage for Yourself Plus Spouse or Domestic Partner*: If you elect to cover "Yourself Plus Spouse or Domestic Partner," your spouse or domestic partner has a Principal Sum equal to 100% of your Principal Sum, up to a maximum of $1,000,000.
  - Coverage for Yourself Plus Eligible Dependent Children: If you elect to cover "Yourself Plus Eligible Dependent Children," each child has a Principal Sum equal to 25% of your Principal Sum, up to $250,000. If your dependent child suffers a dismemberment, paralysis, or Loss of sight, speech or hearing as a result of a covered accident, the Principal Sum benefit will be doubled, to a maximum of $250,000. If your child dies within 90 days of the covered accident, only the Loss of life benefit will be paid.
  - *Coverage for Yourself Plus Family:* If you elect to cover "Yourself Plus Family," your spouse or domestic partner has a Principal Sum equal to 75% of your Principal Sum, to a maximum of $750,000. Each child has a Principal Sum equal to 25% of your elected Principal Sum, up to $250,000.

Additional Basic and Supplemental AD&D Insurance Plan Coverage

If you or your dependents suffer a Loss as described in the *AD&D Plan Benefits* chart as a result of a covered accident, you may be entitled to the following benefits at no additional cost to you.

If you become Totally Disabled (as determined by MetLife), you will be paid your Principal Sum, less any amount paid for dismemberment, paralysis, or Loss of sight, speech or hearing, if:

1. It occurs within 365 days of a covered accident,
2. Your Total Disability extends for one year, and
3. You are deemed by MetLife to meet the definition of Permanent Total Disability (PTD) at the end of that year.

The PTD benefit is not available to employees age 70 and older.

Permanent Total Disability Benefit (For Employees Only)

Total Disability is the complete inability to perform every duty of your own occupation.

Permanent Total Disability (PTD) is the inability to engage in any occupation suitable to your education, training or experience for the remainder of your life, as determined by MetLife.

Air Bag Benefit

The Basic and Supplemental AD&D Insurance Plans will pay an additional benefit of 5% of the Principal Sum if you or your covered dependent suffers Loss of life as a result of a covered accident that occurs while you are driving or riding in a private passenger car that is equipped with air bags (driver-side if driving, dual if a front-seat passenger). The amount of this benefit will not be less than $1,000 or more than $10,000.

Seat Belt Use Benefit

If you or a dependent dies as a result of an accidental injury, MetLife will pay an additional Seat Belt Use benefit of 20% of the Principal Sum (minimum $1,000, maximum $25,000) if:

1. A benefit is paid for Loss of life under the Accidental Death & Insurance section,
2. This benefit is in effect on the date of the injury, and

3. Proof is received that the deceased person:
   - was in an accident while driving or riding as a passenger in a passenger car
   - was wearing a seat belt that was properly fastened at the time of the accident, and
   - died as a result of injuries sustained in the accident
4. In the case of a child, "seat belt" means a child restraint, as required by state law and approved by the National Highway Traffic and Safety Administration, properly secured and used as recommended by its manufacturer for children of like age and weight at the time of the covered accident.

Brain Damage

The plans will pay 100% of the Principal Sum if you or your covered dependent suffers Brain Damage. Brain Damage means permanent and irreversible physical damage to the brain, causing the complete inability to perform all the substantial and material functions and activities of normal everyday life, as determined by MetLife. Such damage must be present within 60 days of the accidental injury, require hospitalization for at least 14 days and persist for 12 consecutive months after the date of the accident.

Child Care Center Benefit

If your or your spouse's/domestic partner's death is the result of a covered accident, a day care benefit will be paid for each eligible child who is enrolled in a licensed day care child facility within 365 days from the accidental death. Under the Basic AD&D Insurance Plan, the day care benefit will be $5,000 per child per year.

If you participate in the Supplemental AD&D Insurance Plan, the benefit per child will be 10% of the amount of your coverage, up to a maximum of $10,000 per year.

The day care benefit will be paid for each school year for up to five years or until age 13, whichever occurs first, as long as your child remains enrolled in a licensed child care center.

If you do not have any covered dependents eligible for the Child Care Center benefit at the time of your death, MetLife will pay your beneficiary an additional benefit of $1,000.

Coma Benefit

If you or your covered dependent is injured, becomes comatose within 31 days of the covered accident and remains comatose beyond a waiting period of 31 days, you will receive 1% of your Principal Sum on a monthly basis for a maximum of 11 consecutive months.

Benefit payments will cease on the earliest of:

- The end of the month in which there is recovery from the coma,
- The end of the 11th month for which this benefit is payable, or
- The end of the month in which death occurs.

If you or a covered dependent dies from any cause as a result of the covered accident while the Coma Benefit is payable, or remains comatose after the benefit has been paid for 11 straight months, you will receive a lump-sum benefit equal to the Principal Sum, reduced by the amount (if any) already paid with respect to the covered accident.

If you receive Coma Benefits, you may not receive PTD benefits. However, if you are receiving a Coma Benefit and recover from the coma within the 11-month period, the Coma Benefit will cease. You may then be eligible for the PTD benefit (less any amount paid under the Coma Benefit), provided you are deemed to be PTD within 365 days of the date of the accident.

If you receive 11 months of the Coma Benefit and the 100% lump-sum payment after the 11-month period, you will not be eligible for the PTD benefit even if you recover. This is because you will have already received 111% of the Principal Sum:

- 1% monthly for maximum of 11 consecutive months, plus
- 100% lump-sum payment if coma continues after 11 months

Common Disaster Benefit (Supplemental AD&D Insurance Plan Only)

If you elect coverage for Yourself Plus Family, and you and your spouse or domestic partner die within one year of each other as the result of injuries received in the same accident or separate accidents that occur within 24 hours of each other, a Principal Sum benefit will be paid for each death. The Principal Sum applicable to your spouse or

domestic partner will be increased to 100% of your Principal Sum, subject to a $2,000,000 combined maximum.

Education Benefits for Spouse or Domestic Partner and Dependent Children

For Spouse or Domestic Partner

In the event of your covered death within 365 days of an injury resulting from a covered accident, your spouse or domestic partner may receive an education benefit equal to the cost of tuition. Under the Basic AD&D Insurance Plan, the benefit may be up to a lifetime maximum of $5,000. Under the Supplemental AD&D Insurance Plan, the benefit may be up to a lifetime maximum of $15,000.

To be eligible to receive this benefit, your spouse or domestic partner must:

- Enroll in an Occupational Training (as defined below) program for the purpose of obtaining an independent source of income, and
- Incur the cost for Occupational Training within 30 months following the date of your death.

"Occupational Training" means any education, training or trade training that prepares a spouse or domestic partner for an occupation for which he/she otherwise would not have been qualified.

The expense incurred means the actual tuition charges, excluding room and board, and actual cost of materials needed for the Occupational Training program.

For Dependent Children

In the event of your covered death within 365 days of an injury resulting from a covered accident, your eligible children may receive an education benefit. The Basic AD&D Insurance benefit will be $5,000 per child per year. The Supplemental AD&D Insurance benefit, if enrolled, will equal 10% of your Principal Sum or $25,000 per child per year, whichever is less. The benefit will be paid for a maximum of four consecutive annual payments if he/she remains enrolled as a full-time student.

To be eligible to receive this benefit, your child must be a full-time student in:

- A grade higher than the 12th grade level, or
- The 12th grade level and subsequently enrolled as a full-time student in a higher grade within 365 days of your death.

If you do not have any covered dependents eligible for the education benefit at the time of your death, MetLife will pay your beneficiary an additional benefit of $1,000.

Exposure to the Elements

If you or your covered dependent is in an accident and it results in unavoidable exposure to the elements, MetLife will consider any Loss to be the direct result of an accidental injury.

In-Hospital Income Benefit

If you or your covered dependents are hospitalized for 24 hours or more within 90 days of a covered accident, the Plan will pay a monthly income of 1% of the insured's Principal Sum. Benefits may begin after a seven-day waiting period and are subject to a $1,000 per-month maximum and $30 per-month minimum, for up to 24 months during the period of hospitalization.

Job-Related Injury

The Plan will pay an additional 100% of the Principal Sum if you suffer a job-related injury. "Job-related injury" means any injury for which you are entitled to benefits under a workers' compensation or similar law, or any arrangement that provides for you to be compensated for work performed.

Rehabilitation Benefit (for Active Employees Only)

If you suffer an injury that results in any Loss other than Loss of life, you will receive a rehabilitation benefit equal to the lesser of:

- The expense incurred for Rehabilitative Training (as defined below)
- 5% of the amount of coverage, or $5,000

Rehabilitative Training is training required as a result of your injury that prepares you for any occupation in which you would not have engaged had it not been for the injury.

The expense or cost of the training and the materials needed for the training must be incurred within 24 months of the date of the accident. The Loss must be due to a covered injury and must occur within 365 days of the accident.

Repatriation of Remains

The Basic AD&D Insurance Plan will pay an additional benefit equal to the charges incurred for the preparation and transportation of the deceased employee's body to his/her city of principal residence, up to $5,000.

Basic and Supplemental AD&D Insurance Plan Exclusions

No payment will be made for any Loss if it results from or is caused or contributed to by:

- Intentionally self-inflicted injury, suicide or attempted suicide
- Service in the armed forces or units auxiliary
- War, whether declared or undeclared, or act of war, riot or insurrection
- Travel or flight in any aircraft that:
  - Does not have a valid certificate of airworthiness
  - Is flown by a pilot without a valid license
  - Is a military aircraft (other than Mobility Air Command)
  - Is being used for experiments
- Flying in any aircraft as a pilot or crew member (this exclusion does not apply to you if you are a corporate pilot flying on Morgan Stanley business)
- Sickness, disease, bodily or mental infirmity or medical or surgical treatment, or bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external bodily injury or accidental food poisoning.

If you or a Dependent sustain an accidental injury that is the Direct and Sole Cause of a Covered Loss described in the SCHEDULE OF BENEFITS, Proof of the accidental injury and Covered Loss must be sent to MetLife. When MetLife receives such Proof, MetLife will review the claim and, if MetLife approves it, will pay the insurance in effect on the date of the injury.

- **Direct and Sole Cause** means that the Covered Loss occurs within 12 months of the date of the accidental injury and was a direct result of the accidental injury, independent of other causes and that the Covered Loss was not caused or contributed to by nonaccidental events, such as suicide, attempted suicide **(See notice page for residents of Missouri)**, intentionally self-inflicted injury, physical or mental infirmity, or the diagnosis or treatment of such illness or infirmity or by infection (other than infection occurring in an external, accidental wound). Nor may the Covered Loss be caused or contributed to by voluntary actions such as:
  - the voluntary intake or use by any means of any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician, or
    - an "over-the-counter" drug, medication or sedative taken as directed;
  - the voluntary intake or use by any means of alcohol in combination with any drug, medication, or
  - sedative; or
  - the voluntary intake or use by any means of poison, gas or fumes.
- MetLife will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

If you or a Dependent sustains an accidental injury that is the Direct and Sole Cause of a Covered Loss, Proof of the accidental injury and Covered Loss must be sent to MetLife. When MetLife receives such Proof, MetLife will review the claim and, if MetLife approves it, will pay the insurance in effect on the date of the injury.

- **Direct and Sole Cause** means that the Covered Loss occurs within 12 months of the date of the accidental injury and was a direct result of the accidental injury, independent of other causes, and that the Covered Loss was not caused or contributed to by nonaccidental events, such as suicide, attempted suicide **(See notice page for residents of Missouri)**, intentionally self-inflicted injury, physical or mental infirmity, or the diagnosis or treatment of such illness or infirmity or by infection (other than infection occurring in an external, accidental wound). Nor may the Covered Loss be caused or contributed to by voluntary actions such as:

  - the voluntary intake or use by any means of any drug, medication or sedative, unless it is:
    - taken or used as prescribed by a Physician, or
    - an "over-the-counter" drug, medication or sedative taken as directed;
  - the voluntary intake or use by any means of alcohol in combination with any drug, medication, or
  - sedative; or
  - the voluntary intake or use by any means of poison, gas or fumes.
- MetLife will deem a loss to be the direct result of an accidental injury if it results from unavoidable exposure to the elements and such exposure was a direct result of an accident.

Note: These are accident-only policies. The AD&D Plan does not pay benefits for Losses caused by or resulting from illness, disease or bodily infirmity, as determined by MetLife.

BTA Insurance Plan Coverage

Morgan Stanley provides BTA Insurance coverage at no cost to you when you are traveling on approved Morgan Stanley business away from your regular work assignment or location. As with AD&D Insurance, BTA Insurance provides benefits if you are seriously injured and suffer dismemberment; paralysis; loss of sight, speech or hearing; or loss of life. Your BTA coverage begins at the start of the business trip when you leave your home or workplace, whichever occurs last. Your coverage ends the moment you return to your workplace or home, whichever occurs first.

BTA coverage is provided for you, your spouse or domestic partner, and eligible dependent children who accompany you on a business trip that has been authorized and approved by Morgan Stanley:

- **Coverage for Yourself.** The amount of your BTA coverage is up to five times your Benefits Eligible Earnings, subject to a minimum amount of $100,000 and a maximum amount of $3,000,000. This amount is known as your Principal Sum.
- **Coverage for Your Spouse or Domestic Partner and Eligible Dependent Children.** Your spouse or domestic partner and dependent children are covered while traveling with you or in conjunction with your business travel and/or relocation, provided the trips have been authorized and approved by Morgan Stanley. Your spouse or domestic partner's Principal Sum is 50% of your Principal Sum. Each dependent child's Principal Sum is 20% of your Principal Sum.

Your domestic partner is considered an eligible dependent provided he/she meets the criteria listed in the *Domestic Partner Eligibility* section on page 9 prior to the business trip.

Plan Limits

There are situations in which covered benefits will differ from the *AD&D Plan Benefits* chart on page 118 including:

- **Aggregate Limit**. If you and your covered dependents are traveling on a trip authorized and approved by Morgan Stanley and suffer a covered Loss from the same aircraft accident, the maximum the BTA Insurance Plan will pay for all accidental death losses to all beneficiaries is $75,000,000 per aircraft accident. If total accidental death losses exceed $75,000,000, the accidental death benefits paid on each covered person will be reduced proportionately so as not to exceed the $75,000,000 BTA Insurance Plan limit.
- **Terrorist Act**. If you and your covered dependents suffer a covered Loss as a result of the same terrorist act on the premises of Morgan Stanley, the maximum the BTA Insurance Plan will pay for all covered losses to all beneficiaries is $25,000,000 per incident. If total losses exceed $25,000,000, the benefits paid on each covered person will be reduced proportionately so as not to exceed the $25,000,000 BTA Insurance Plan limit. Cigna, the BTA Insurance plan administrator, determines whether an incident is considered a terrorist act.

Additional BTA Insurance Plan Coverage

If you or your dependents suffer a Loss as a result of a covered accident while traveling on approved company business, you may be entitled to the following benefits at no additional cost to you.

Coma Benefit

Please see the *Coma Benefit* section on page 120 for details.

Extraordinary Commutation

The BTA Insurance Plan will pay benefits for a covered Loss from an accident that occurs while you are commuting directly between your home and your usual Morgan Stanley workplace if:

- You use an alternate means of transportation for such commute, and
- It is necessary to use such transportation due to discontinuance of service, strike or major breakdown of one or more public transportation systems that you regularly use in commuting

Felonious Assault Coverage

Felonious Assault is an act of violence against you and/or an act that reasonably puts you in fear of physical violence while you are on the premises of Morgan Stanley and/or its affiliates.

The BTA Insurance Plan provides coverage for covered Losses sustained as the result of a Felonious Assault or attempt to commit any of the following acts against the property of Morgan Stanley:

- Robbery,
- Common-law or statutory larceny,
- Theft, or
- Hijacking

Personal Deviations Coverage

The BTA Insurance Plan extends coverage to include Losses that occur while you engage in personal business while traveling for Morgan Stanley. This may include approved home visits for expatriate employees.

Relocation

If you are relocated as an employee of Morgan Stanley and your travel expenses are reimbursed, you and your eligible dependents are covered for any Losses that may occur during travel for your relocation.

Your relocation coverage begins on the later of:

- Your departure from your place of residence, or
- Your departure from the prior Morgan Stanley workplace

Relocation coverage for your spouse or domestic partner and eligible dependent children begins at departure from their place of residence. Relocation coverage ends on the date of arrival at the new place of residence.

Seat Belt Benefit

If you or your covered dependent suffers Loss of life as a result of a covered accident that occurs while driving or riding in a private passenger car and wearing a seat belt, the BTA Insurance Plan will pay an additional benefit of 20% of the Principal Sum to a maximum of $25,000 provided that:

- The car is equipped with seat belts,
- The seat belt was in actual use and properly fastened at the time of the accident, and
- The position of the seat belt is certified in the official report of the accident by the investigating officer

A copy of the police report must be submitted with the claim. If such certification is not available and it is unclear whether the covered person was properly wearing a seat belt, the BTA Insurance Plan will pay a fixed benefit of $1,000 to the named beneficiary.

In the case of a child, “seat belt” means a child restraint, as required by state law and approved by the National Highway Traffic and Safety Administration, properly secured and used as recommended by its manufacturer for children of like age and weight at the time of the covered accident.

BTA Insurance Plan Exclusions

No payment will be made for any Loss if it results from, or is caused or contributed to by:

- Suicide, attempted suicide or whenever a covered person injures himself/herself on purpose, while sane or insane (in Missouri only, this does not apply if the covered person is insane)
- War or acts of war, whether or not declared, in the U.S., Afghanistan, Iran, Iraq and Pakistan
- Injury while a covered person is on full-time active duty in any armed forces
- Travel or flight in any spacecraft, or flight in any aircraft that:

  - Does not have a valid certificate of airworthiness
  - Is flown by a pilot without a valid license
  - Is a military aircraft (other than Air Mobility Command)
  - Is being used for crop dusting, spraying or seeding; firefighting; sky writing; sky diving or hang gliding; pipeline or power line inspection; aerial photography or exploration; racing, endurance tests, stunt or acrobatic flying; any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on); or any use for which a charge is made
- Any bacterial infection that was not caused by an accidental cut, wound or food poisoning

Note: This is an accident-only policy. The BTA Insurance Plan does not pay benefits for Losses caused by or resulting from illness, disease or bodily infirmity, as determined by Cigna.

Designating a Beneficiary

You may name anyone as your beneficiary under each of the Life and Accident Insurance Plans, and you may change your beneficiaries at any time.

You may designate a person, charitable organization, estate or trust as your beneficiary through the Benefit Center website.

If you designate a trust as a beneficiary, you will be required to provide trust documentation demonstrating that:

- The trust is valid under state law (or would be but for the fact there is no corpus)
- The trust is irrevocable or will, by its terms, become irrevocable upon your death
- Beneficiaries are identified

Your Beneficiary Designation will not be approved until the required trust documentation is provided to HR Services.

The last properly executed beneficiary designation on file with HR Services (either electronic or paper) on the date of death is the valid designation used by the Life and Accident Insurance Plans. If there is no valid beneficiary designation on file, the beneficiary will be determined under the Plans' default beneficiary rules. **It is your responsibility to make sure your beneficiary designations are properly recorded on the Benefit Center website.**

You may use the interactive GVUL website at https://mybenefits.metlife.com to make changes to your Beneficiary or you may contact a GVUL Customer Relations Specialist at 1-800-756-0124 Monday through Friday, 7:00 a.m. to 7:00 p.m. Central Time.

Default Beneficiary Rules

Life Insurance Plan

If there is no valid beneficiary designation on file with HR Services or if your named beneficiary predeceases you, your Life Insurance Plan benefits will be paid in the following order:

- Your surviving spouse, if any
- If there is no surviving spouse, equally among your surviving children
- If there is no surviving spouse or children, equally among your surviving parents
- If there is no surviving spouse, children or parents, equally among your brothers and sisters
- If there is no surviving spouse, children, parents, brothers or sisters, your estate

Please note: If you want your domestic partner to be a beneficiary, you **must** name him/her as a beneficiary. Unlike spouses, domestic partners are not considered beneficiaries under the Life and Accident Insurance Plans' default beneficiary rules.

Spouse and Child Life Insurance

You are the beneficiary for any spouse's or domestic partner's and dependent children's coverage. This beneficiary designation cannot be changed to anyone other than yourself.

Accident Insurance Plans

If there is no valid beneficiary designation on file with HR Services or if your named beneficiary predeceases you, your Accident Insurance Plan benefits will be paid to the beneficiary you name under the Basic Life Insurance Plan. If a valid Basic Life Insurance Plan beneficiary designation is not filed with HR Services or if there is no named beneficiary living at the time of your death, any

benefits will be paid under the default rules for the Life Insurance Plan outlined above.

If you suffer an accidental injury that results in your dismemberment or paralysis, or in the Loss of your sight or hearing, the benefit for such Loss will be paid to you.

Please note: If you want your domestic partner to be a beneficiary, you **must** name him/her as a beneficiary. Unlike spouses, domestic partners are not considered beneficiaries under the Life and Accident Insurance Plans' default beneficiary rules.

You are the beneficiary for any spouse's or domestic partner's and dependent children's Accident Insurance coverage.

Assignment of Benefits

You may assign or transfer the ownership of your coverage under the Life and Accident Insurance Plans to a trust or other third party. When you assign coverage, you are transferring all rights to an assignee for that coverage.

Such assignments are irrevocable and will transfer all right, title, interest and incidence of ownership, both now and in the future. Included in the assignment or transfer of ownership are your rights to name a beneficiary or to convert coverage to an individual policy.

There may be tax consequences to any assignment or transfer of ownership of Life and Accident Insurance Plan benefits. Consult a tax advisor before you make a decision to assign Plan benefits.

If you decide to assign your coverage under the Life and Accident Insurance Plans, contact HR Services to obtain the appropriate form. The completed form should be returned to MetLife or Cigna, as applicable, at the address indicated on the form. MetLife or Cigna will review your assignment request and notify you of its approval. It is your responsibility to follow up with MetLife, HR Services or Cigna to ensure approval of your assignment.

Under the BTA Insurance Plan, the employee has the right to select or change the beneficiary. You do not need the consent of the beneficiary to make such a change, to assign his/her rights or benefits, or to change his/her coverage. The BTA Insurance Plan will not be bound by an assignment, or by a selection or change of beneficiary, until HR Services receives a signed copy of it. The BTA Insurance Plan and HR Services are not responsible for its validity or sufficiency.

If You Terminate Employment or Become Ineligible for Benefits

Life Insurance

Your Basic and Supplemental Life Insurance coverage (including coverage for your spouse, domestic partner or dependents) will generally end on the last day of the month in which your employment ends, you lose eligibility or you stop making the required payments, whichever occurs first. If you wish to continue your life insurance coverage, you have two options:

- Conversion–When you choose the conversion option, you are converting your group Morgan Stanley life insurance coverage into a new individual policy. This new policy is completely separate from your previous Morgan Stanley coverage and may have different terms, conditions and options for coverage.
- Portability–When you choose the portability option, you are porting or carrying your existing group Morgan Stanley Life Insurance coverage amount with you. Even though you will no longer be associated with Morgan Stanley, your ported coverage will transition to another group policy, and it will hold many of the same features and terms as your prior group Morgan Stanley Life Insurance coverage. However, please contact MetLife for more detailed information about the features and terms of the coverage you wish to port.

All life insurance coverages may be converted or ported, and EOI is not required. However, to qualify for a lower-premium rate or to increase coverage under Conversion or Portability, you may provide EOI to MetLife. The EOI form is provided as part of the Portability Election form and will be provided at the time of the conversion request. MetLife will review the EOI form, and if approved, MetLife will notify you whether a lower-premium rate will apply to you.

You can apply for a life insurance policy under the conversion and/or portability privilege within 60

days after coverage terminates. If you die within the 60-day period in which you are eligible to apply for conversion or portability, your Morgan Stanley coverage will be considered to be in force.

If you leave Morgan Stanley due to Release, as defined in the Glossary, your Basic and Supplemental Life Insurance coverage may be continued for a period of time following your Release date if you have:

- Been covered under the Life Insurance Plan for at least one year,
- Not reached age 60 on the date your employment terminates, and
- Not converted your coverage to an individual policy.

If you meet the eligibility criteria listed above, coverage will be continued, at no cost to you:

- For one month for each year that you have been covered under the Life Insurance Plan, not to exceed three months, and
- For the amount of life insurance in effect on the date your employment terminated.

Basic and Supplemental Life Insurance Portability Eligibility

You may port your Basic and Supplemental Life Insurance coverage if:

- Immediately prior to termination of employment you were an active employee not on an unpaid leave or disability and were not ill or injured and away from work
- Your spousal or domestic partner relationship ends, or you pass away
- Your dependent child no longer meets Morgan Stanley's definition of "child" for life insurance purposes

If you meet these requirements, you may port up to the amount of insurance coverage you had in effect prior to termination, up to:

- $50,000 of Basic Life Insurance,
- $2,000,000 of Supplemental and Basic Life Insurance combined,
- $200,000 of Spouse or Domestic Partner Life Insurance, and
- $20,000 of Child Life Insurance.

You may only port coverage amounts that are at least:

- $5,000 for yourself
- $1,000 for your spouse or domestic partner
- $1,000 for your dependent children

You may convert all or part of your Supplemental Life Insurance coverage that exceeds these portability amounts at the same time you port coverage.

However, you will be unable to port coverage for yourself or your covered dependents if:

- Any of your life insurance coverage has previously been converted to an individual policy

Ported Coverage Benefits

If you choose to port coverage, the benefit amount that you receive will be reduced when you meet certain age thresholds.

- The amount of coverage that you hold on the day before your eligibility to port will remain in effect until you reach age 70.
- On January 1 after your 70th birthday, or if you are over 65 when you port coverage, your initial amount will be reduced by 50%.
- On January 1 after your 100th birthday, your coverage will be cancelled.
- For your spouse, coverage terminates at age 70.
- For children, coverage under the employee terminates at age 26, but the child can elect portability on themselves beyond age 26.

How to Port Coverage

When your Morgan Stanley Life Insurance Plan benefits end, you will receive a packet in the mail from MetLife regarding both your Portability and Conversion options as well as instructions on next steps to submit your application. You will also receive outreach from a Massachusetts Mutual Life Insurance Company (MassMutual) professional to educate you on time-sensitive conversion and portability options and additional policy options where health questions may be requested.

Portability rates for coverage are generally higher than the active group life rates you currently pay but less than the available conversion rates. The Life Insurance coverage you port continues to retain many of the same features and terms as the

coverage you currently hold, but you are able to carry it with you after your employment with Morgan Stanley ends. However, please contact MetLife for more detailed information about the features and terms of the coverage you wish to port.

To port your life insurance coverage, you must submit the appropriate portability application form to MetLife within 60 days of your loss of coverage. Portability application forms and premium rates are available in the packet you will receive from MetLife. For coverage to be ported, your application and first premium must be received by MetLife within 60 days of the date your life insurance coverage terminates.

Ported coverage becomes effective at the end of the 60-day period during which you may elect to port coverage ("Portability Date"). The ported MetLife coverage is separate from the Morgan Stanley Life Insurance Plan and therefore has its own terms and conditions, which may differ from the Morgan Stanley Life Insurance Plan. If you have any questions, contact MetLife at 888-252-3607.

GVUL Portability of Coverage

Upon retirement or termination of employment, GVUL coverage can be continued under the certificate's portability option. Your portability rates will be based on your status when you leave. When MetLife is notified of a change in your employment status, a communication will be sent to the Owner's address describing your direct bill payment options. If you have any questions about your options, you may contact a GVUL Customer Relations Specialist at 1-800-756-0124 Monday through Friday, 7:00 a.m. to 7:00 p.m. Central Time.

GVUL Policy Surrender

If you wish to surrender your contract, which ultimately cancels both your supplemental and spouse coverage, you may do so by contacting a GVUL Customer Relations Specialist at 1-800-756-0124 Monday through Friday, 7:00 a.m. to 7:00 p.m. Central Time.

Premium Contributions

You will receive new premium contribution rates for any life insurance coverage that you choose to port. These premium rates will change each January 1 on an ongoing basis. Premium contributions must be paid directly to MetLife and will be subject to a direct billing charge. The amount of the charge may be adjusted by MetLife but not more than once a year.

Termination of Coverage

Your ported Life Insurance coverage will end on whichever event occurs first:

- 31 days after you fail to pay the required premium,
- The first anniversary of your Portability Date following your 100th birthday, or
- Your death.

Your spouse's, domestic partner's or dependent child's ported Life Insurance coverage will end on whichever event occurs first:

- The first anniversary of your spouse's or domestic partner's Portability Date following their 70th birthday
- The first anniversary of your dependent child's Portability Date following the date he/she reaches eligibility limiting age. Note your dependent child has the option to continue portability insurance on their own following age 26.

Conversion of Your Life Insurance

You may convert the following Morgan Stanley Life Insurance Plan's coverage:

- Your Basic Life Insurance,
- Any amount of Supplemental Life Insurance coverage to which portability does not apply,
- Any amount of Supplemental Life Insurance coverage to which portability does apply but which you do not elect to port,
- Any amount of Supplemental Life Insurance coverage that ends because of age, or
- Any amount of spouse, domestic partner or child Life Insurance coverage that ends due to no longer meeting the Morgan Stanley definition of spouse, domestic partner or child.

Conversion is not available for any amount of life insurance that is ported. For information about Portability, please see the *Basic and Supplemental Life Insurance Portability Eligibility* section on page 127.

When your life insurance benefits end, you will receive a packet in the mail from MetLife regarding both your portability and conversion options, as well as instructions on next steps to submit your application. You will also receive outreach from a Massachusetts Mutual Life Insurance Company (MassMutual) professional to educate you on time-sensitive conversion and portability options, and additional policy options where health questions may be requested. Because the new, converted policy will be an individual policy, your new rates will likely be higher than those available as a participant in the active group Morgan Stanley Life Insurance Plan. Remember, if you choose to convert your existing coverage, EOI is not required. However, if you chose to provide EOI, then you may be qualified with lower premium rates.

How to Convert Coverage

To convert your life insurance coverage, you must submit the appropriate conversion application form to MetLife within 60 days of your loss of coverage. Conversion application forms and premium rates are available in the packet you will receive from MetLife. For coverage to be converted, your application and first premium must be received by MetLife within 60 days of the date your life insurance coverage terminates.

Converted coverage becomes effective at the end of the 60-day period during which you may elect to convert coverage. The converted MetLife coverage is separate from the Morgan Stanley Life Insurance Plan and therefore has its own terms and conditions, which may differ from the Morgan Stanley Life Insurance Plan. If you have any questions, contact MetLife at 877-275-6387 to arrange for a local MassMutual Professional to contact you directly.

Individual policies become effective at the end of a 60-day conversion period. Premiums for the converted policy will be at MassMutual's customary rates for the same policy issued to any other person of the same class of risk and age at the time the converted policy becomes effective.

Accident Plans

Basic and Supplemental AD&D Insurance coverage will generally end on the last day of the month in which your employment ends, you lose eligibility or you stop making the required payments, whichever occurs first.

BTA Insurance coverage for you and your dependents will terminate on the earliest of the following:

- The date your employment terminates for any reason
- The date you become ineligible for benefits due to an employment status change, including any leave of absence, or the date you are no longer in an eligible class

Dependent coverage will also cease when your dependents are no longer eligible.

Accident insurance (including BTA Insurance) is not convertible or portable.

LTD Insurance

LTD coverage ends on your last day of employment. You have the option to continue your LTD coverage.

Converting your LTD group coverage means you may purchase an individual LTD policy. The purchased policy will differ from Morgan Stanley's group LTD policy. If you choose this option, MetLife will issue your individual policy without EOI, as long as you complete the required forms and pay the premium within the election period.

When your LTD coverage ends, you will receive information in the packet mailed to you by MetLife regarding your LTD Conversion option, as well as instructions on next steps to submit your application. The instructions on next steps are also noted below.

Please note that your option to continue your LTD coverage is time-sensitive.

Please call MetLife at 1-800-929-1492 (prompt #5, then speak "Customer Service") if you have questions about your eligibility or to request an LTD conversion application package. In order for your converted coverage to take effect, you will need to return all of the required paperwork to MetLife within 60 days from the date your LTD coverage ends.

If you have additional questions, you can also contact MetLife at 877-275-6387 to arrange for a local MassMutual Professional to contact you directly.

If You Retire

Life and AD&D Insurance coverage for active employees terminates on the last day of the month in which you retire. BTA Insurance terminates on the day you retire.

The conversion privilege for the Basic Life Insurance coverage described for terminated employees also applies to retired employees, but only to the difference between your active life insurance coverage amount and your retiree life insurance coverage amount (if applicable). When you retire, you can convert the balance of your Basic Life Insurance coverage to an individual policy.

You may convert all of your Supplemental Life Insurance coverage to an individual policy or port up to $2,000,000 of existing Supplemental Life Insurance coverage.

To convert or port any of your coverage, you must apply for an individual policy under the conversion/portability privilege within 60 days after your life insurance coverage terminates. Please see the *Basic and Supplemental Life Insurance Portability Eligibility* section on page 127 for more information.

Accident insurance (including BTA Insurance) is not convertible or portable.

Retiree Life Insurance

Upon retirement from Morgan Stanley, certain employees are eligible to receive retiree life insurance coverage for themselves at Morgan Stanley's expense.

If you were an employee of Global Wealth Management (excluding Private Wealth Management), Individual Asset Management (excluding Van Kampen Investments), or Infrastructure and Company supporting these groups and you:

- **Retired prior to July 1, 1967**, with $1,000 of Basic Life Insurance, you will continue to be insured for that amount
- **Retired prior to January 3, 1978**, from Reynolds Securities Inc., with $5,000 of Basic Life Insurance, you will continue to be insured for that amount
- **Retired prior to January 1, 1989**, from Dean Witter Reynolds Inc., you will continue to have your amount of life insurance reduced each July 1, according to the reduction provisions in effect on your day of retirement, through the final reduction
- **Retired between January 1, 1989, and April 30, 1993**, you will continue to have your amount of life insurance reduced each April 1, according to the reduction provisions in effect on your day of retirement, through the final reduction
- **Retired after April 30, 1993**, and were at least age 55 with 20 years of continuous service or age 60 with 15 years of continuous service on April 30, 1993, you are eligible to receive $5,000 of retiree life insurance coverage for yourself
- **Retired after April 30, 1993**, and did not satisfy the foregoing age and service requirements on or before April 30, 1993, you are not eligible for retiree life insurance

If you are an employee of Institutional Securities, Institutional Investment Management, Private Wealth Management, Van Kampen Investments, or Infrastructure and Company supporting these groups and you:

- **Retired prior to July 1, 1985**, you may be eligible to receive $100,000 of retiree life insurance. Contact HR Services to see if you are eligible;
- **Retired prior to January 1, 2004**, or were at least age 55 with 10 years of service on December 31, 2003, you are eligible to receive $5,000 of retiree life insurance coverage for yourself; or
- **Retired on or after January 1, 2004**, and did not satisfy the foregoing age and service requirements on or before December 31, 2003, you are not eligible for retiree life insurance.

Disability Plan

The Morgan Stanley Disability Plan provides you with financial protection if you become disabled and are unable to work due to illness, injury or pregnancy.

There are four components of the Morgan Stanley Disability Plan:

- Short-Term Disability (STD) benefits, provided by Morgan Stanley, continue your base salary or a portion of your commissions or incentive compensation for up to 180 days if you are

unable to work due to illness, injury or pregnancy

- Long-Term Disability (LTD) group benefits, if elected, continue to pay a portion of your Benefits Eligible Earnings after you have been disabled for 180 consecutive days under the terms of the Disability Plan
- Individual Disability Income Insurance Policies are available to a select group of Morgan Stanley employees for purchase through Unum
- Corporate Excess Disability Insurance (CEDi) Program is available to all Morgan Stanley employees for purchase through Lloyd's of London

The Morgan Stanley Disability Plan (with the exception of the Individual Disability Income Insurance Policy and CEDi Program) is administered by the Metropolitan Life Insurance Company (MetLife).

Please note: The STD benefits described in this SPD do not apply to Saxon employees of the Morgan Stanley U.S. Residential Mortgage Business. For more information, Saxon employees should see the Benefit Center website for their STD policy.

About the STD Program

How the Plan Works

As an employee of Morgan Stanley and/or its participating subsidiaries, you are eligible for STD benefits after your fifth day of active employment or benefits eligibility, whichever is later.

You will be considered disabled by MetLife based on medical information provided by your physician related to your absence from work as a result of illness, injury or pregnancy if you are:

- Unable to perform the essential functions of **your** regularly scheduled occupation, or
- Unable to perform **any** other job Morgan Stanley offers you for which you are qualified.

You are not allowed to work for profit or remuneration while on an approved STD leave. However, you may be considered disabled and receive STD benefits if you are performing job responsibilities as part of an Alternative Work Duty assignment (*see the Alternative Work Duty section on page 134*) approved by MetLife.

STD Benefits

STD benefits may be paid if you are determined to be disabled and unable to work due to an injury, illness or pregnancy for eight or more consecutive calendar days. STD benefits will be paid up to a maximum of 180 days, retroactive to the first day of your disability. If approved for STD, any sick days used to meet the eight-day waiting period will be restored. STD benefits are generally taxable.

How Benefits Are Calculated

The STD benefits you receive are based on how you are paid, as outlined below.

- If you **receive a base salary or are a commissioned salesperson of Investment Management:**
  - STD benefits are 100% of your regular base salary in effect prior to your date of disability, excluding bonuses, commissions, incentive compensation, overtime, shift differential, premium pay, expense allowances, any extra compensation or income received from sources other than Morgan Stanley, and certain other amounts that are not covered under the Disability Plan. A regular monthly draw will be used instead of base salary in determining STD benefits for commissioned sales personnel of Investment Management.
- If you are a Financial Advisor or Investment Representative who receives incentive compensation (other than commissioned sales personnel of Investment Management):
  - Salaried employees receive 100% of regular base salary in effect prior to the date of disability, excluding amounts not covered under the Disability Plan (see above)
  - Commissioned-based employees:
    - *Receive 75% of your trailing 12-month compensation (additional salary, FA salary, excess draw, incentive compensation)*
    - *Deficit resulting from the leave of absence payment is written off each month*
    - *Incentive Compensation above the leave-of-absence payment is paid each month*

- Salaried and commissioned-based employees:
  - *Receive 100% salary and 75% of your trailing 12-month compensation (excess draw, incentive compensation) (T12)*
  - *Deficit resulting from the leave of absence payment is written off each month*
  - *Incentive Compensation above the 75% of the T12 calculated amount is paid each month*

If any incentive compensation is earned during a calendar production month, only the portion that exceeds the actual STD payment/state minimum payment will be paid. (**Earned** revenue is defined as revenue generated in the respective production month and paid on the 10th calendar day of the month after the conclusion of the production month [or the nearest business day prior in the instances of weekends/firm holidays]). The earned revenue is calculated monthly and then offset against the actual paid STD payment/state minimum payment in the relevant production month. If the result is a surplus in incentive compensation, it shall be extended accordingly.

STD benefits do not include bonuses, expense allowances, any extra compensation or income received from sources other than Morgan Stanley, and certain other amounts not covered under the Disability Plan.

Please note that if your disability continues past 180 days and you are covered by LTD, the LTD benefits you will receive are not the same as your STD benefits. For more information on how your LTD benefit is calculated, see page 137.

Requesting Benefits

To request STD benefits, you must:

- First, contact your manager and HR Representative to report any absence of at least eight consecutive calendar days.
- Then, call MetLife at 800-498-5306. MetLife will send you a medical disclosure authorization form that you must complete, sign and send or fax to MetLife. This form allows MetLife to contact your physician and obtain any needed medical information to make a determination on your request. MetLife may not make a determination that you are entitled to STD benefits without your signed medical disclosure authorization form and any necessary information from your physician.
- **All requests must be received by MetLife within 90 days of the disability or your claim may be denied**.

Note: You must see your physician prior to the eighth consecutive calendar day following your last day worked in order to receive full benefits under the STD Plan. Failure to receive prompt treatment from your physician may delay or reduce your benefits.

Upon receiving your request, MetLife will verify certain information with your manager or HR Representative, including:

- Your last day worked, and
- Your job responsibilities.

MetLife will also verify certain information with your physician, including:

- That you are under the regular care of a physician who is qualified to treat your type of injury or illness,
- The date of your disability,
- The cause of your disability,
- The extent of your disability, including any restrictions and limitations preventing you from performing your regular occupation, and
- The name and address of any hospital or institution where you received treatment, including all attending physicians.

If the information required by MetLife is not received and a determination is not made within 30 calendar days from your first day absent, you will be placed on an unpaid leave. If your claim is subsequently approved, you will be paid STD benefits retroactively to your first day of approved disability.

If your claim is approved more than 12 months from your first day absent or last day of approved absence, whichever is greater, Morgan Stanley may provide your STD benefit as a one-time cash payment, and any benefit entitlements may be prospective only.

If MetLife does not approve your claim and you do not return to work, your employment may be terminated at Morgan Stanley's discretion.

During your disability, MetLife may periodically request that you provide proof of continuing disability and that you are under the regular care of a physician **who is qualified to treat your type of injury or illness.** This proof, provided at your expense, must be received as soon as possible and no later than 15 calendar days after the request to avoid an interruption in your benefits.

STD Benefits Duration

Once STD benefits are approved by MetLife, benefits will continue until the:

- Date you are no longer disabled under the terms of the STD Plan or you return to work (Financial Advisors may not return to work on a part-time basis or reduced schedule while collecting STD benefits)
- End of the maximum period of payment (180 days)
- Date you fail to submit proof of continuing disability
- Date you qualify for LTD benefits, if eligible
- Date when you are able and approved to return to work in a temporary Alternative Work Duty assignment for which you are qualified because of your education, training or experience, but refuse the offer of such assignment by Morgan Stanley
- Date you die
- Date you start an unpaid leave of absence (other than FMLA)

Payment of Benefits

Morgan Stanley will make all STD payments directly to you. If Morgan Stanley determines that you are unable to care for your affairs, Morgan Stanley may make payment to another person on your behalf. Any such payment will be in satisfaction of the full benefit due to you.

Morgan Stanley has the right to recover any overpayment, including any overpayment due to:

- Fraud,
- Mistakes in payment or errors in processing a claim,
- Your receipt of any monetary award or settlement from a third party as a result of your disability, or
- Your eligibility for any state-mandated benefit.
- You must promptly reimburse Morgan Stanley in full for any overpayments. Morgan Stanley will determine the method by which repayment shall be made, which may include Payroll deduction.

Continuation of Other Morgan Stanley Benefits While on STD

While you are employed by Morgan Stanley and receiving STD benefits, you will continue to participate in many of the Company-provided and optional benefit plans you were enrolled in prior to your disability. Your contributions will continue through automated Payroll deductions, where applicable, while on your approved disability leave.

You may continue to participate in the following programs while on STD:

- Medical, Dental and Vision Plans
- Basic and Supplemental Life Insurance
- Basic and Supplemental AD&D Insurance
- FSAs and HSA
- LTD Plan
- Group Personal Excess Liability Insurance
- Legal Assistance Plan
- Long-Term Care Plan
- 401(k) Plan
- Continued accrual of vacation days (if eligible)
- Employee Offers (such as Group Auto and Home Insurance and Pet Care Plans)

The following benefits will not continue while you are on STD:

- BTA Insurance Plan–Upon your return to work, your BTA Insurance coverage will automatically resume.
- Commuter Benefits Program (CBP)–Your CBP contributions will cease, and your participation in the program will be terminated. **When you return to work, you must re-enroll in the CBP if you would like to resume participation.**

Additional Disability Information

STD Coverage While on a Paid Leave

If you become disabled while on a paid leave of absence, you are eligible for STD benefits.

Pregnancy/Parental Leave

A disability resulting from a pregnancy is treated the same as any other disabling medical condition. If approved by MetLife, authorized time off taken before the baby's birth is considered STD. There is generally also a period of disability that follows the baby's birth. However, the post-birth portion of disability runs concurrently with—and is usually exceeded by—Morgan Stanley's Paid Parental Leave policy. If eligible, the Paid Parental Leave policy provides salary continuation for up to 16 weeks following a baby's birth. For more information about Morgan Stanley's Paid Parental Leave policy (including eligibility), contact your HR Representative or MetLife or visit the HR Policies section of the me@MS tab on the Morgan Stanley intranet.

If complications from pregnancy result in a period of disability that exceeds Morgan Stanley's Paid Parental Leave policy, eligibility for STD benefits will be determined according to the same standards as for any other disability.

Other Disability Income

The states of California, Hawaii, New Jersey and Rhode Island and the Commonwealth of Puerto Rico offer state disability programs that may differ from the Morgan Stanley-provided plan. **If you work in one of these states, you must apply for benefits through the applicable state disability plan.**

For your convenience, the amount of state-provided benefits you are eligible to receive is included in your Morgan Stanley check. **You must apply for the state disability plan and return the benefits you receive to Morgan Stanley.** You are not entitled to receive more than the total amount of Morgan Stanley STD benefits, and any state-provided benefits are an offset to the benefits provided by the STD benefits under the Plan. If you have any questions, please contact MetLife for information about your state-mandated STD coverage.

If you become eligible to receive STD benefit payments under any other group STD plan, you will not be eligible for STD payments under the Morgan Stanley Disability Plan.

Recurrent Disability

A Recurrent Disability results from the same or a related illness or injury as a prior disability within a specified period of time. If you have a Recurrent Disability after you return to your regular work schedule for 90 calendar days or less, benefits will begin immediately. Your Recurrent Disability will be subject to the same STD Plan terms as your prior disability.

If MetLife determines that this successive period of disability is unrelated to your prior disability or you have returned to work for more than 90 calendar days, your later disability will be treated as a new disability and subject to all of the STD Plan provisions.

Alternative Work Duty

During an approved STD leave, MetLife may approve your return to work on a full-time or part-time basis, performing the job responsibilities of a temporary Alternative Work Duty assignment. Such an assignment is intended to promote your recovery and return you to your own job following a disability-related absence.

Please note that Financial Advisors may not return to work on a part-time basis or reduced schedule while collecting STD benefits.

During an Alternative Work Duty assignment, you may:

- Perform your regular duties on a reduced work schedule,
- Work on a full-time basis but perform modified job duties, or
- Perform the duties of a temporary assignment that you are qualified for because of your education, training or experience on either a full-time or part-time basis.

If MetLife determines that a short-term modification of your job responsibilities is appropriate, a temporary Alternative Work Duty assignment may be approved before or after you begin disability under the Disability Plan. A temporary Alternative Work Duty assignment may generally last for up to

12 weeks. Each assignment will be reviewed by MetLife periodically, but at least once every four weeks.

You will be considered disabled during a temporary Alternative Work Duty assignment as long as you satisfy the conditions of the assignment and the requirements of the Disability Plan and the assignment continues to be available. During the assignment, you will be paid for the hours that you work at 100% of your normal rate of base pay in effect immediately prior to the date you became disabled. For the hours that you do not work, STD benefits will be paid in accordance with the Disability Plan's terms. In no event will your rate of pay for hours worked plus any STD benefits paid during a temporary Alternative Work Duty assignment exceed 100% of your pre-disability base pay rate.

If MetLife determines that you are unable to resume the normal responsibilities and work schedule of your regular position at the end of a temporary Alternative Work Duty assignment, you may be eligible to continue to receive STD benefits. In that case, your continued absence from work following an Alternative Work Duty assignment will be considered a continuation of the original period of disability and count toward your LTD elimination period.

Return to Work and the Family and Medical Leave Act of 1993 (FMLA)

You must notify your manager or HR Representative and MetLife of your intent to return to work in any capacity. You should not return to work unless you have been cleared by your attending physician to do so. If you return to work early from your leave, your supervisor may require a return-to-work note from your physician to ensure you are able to return to work safely.

You may contact MetLife or your HR Representative for eligibility requirements and information about whether reinstatement protection is available under FMLA. Additional information about your FMLA rights is available in the HR Policies section of the me@MS tab on the Morgan Stanley intranet.

STD Exclusions

STD benefits are not paid for any disability incurred in connection with:

- An occupational injury or illness covered by Workers' Compensation law,
- An intentionally self-inflicted injury,
- War, whether declared or undeclared, or act of war, riot or insurrection,
- Active participation in a riot,
- Suspension, revocation or surrender of a professional license, occupational license or certification,
- Any period of time during which you are incarcerated,
- Any injury or illness to which a contributing cause was your committing or attempting to commit a felony, or your being engaged in an illegal operation, or
- While you are working in any capacity for profit or remuneration.

STD Coverage While on an Unpaid Leave

If you become disabled while on an unpaid leave, you are not eligible for STD benefits unless the unpaid leave is an approved FMLA leave.

Termination of Coverage

Morgan Stanley reserves the right to terminate your STD payments if:

- Your employment with Morgan Stanley terminates for any reason, including termination by Morgan Stanley for "cause" or if Morgan Stanley determines it could have terminated your employment for "cause,"
- You announce your resignation or retirement,
- MetLife denies your claim,
- You fail to repay any state-provided benefits to Morgan Stanley,
- You fail to timely provide evidence of disability or any other information requested by MetLife or Morgan Stanley,
- You are no longer eligible for coverage, as determined by Morgan Stanley or MetLife,
- MetLife determines that you are capable of performing your job despite your medical condition,

- The STD portion of the Disability Plan is terminated, or
- You are placed on an unpaid leave of absence (other than FMLA) prior to termination date.

If you notify MetLife or Morgan Stanley that you are disabled **after** announcing your resignation or receiving notice of termination, your STD payments will end on the otherwise scheduled or communicated date of resignation or termination from Morgan Stanley. However, if you become disabled and provide notice of disability to MetLife as described in the *Payment of Benefits* section on page 169 **before** you either announce your resignation or receive notice of termination, you will remain eligible to receive STD benefits beyond your otherwise scheduled date of resignation or termination except as described above. At Morgan Stanley's discretion, your date of resignation or termination may be deferred until the date your STD benefits end.

Morgan Stanley, at its discretion, may pay STD benefits as a one-time lump sum if employment is terminated due to reduction in force, sale of business or other situation deemed appropriate by Morgan Stanley.

If Employment Is Terminated

While you're on a leave, including for disability, Morgan Stanley may terminate your employment subject to applicable law and at its discretion. Contact HR Services or visit the *HR Policies* section of the me@MS tab on the Morgan Stanley intranet for more information.

About the LTD Program

Morgan Stanley's LTD program gives you an opportunity to protect 60% of your Benefits Eligible Earnings, up to a maximum benefit of $25,000 per month for disabilities. (For more information about *Benefits Eligible Earnings*, see page 13). LTD coverage typically begins after a 180-day waiting period, during which time you may be eligible to receive STD benefits.

Because you pay for LTD coverage with after-tax dollars, your benefit is generally free from federal and most state income taxes. LTD coverage is insured and provided by MetLife. Notwithstanding anything else in this SPD, LTD benefits are provided only to the extent available under the Disability Plan's insurance policy with MetLife.

Evidence of Insurability (EOI)

You will be automatically enrolled in LTD coverage on your date of hire or the date when you become benefits-eligible. You will not be required to provide EOI. You will automatically be enrolled each January 1 thereafter without the need for EOI. However, if you are not actively at work on January 1, due to a disability, you must return to work for at least 90 days in order for the recurrent disability provisions of this plan to apply to the same disability.

If you do not want to enroll in LTD coverage, you must actively waive LTD coverage during each annual enrollment period.

If you elect LTD coverage at any time after your initial 31-day enrollment period, you will be required to complete an Evidence of Insurability (EOI). LTD requiring MetLife's approval will be effective from the date the EOI is approved; until that time, you will not receive LTD coverage. It is your responsibility to follow up with MetLife regarding the status of the EOI.

LTD coverage does not begin until you are actively at work and are performing all the usual and customary duties of your job on a full-time basis.

This must be done at:

- Your work location or an alternate work space approved by the Firm
- A place to which the Firm's business requires you to travel

You will be deemed actively at work during weekends or firm-approved holidays, vacations or business closures if you were actively at work on the last scheduled work day preceding such time off.

How the Plan Works

LTD benefits provide monthly income to you after you satisfy a 180-day Elimination Period. Although you do not need to be confined in a hospital or an extended health care facility to receive LTD benefits (other than mental or nervous conditions lasting beyond 24 months), you must be under the regular care of a physician and determined to be disabled by MetLife. Generally, you are considered

to be disabled as a result of illness, injury, pregnancy or a complication of pregnancy following a 180-day Elimination Period if MetLife determines that you:

- Cannot perform all of the material duties of your regular occupation, or
- Cannot perform all of the material duties of your regular occupation on a full-time basis but you:
  - Are performing at least one of the material duties of your regular occupation or another occupation on a part-time or full-time basis, and
  - Have a loss of earnings of at least 20 percent per month as a result of the same sickness or injury.

To determine whether there is a loss of earnings of at least 20 percent, MetLife will consider your Benefits Eligible Earnings in effect at your date of disability as your predisability earnings.

You do not need to continue to be employed by Morgan Stanley to receive LTD benefits, as long as you were actively employed by Morgan Stanley and enrolled in LTD coverage on the date you became disabled.

If you become disabled, as determined by MetLife, determination of disability will continue to apply up to the Maximum Benefit Period described in that section.

Elimination Period

Before LTD benefits become payable, you must satisfy a 180-day Elimination Period. The Elimination Period is satisfied on the date your salary continuation (STD) payments end, or the date your Paid Parental Leave payments end (as defined by Morgan Stanley's Paid Parental Leave Policy, if applicable), or 180 days from the start of your disability, whichever is latest.

If your disability stops during the Elimination Period for 90 days or less, the disability will be treated as continuous for purposes of the Elimination Period. The days that you are not disabled, however, will not count toward the 180 days of disability required to satisfy the Elimination Period.

LTD Benefits

How LTD Payments Are Calculated

The monthly benefit amount that you will be paid while you are disabled is calculated as follows:

60% of your Benefits Eligible Earnings in effect at the first date of disability offset by Other Income Benefits with a minimum monthly benefit after offsets equal to $100 or 10% of your gross monthly benefit, whichever is greater

- Up to a maximum benefit of $25,000 per month when combined with family Social Security benefits, if any; the monthly LTD benefit may not exceed 60% of your Benefits Eligible Earnings or $25,000, whichever is less.

Cost of Coverage

You may view your LTD contribution rates by visiting the Benefit Center website.

Maximum Benefit Period

LTD benefits continue for as long as you remain disabled, subject to the following Maximum Benefit Periods:

COMPLETED AGE AT DISABILITY	MAXIMUM BENEFIT PERIOD WHILE DISABLED
Less than 60	To age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

Mental Illness Limitation Period

Disabilities that are primarily due to mental illness have a Maximum Benefit Period of up to 24 months. If you meet one or both of the following conditions, MetLife will continue to extend payments beyond the 24-month period:

1. If you are confined to a Hospital or Institution at the end of the 24-month period, MetLife will continue payments during confinement. If you

are still disabled when you are discharged, MetLife will send you payments for a recovery period of up to 90 days. If you become reconfined at any time during the recovery period and remain confined for at least 14 days in a row, MetLife will make payments during that additional confinement and for one additional recovery period up to 90 additional days.

2. In addition to the above, if, after the 24-month period for which you received payments, you continue to be disabled and subsequently become confined to a Hospital or Institution for at least 14 days in a row after the 24-month period ends, MetLife will provide payments during the length of the reconfinement.

MetLife will not pay beyond the Mental Illness Limitation Period or the Maximum Benefit Period, whichever occurs first. MetLife will not apply the Mental Illness Limitation to dementia, schizophrenia or organic brain disease.

Mental Illness means a psychiatric or psychological condition regardless of cause, such as depression, manic depressive or bipolar illness, anxiety, personality disorders and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs or other similar methods of treatment. **Mental or Nervous Disorder or Disease** means a medical condition that meets the diagnostic criteria set forth in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders as of the date of your disability. A condition may be classified as a Mental or Nervous Disorder or Disease regardless of its cause.

Hospital or Institution means an accredited facility licensed to provide care and treatment for the condition causing your disability.

MetLife makes all determinations about whether a disability is due to mental illness or subject to a mental illness Limitation Period.

Requesting Benefits

If you request STD benefits during your 180-day Elimination Period, MetLife will:

- Determine your eligibility for LTD benefits based on the information provided by you and your physician during your STD benefit review,
- Request additional information, if needed,
- Either accept or deny the claim, and
- Notify you of its determination in a timely manner.

Any disabilities you incur during your leave will be subject to exclusions under the LTD portion of the Plan. If you become disabled while on an unpaid leave or did not request STD benefits and are participating in the LTD Plan, you must contact MetLife directly to request benefits. You will be required to complete the 180-day Elimination Period prior to receiving LTD benefits regardless of whether or not you receive STD benefits. You must file a claim for LTD benefits within 90 calendar days following your first day of disability or your claim may be denied. Generally, for employees on STD, MetLife will file your LTD claim on your behalf after the 13th week of your disability. However, it is your responsibility to confirm your claim has been filed and to follow up with any additional information that may be required.

Other Income Benefits

Other Income Benefits are benefits paid to you separately from your LTD benefit. Morgan Stanley's Long Term Disability Plan requires you to apply to the following sources of "Other Income" as long as there is a reasonable basis for you to do so. "Reduction" will relate only to amounts from other income received as a result of the same disability and inability to work for which you are claiming benefits under the Disability Plan. These may include, but are not limited to:

- Workers' Compensation or any other state disability benefits,
- Any income received for disability or for retirement, if such retirement income begins while you are disabled, under the Morgan Stanley Employees Retirement Plan, to the extent that it can be attributed to Morgan Stanley's contributions,
- Disability income under a governmental retirement system, except a government employee pension benefit,

- Disability or retirement benefits paid by U.S. Social Security, a foreign pension plan, or a federal, state or provincial plan,
- Disability income benefits paid under any other group plan, including any other Morgan Stanley group plan,
- Disability income benefits from company-sponsored individual disability insurance policies. Please note, individual disability insurance policies purchased outside of the Morgan Stanley LTD Plan are not considered Other Income Benefits (the Individual Disability Income Insurance Policy and the CEDi Policy are not offsets),
- LTD payments will be an offset to Salary continuation income received as part of your STD coverage or Paid Parental Leave policy, any income received for disability or for retirement, if such retirement income begins while you are disabled, under the Morgan Stanley Employees Retirement Plan, to the extent that it can be attributed to Morgan Stanley's contributions.
- To apply for the above benefits means to pursue such benefits until you receive an approval from the above sources or until you receive a denial of benefits from a Social Security administrative law judge.

After your LTD benefit is initially reduced by any of the Other Income Benefits listed above, your LTD benefit will not be further reduced due to any cost-of-living increases to these Other Income Benefits.

Continuation of Other Morgan Stanley Benefits

If you are employed by Morgan Stanley[1] and receiving LTD benefits, you are placed on an unpaid leave status, not actively at work status, and are eligible for continuation of certain health, insurance, retirement, savings and other benefits on an after-tax basis. These include the continuation of the following benefits, if you were enrolled in them immediately prior to your disability (subject to your continued contributions, where applicable):

- Medical, Dental and Vision Plans
- If you are approved for U.S. Social Security Disability Insurance and are Medicare-eligible due to your disability or age, Medicare is considered your primary medical plan coverage and the Morgan Stanley Medical Plan (if enrolled) will be your secondary coverage. You will need to submit your expenses to Medicare first. Once Medicare has determined how much it will pay, you may submit any uncovered expenses to Morgan Stanley's Medical Plan. **If you are on LTD and your spouse is eligible due to age or disability, then Medicare is considered their primary medical coverage and the Morgan Stanley Medical Plan (if enrolled) will be secondary coverage, even if you are not yet eligible for Medicare.**
  - **To receive maximum medical coverage, it is important for you and your spouse to enroll in Medicare Parts A and B upon attaining age 65 or if under 65 but approved for U.S. Social Security Disability Insurance because your benefits under the Morgan Stanley Medical Plan will immediately be computed as though you received Medicare benefits, even if you have not enrolled in this coverage. This does not apply to Medicare prescription drug coverage.**
- Health Care Flexible Spending Account and Limited Purpose Flexible Spending Account (through the end of the calendar year that you began receiving LTD benefits)
- Basic and Supplemental Life Insurance Plan **(up to a maximum age of 65)**
- Morgan Stanley 401(k) Plan contributions cease; however, you may receive Company contributions, if eligible, for the year you begin receiving LTD benefits
- MetLife Group Auto and Home Insurance
- MassMutual, MetLife, Prudential or John Hancock Long-Term Care Insurance
- Basic and Supplemental AD&D Insurance (for a maximum of 24 months)
- Legal Assistance Plan

[1] The benefits described in this section will end if Morgan Stanley chooses to terminate your employment or your employment is terminated for any reason at any time during your disability. There is no guarantee that Morgan Stanley will continue your employment throughout your total period of disability.

- Group Personal Excess Liability Insurance
- Pet Care Plans
- The following benefits will cease when you begin receiving LTD benefits:
  - BTA Insurance,
  - Dependent Day Care Flexible Spending Account, and
  - Commuter Benefits Program.

If Employment Is Terminated

While you're on a leave, including for disability, Morgan Stanley may terminate your employment subject to applicable law and at its discretion. Contact HR Services or visit the HR Policies section on the me@MS tab on the Morgan Stanley intranet for more information.

Upon termination of your employment with Morgan Stanley:

- You may be eligible to continue your Medical, Dental and Vision benefits through COBRA for up to 18 months and your HCFSA, LPFSA and HSA through the end of the calendar year. You may be eligible to receive up to 11 additional months of COBRA if you are deemed disabled for Medicare purposes. (See the *Continuation Coverage Rights Under COBRA* section on page 184).
- Basic Life Insurance may continue until the earlier of the date you stop receiving LTD benefits, the date you reach age 65 or your settlement effective date if you receive a lump-sum disability settlement from MetLife or Unum (the previous insurer of LTD benefits).
- If you are receiving LTD benefits, are not actively working, and are under age 65, you may be able to continue your Employee Supplemental Life Insurance Coverage by paying the same rates as active employees. Upon termination of your LTD coverage, you may convert or port your Employee Supplemental Life Insurance to an individual policy. You must contact HR Services within 31 days of the date your employment ends and contact MetLife within 60 days of termination to port or convert coverage.
- All other benefits generally cease at your date of termination from Morgan Stanley. (See the *Continuation of Coverage During Work or Life Events* section on page 24.)

Additional Disability Information

Pre-Existing Condition Exclusion

If you do not elect LTD coverage when you are first eligible or if you do not elect coverage on a timely basis and you received medical treatment, consultation, care or services, or took prescribed drugs or medicines for a condition during the three-month period prior to the effective date of your LTD coverage, it will be considered a Pre-Existing Condition.

No benefit is payable for disabilities resulting from a Pre-Existing Condition. A Pre-Existing Condition is one for which medical advice or treatment was received in the three-month period prior to becoming covered by the LTD Plan, or for which a reasonably prudent person would have sought advice or treatment, unless the disability begins after 12 months of coverage.

If a Pre-Existing Condition applies to you and you become disabled:

- As a result of a medical condition that is not related to your Pre-Existing Condition, you will be eligible for disability benefits, provided you meet the conditions of LTD coverage
- As a result of a Pre-Existing Condition and the disability begins within the first 12 months after enrolling in LTD coverage, you will not be eligible for disability benefits for that medical condition
- After 12 months of LTD coverage, Pre-Existing Conditions will not limit your coverage and you will be eligible for disability benefits for any medical condition, provided you meet the conditions of LTD benefits coverage

Recurrent Disability

A Recurrent Disability is one that MetLife determines has resulted from the same or related illness or injury as a prior disability for which a monthly benefit was payable during a specified period of time. MetLife will consider a successive period of disability to be a Recurrent Disability if it is due to the same or a related cause and occurs less than 180 days after the end of the previous period of disability. If you have an approved

Recurrent Disability, you do not need to satisfy an additional Elimination Period.

If your successive period of disability does not meet the Recurrent Disability terms described above, it will be considered a new disability. You will be required to complete a new Elimination Period before LTD benefits become payable. In that instance, you may be eligible for STD benefits during the first 180 consecutive days of your disability under STD (see the STD Benefits subsection).

Residual Disability

While you are disabled, you may be permitted to work upon receiving approval from MetLife. Generally, Financial Advisors are not eligible to work while disabled and receiving LTD benefits.

The Residual Disability benefit is proportionate to your loss of earnings (for example, if you have a loss of earnings of 40%, you will receive 40% of your monthly LTD benefit) and is payable for the Maximum Benefit Period. If your loss of earnings is not at least 20%, you will no longer be Residually Disabled and your LTD payments will cease.

Work Incentive Benefit

Work Incentive

If you are Residually Disabled, to encourage your return to work, MetLife provides a Work Incentive Benefit for 12 months following the date you return to work.

If you work while you are disabled and receiving Monthly Benefits, your Monthly Benefit will be adjusted as follows:

- Your Monthly Benefit will be increased by your Rehabilitation Program Incentive; and
- Reduced by Other Income as defined in the Disability Income Insurance: Income which will reduce your disability Benefit section.

Your Monthly Benefit as adjusted above will not be reduced by the amount you earn from working, except to the extent that such adjusted Monthly Benefit plus the amount you earn from working and the income you receive from Other Income exceeds 100% of your Predisability Earnings as calculated in the definition of Disability.

In addition, the Minimum Monthly Benefit will not apply.

Limit on Work Incentive

After 12 months following your return to work, we will reduce your Monthly Benefit by 50% of the amount you earn from working while disabled.

Survivor Benefit

If you die 180 or more consecutive days after you become disabled and receive or will receive an LTD benefit, your Eligible Survivors (including your estate if there are no Eligible Survivors) will receive a lump-sum payment from MetLife equal to three times your last monthly benefit. An Eligible Survivor is defined as your spouse or registered domestic partner if living; otherwise, it is defined as your children under age 26.

LTD Exclusions

LTD benefits are not paid for any disability incurred in connection with:

- An intentionally self-inflicted injury,
- War, whether declared or undeclared, or act of war, riot or insurrection,
- Active participation in a riot,
- Suspension, revocation or surrender of a professional license, occupational license or certification,
- Any period of time during which you are incarcerated,
- Any illness or injury to which a contributing factor was the result of your committing or attempting to commit a felony, or your being engaged in an illegal operation, or
- Any loss excluded by name or specific description in the insurance policy.

Termination of Coverage

LTD benefits will stop:

- When you are no longer disabled, as determined by MetLife,
- In the event of your death,
- When you reach the Maximum Benefit Period, including the Mental Illness Limitations,

- On the date your current earnings equal or exceed 80 percent of your predisability[1] earnings, or
- On the date you refuse the care of a physician who is qualified to treat the type of injury or illness for which your claim is made, and whose care is intended to help you return to work in your occupation.

In addition, MetLife and the Disability Plan reserve the right to terminate your LTD benefits if you fail to provide evidence of disability or any other information requested by MetLife or the Disability Plan.

You may convert your group LTD coverage, if approved, by paying premiums directly to MetLife. The rate you pay is based on your age to age 65. The maximum monthly benefit is $4,000, with an Elimination Period of 180 days. You must provide your conversion notice letter from HR Services along with your application. For premium rates and information on how to convert your LTD coverage, call MetLife at 800-929-1492, Prompt 5.

Right to Reimbursement (Subrogation Agreement)

The Disability Plan has the right to receive reimbursement for any recovery from a third party due to an injury or other condition for which the Disability Plan provided benefits, as applicable. This right is called “subrogation.” The Medical Plan’s subrogation rules apply to the Disability Plan. See the *Right to Reimbursement (Subrogation Agreement)* section on page 17. This does not apply to the Individual Disability Income Insurance Policy and the CEDi Policy.

Individual Disability Policy

Eligibility

If your Benefits Eligible Earnings (BEE) are at least $500,000, you may be eligible for up to $20,000 per month of portable Individual Disability Income Insurance coverage issued by Unum. Your total monthly benefit, including group and individual coverage (including any previously ported individual coverage), may provide a maximum monthly income of $45,000 per month. Lenox Advisors, financial professionals with expertise in executive benefits and individual insurance, is available to act as your advisor and can provide additional information about the individual disability coverage available to you.

This Unum Individual Disability Income Insurance policy is only available to participants under age 70 who have a BEE of at least $500,000.

Enrollment

To enroll, you must complete the Benefit Enrollment process with your assigned Lenox Advisors Relationship Manager. The enrollment process must be completed during the Individual Disability Income Insurance annual enrollment period. Morgan Stanley may offer periodic opportunities to enroll, but these are not guaranteed. Unum does not require Evidence of Insurability (EOI) for the Individual Disability Income Insurance policy (up to the guaranteed issue amount of $20,000), as long as you have been actively at work without restrictions for the 180 days prior to signing the application. If you have been offered and have declined coverage through this program two times previously, EOI may be required to enroll.

Once you enroll and the policy is issued, your individual policy is noncancelable and guaranteed renewable until you reach the Noncancelable Expiration Date as long as you pay your premiums on time (unless you increase the benefit amount of your original policy). If your policy is issued prior to your 63rd birthday, the Noncancelable Expiration Date is your 67th birthday for non-California residents or your 65th birthday for California residents. If your policy is issued after your 62nd birthday, the Noncancelable Expiration Date is five years from your policy effective date.

After the Noncancelable Expiration Date, you can renew the policy only if you are working at least 30

[1] Predisability earnings are defined as your Benefits Eligible Earnings used for LTD purposes in effect at the date of your disability, adjusted on the first anniversary of benefit payments and on each following anniversary. Each adjustment will be based on the lesser of 10% or current annual percentage increase in the Consumer Price Index. For a definition of Benefits Eligible Earnings, see the *Benefits Eligible Earnings* section on page 13.

hours per week. Premium rates are subject to change after your Noncancelable Expiration Date.

If you are not offered this individual policy or do not complete the enrollment process, you will not receive a Unum Individual Disability Income Insurance policy.

Cost of Coverage

Your individual policy premiums will reflect your particular risk profile on the date you enroll. It will differ from your contribution rates for group LTD coverage under the Disability Plan since your group LTD coverage contribution rates are based on composite pricing (a blended rate for the entire population participating in LTD coverage).

Requesting Benefits

You must send all completed authorization and claim forms for the Individual Disability Income Insurance policy to Lenox Advisors. If you choose to receive benefit payments by check, you will receive two separate checks (one from MetLife for the group LTD coverage and one from Unum for the Individual Disability Income Insurance). If you choose to receive benefit payments by direct deposit, you will receive two separate deposits (one from MetLife and one from Unum).

Individual Policy Provisions

When Unum issues your policy, you will receive an individual policy contract. For complete policy details, please contact your assigned Lenox Advisors Relationship Manager.

Elimination Period

The Elimination Period is the number of days you have to wait before you become eligible for benefits. The Elimination Period for the Individual Disability Income Insurance policy is 180 days.

Recurrent Disability

A Recurrent Disability is a successive period of disability that results from the same or a related illness as a prior disability claim that occurs during a specified period of time (within 12 months for California and within six months for all other states) after the end of the previous period of disability.

You may claim benefits for Recurrent Disabilities without having to satisfy an additional 180-day Elimination Period.

Recovery Benefit

A Recovery Benefit is provided under the Unum Individual Disability Income Insurance policy to encourage your return to work after an approved disability when you are no longer disabled, up until your 67th birthday. You are eligible for a Recovery Benefit if you:

- Have satisfied the Elimination Period,
- Are no longer disabled,
- Have returned to full-time work in your occupation,[1] and
- Have a loss of earnings of at least 20% due to the injury or sickness that caused your disability.

The Recovery Benefit is proportionate to your loss of earnings (for example, if you have a loss of earnings of 40 percent, you will receive 40 percent of your monthly benefit). If your loss of earnings is no longer at least 20 percent and you are still in your Recovery Benefit Period, you will no longer be eligible for the Recovery Benefit and your Individual Disability Income Insurance benefit payments will end.

Survivor Benefit (Non-California residents)

Three months of Individual Disability Income Insurance benefits will be paid as a lump sum to your estate if you have satisfied the Elimination Period and are receiving benefits at the time you pass away.

Lifetime Continuation Provision

The Lifetime Continuation Provision is not available for Individual Disability Income Insurance policies issued by Unum on or after January 1, 2014.

All determinations made under or with regard to the Individual Disability Income Insurance policy issued on or after January 1, 2014, are made by Unum, the issuer of the Individual Disability Income Insurance policy, in its discretion. All determinations made under a policy issued prior to January 1, 2014, are made by the issuer of that individual disability policy.

[1] Your occupation means the occupation in which you are regularly engaged at the time you become disabled.

If You Terminate, Become Ineligible or Otherwise Cease to Participate in LTD Coverage

If you own an individual disability policy that you purchased under the LTD Plan prior to December 31, 2013, please contact the Covala Group at 800-235-3551 for additional information.

Continuation Privilege

You maintain your Unum Individual Disability Income Insurance policy by continuing to pay premiums directly to Unum. The premium you pay for your coverage will not change and is fixed for the duration of the policy, up until age 65 for California residents or age 67 for non-California residents (or five years from issue, if later). The discounted rates remain with the policy regardless of your employment status with Morgan Stanley.

There is no guarantee that the individual disability policy provides the lowest rates available to you. For premium rates and information on your individual policy, call Lenox Advisors.

Termination of Individual Policy Benefits

Your Unum Individual Disability Income Insurance policy will end on the earliest of:

- The date you stop paying premiums
- Your Noncancelable Expiration Date, if you are no longer working at least 30 hours per week

This is a brief summary of the general coverage provided by the Individual Disability Income Insurance policy and not an insurance contract. The policy or its provisions may vary or be unavailable in some states. The Individual Disability Income Insurance policy also has exclusions and limitations that may affect any benefits payable. Your individual coverage may be limited or not issued based on your answers to questions on the application. Please contact Lenox Advisors for complete details on provisions and availability. Should there be any discrepancy between the provisions outlined in this document and the insurance policy, the provisions of the insurance policy shall prevail.

For more information, contact Lenox Advisors at 212-536-8782.

Corporate Excess Disability Insurance (CEDi) Program

Eligibility

Employees may elect Corporate Excess Disability Insurance (CEDi) coverage issued by Lloyd's of London. The amount of available coverage is based on your eligible pay.

There are two options available based on eligible pay: Lump Sum Benefits or Monthly Benefits.

Enrollment

Once you enroll and the policy is issued, your policy is noncancelable during its term as long as you pay your premiums on time.

If you are not offered this individual policy or do not complete the enrollment process, you will not receive a CEDi policy.

If, at time of enrollment/application, you cannot meet the actively at work requirement, you will be asked to explain your inability to meet the 180-day standard. Lloyd's underwriters may or may not issue coverage, or may issue rated coverage based on your response.

Note: This is a brief summary of the general coverage provided by the CEDi policy and not an insurance contract. The policy or its provisions may vary or be unavailable in some states. The CEDi policy also has exclusions and limitations that may affect any benefits payable. Your individual coverage may be limited or not issued based on your answers to questions on the application.

Please contact the CEDi plan administrator, Dye & Eskin Inc., for complete details on provisions and availability. Should there be any discrepancy between the provisions outlined in this document and the insurance policy, the provisions of the insurance policy shall govern.

Lump Sum Benefits:

Insurable Income: Eligible pay derived from Morgan Stanley only.

This lump sum benefits policy is only available to participants age 65 or under.

All benefits-eligible employees earning $500,000 or more (Class 1) who have satisfied the 180 days of actively at work requirement (any exceptions are subject to underwriter approval) are

eligible for up to two times his or her eligible pay up to a maximum of $3,000,000 of Modified Guaranteed Standard Issue (GSI) portable Lump Sum Disability insurance policy, issued by Lloyd's of London.

Total benefit is two times your eligible pay up to a maximum of $3,000,000 and will not be offset by any coverage calculated by a maximum of two times annual earnings.

Lump Sum Benefit (Class 1):

Ages 59 and younger: up to $3,000,000

Ages 60-65: up to $1,000,000

Benefit Options:

Option 1: $500,000

Option 2: $1,000,000

Option 3: $2,000,000

Option 4: $3,000,000

All benefits-eligible employees earning less than $500,000 (Class 2) who have satisfied the 180 days of actively at work requirement (any exceptions subject to underwriter approval) are eligible for up to two times his or her eligible earnings up to a maximum of $300,000 of Modified Guaranteed Standard Issue (MGI) portable Lump Sum Disability benefit, issued by Lloyd's of London.

For purposes of eligibility, actively at work shall mean that insured is not on any type of leave from their employment at Morgan Stanley.

Total benefit is two times your eligible pay to a maximum of $300,000 and any other disability policies will not be an offset.

Lump Sum Benefit Options (Class 2):

Option 1: $100,000

Option 2: $200,000

Option 3: $300,000

Cost of Coverage

Your individual policy premiums will reflect your particular risk profile on the date you enroll.

Requesting Benefits

You must send all completed authorization and claim forms for the CEDi policy to the following:

Hanleigh Management Inc.

50 Tice Blvd, Suite 122

Woodcliff Lake, NJ 07677

Attn: Matthew Zuba & Graham Southall

Please call the office at 201-505-1050 for transmittal options.

Claims will be adjudicated and paid by Lloyd's of London or its delegated Third-Party Administrator.

Individual Policy Provisions

When your policy is issued, you will receive an individual policy certificate. For complete policy details, please contact the plan administrator, Dye & Eskin, Inc. at 888-556-8767 to speak with a representative between the hours of 8 a.m. and 6 p.m. ET.

Elimination Period

The Elimination Period is the number of days you have to wait before you become eligible for benefits. The Elimination Period for the Lump Sum CEDi policy is 365 days.

Definition of Disability (Lump Sum Benefits)

CEDi will pay the Permanent Total Disability Benefit shown on the schedule for a periodic loss of income if:

3. The Insured becomes permanently and totally disabled as defined below as a direct result of
   a) an injury which occurs while this benefit is in force and causes permanent total disability due to the injury to begin within 730 days of a covered accident; or
   b) a sickness which first manifests itself while this benefit is in force and causes permanent total disability to commence within 730 days of a covered sickness; and
4. The Insured satisfies the elimination period shown on the schedule; and
5. The Insured is under the regular care of a physician who is appropriate for the condition causing the disability.

A participant is *permanently and totally disabled* if, as a result of a covered injury or sickness, the Insured is permanently and totally unable to perform the substantial and material duties of his or her regular occupation as shown on the

schedule for the entire elimination period and is not expected to recover for the remainder of his or her life. The Insured must also be under the regular care of a physician who is appropriate for the condition causing the disability.

No benefit will be paid prior to the completion of the elimination period. In no event will the policy pay more than the aggregate limit shown in the schedule.

In the event your death occurs before the elimination period, no benefit will be paid; however, premiums paid during your elimination period will be refunded to your estate.

This provision is subject to all certificate terms, conditions and limitations.

Pre-Existing Condition

Pre-existing condition means a sickness or accidental injury for which you, in the 24 months before your insurance or any increase in the amount of insurance under this certificate takes effect, have:

- Received medical treatment, consultation, care or services;
- Taken prescription medication or had medication prescribed; or
- Had or have any symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment.

CEDi will not pay benefits, or increase a benefit amount related to an elected increase in the amount of your insurance for disability that results from a pre-existing condition unless for a continuous 12-consecutive-month period after the effective date of your CEDi policy, or the date on which the elected increase in the amount of such insurance takes effect under this certificate you have been actively at work, and have not:

- Received medical treatment, consultation, care or services or
- Taken prescription medication or had medication prescribed or
- Had or have any symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment.

Certain pre-existing conditions may be covered if they have been fully disclosed to underwriters and are not excluded from coverage by name or specific description or have been included on special terms. Contact the CEDi plan administrator, Dye & Eskin, for more information.

Portability

You may port your CEDi policy if you terminate your Morgan Stanley employment, provided you remain actively employed in your insured profession and continue payment of premiums for the remainder of the policy period.

A terminated employee's coverage will change at the time employment terminates:

- The amount of coverage will automatically reduce by 75%
- Premium will automatically increase to the "Portability Rate Scale"

Medical and financial justification will be required at the next anniversary date in order to retain any amount of coverage.

At the end of the policy period, any ongoing coverage will be subject to individual underwriting at terms and conditions applicable to age, health and occupation at that time.

If your Morgan Stanley employment terminates and you are not immediately actively employed in your insured profession, protection provided by this policy may be continued for the 90 days immediately following your termination of employment upon your request and payment of premiums by the insured for the 90-day period.

Any claim for benefits submitted while not actively at work in the insured profession is not guaranteed and is subject to underwriter review and approval.

Contact CEDi plan administrator, Dye & Eskin Inc., at 888-556-8767 for portability options.

Direct Billing

Contact the plan administrator at 888-556-8767 between the hours of 8 a.m. and 6 p.m. Eastern Time, within 30 days of the due date of any premium payment in order to set up direct billing.

Failure to initiate alternative billing methods in a timely manner may cause your coverage to lapse if Payroll deduction ceases and direct billing payment is not received within the grace period.

Monthly Benefits

Insurable Income: Eligible pay derived from Morgan Stanley only

All benefits-eligible employees earning $500,000 or more (Class 1) who have satisfied the 180 days actively-at-work requirement (any exceptions subject to underwriter approval) are eligible for up to $50,000 a month of Modified Guaranteed Standard Issue (MGI) portable Monthly Benefit Disability benefit, issued by Lloyd's of London, which they may elect at time of application.

Total monthly benefit is a maximum of $50,000, including any in-force individual disability coverage, calculated by a maximum of 70% of your monthly earnings, defined as 70% of your eligible pay derived from employment at Morgan Stanley and noted on the application, divided by 12 months.

Monthly Benefits Options:

Option 1: $5,000

Option 2: $10,000

Option 3: $20,000

Option 4: $35,000

Option 5: $50,000

Benefit Period

If you become disabled, the following Benefit Duration Period will apply based on the age at onset of the disability:

AGE AT DISABILITY	BENEFIT PERIOD
Less than 66	60 months
66-69	12 months

This CEDi Monthly Benefits policy is only available to participants age 65 or under.

Cost of Coverage

Your individual policy premiums will reflect your particular risk profile on the date you enroll.

Requesting Benefits

You must send all completed authorization and claim forms for your CEDi policy to the following: Hanleigh Management Inc.

50 Tice Blvd, Suite 122

Woodcliff Lake, NJ 07677

Attn: Matthew Zuba and Graham Southall

Please call the office at 201-505-1050 for Transmittal options.

Claims will be adjudicated and paid by Lloyd's of London or its delegated third-party administrator.

Individual Policy Provisions

When your policy is issued, you will receive an individual policy certificate. For complete policy details, please contact the Dye & Eskin Inc. office at 888-556-8767 to speak with a representative.

Elimination Period

The elimination period is the number of days you must wait before you become eligible for benefits. The elimination for the monthly benefit CEDi policy is 180 days.

No benefit will be payable if you die before the end of the elimination period.

Definition of Disability (Monthly Benefits)

CEDi will pay the total disability benefit shown on the schedule if:

- The Insured becomes totally disable, as defined below, as a direct result of: (a) an injury which occurs while this benefit is in force and causes total disability due to the injury to begin within 730 days of a covered accident; or (b) a sickness, which first manifests itself while this benefit is in force and causes total disability to commence within 730 days of a covered sickness; and
- The insured satisfies the elimination period shown on the schedule; and
- The insured is under the regular care of a physician other than themself or a member of their immediate family for the disability.

Totally disabled means that, as a result of a covered injury or sickness, the insured is totally unable to perform the substantial and material duties of their regular occupation as shown on the schedule for the entire elimination period and for each month during which benefits are payable.

Written proof of disability must be provided to the administrator at the time the first claim for any period of disability is made, and periodically upon our written request. The insured must also be under the care of a physician, other than the

insured or a member of the insured's immediate family, for the duration of the disability.

Benefits will be payable at the end of each month that the insured is totally disabled as defined above. The monthly benefit will cease after benefits have been paid for the number of months shown on the schedule or on the date the insured is no longer totally disabled, whichever occurs first. Benefits are paid at the rate of 1/30 of the Monthly Benefit for each day that the insured is totally disabled for less than a full month.

If the insured resumes the duties of their regular occupation as shown on the Schedule and, within 90 days becomes totally disabled, as defined above, for the same disability, which results from the same cause, only one elimination periodwill apply.

No benefit will be paid prior to the completion of the elimination period.

Residual Benefit (Monthly benefit only: Class 1)

If an insured suffers loss of earnings while gainfully employed as a direct result of a covered injury or sickness, a residual monthly benefit will be paid after he/she satisfies the elimination period. Benefits will be calculated by dividing the loss of earnings by prior earnings (average monthly earnings for the past 12 months or the prior tax year, whichever is greater).

Preexisting Condition

Preexisting condition means a sickness or accidental injury for which you, in the 24 months before your insurance or any increase in the amount of insurance takes effect, have:

- Received medical treatment, consultation, care or services; or
- Taken prescription medication or had medication prescribed; or
- Had or have any symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment.

CEDi will not pay benefits, or any increase in the benefit amount related to an elected increase in the amount of your insurance for a disability that results from a preexisting condition unless for a continuous 12-consecutive-month period after the effective date of your CEDi policy, or the date on which the elected increase in the amount of such insurance takes effect, if you have been actively at work and have not:

- Received medical treatment, consultation, care or services,
- Taken prescription medication or had medication prescribed, or
- Had or have any symptoms or conditions that would cause a reasonably prudent person to seek diagnosis, care or treatment.

Certain preexistingconditions may be covered if they have been fully disclosed to the underwriters and are not excluded from coverage by name or specific description or have been included on special terms. Contact Dye & Eskin for more information.

Portability

You may port your CEDi policy if your Morgan Stanley employment terminates, provided you remain actively employed in your insured profession and continue payment of premium payments for the remainder of the policy period. At the end of the policy period, any ongoing coverage will be subject to individual underwriting at terms and conditions applicable to age, health and occupation at that time.

If your Morgan Stanley employment terminates and you are not immediately actively employed in your insured profession, protection provided by this policy may be continued for the 90 days immediately following your termination of employment upon request and payment of premiums by you for the 90-day period.

Any claim for benefits submitted while not actively at work in the insured profession is not guaranteed and is subject to underwriter review and approval.

Portability options may be exercised by contacting the CEDi Plan Administrator, Dye & Eskin Inc.

Direct Billing

Contact the Plan Administrator at 888-556-8767 between the hours of 8 a.m. and 6 p.m. Eastern Time within 30 days of the due date of any premium payment in order to set up direct billing.

Failure to initiate alternative billing methods in a timely manner may cause your coverage to lapse if Payroll deduction ceases and direct billing payment is not received within the grace period.

Leave of Absence

Participating employees who are on leaves of absence can maintain their coverage until the termination date of the policy as long as premium payments are made in a timely manner under the terms of the policy. They will still be subject to any and all other provisions of the coverage.

However, at renewal, employees on leaves of absence may be subject to additional underwriting requirements at Lloyd's underwriter's discretion.

Employees who have coverage cancelled or lapsed for nonpayment and wish to re-enroll in or reinstate coverage may do so at Lloyd's underwriter's discretion. They may be subject to additional underwriting or rating requirements. Re-enrollment or reinstatement is determined in Lloyd's sole discretion.

Waiver of Premium

Premiums continue to be due from an insured after the start of their disability and during the elimination period until the claim has been approved by Lloyd's. Once the insured has been deemed disabled by Lloyd's, premiums are waived for the duration of the disability, and any overpayments are refunded.

The CEDi policy is available only to employees, and not to spouses/domestic partners or dependents.

Legal Assistance Plan

The Morgan Stanley Legal Assistance Plan offers employees and their eligible family members confidential and affordable legal services across a wide range of personal legal matters. The Legal Assistance Plan is administered by Hyatt Legal Plans, a MetLife company.

When you elect to participate in the Legal Assistance Plan, you and your family will have access to a nationwide network of law firms and attorneys. The Legal Assistance Plan offers both in-network and out-of-network options with many network services fully covered. If you prefer to use an attorney who does not participate in the Hyatt Legal network, you will be reimbursed for covered legal services according to a fee reimbursement schedule.

The Legal Assistance Plan provides:

- Coverage for a wide range of legal matters, including:
  - Consumer protection
  - Debt matters
  - Defense of civil lawsuits
  - Document preparation
  - Family law
  - Immigration
  - Real estate matters
  - Traffic and criminal matters
  - Will and estate matters
- Access to more than 6,700 law firms and 14,500 network attorneys
- Freedom to use any attorney you choose by receiving out-of-network services
- Telephone advice and office consultations
- Access for you, your spouse or domestic partner, and dependent children (your dependent children to age 26 do not need to reside with you to be covered under the Legal Assistance Plan)
- Instant online access to Hyatt Legal's attorney locator and common legal forms

Please note: You must be paid from a U.S. dollar-based Payroll to be eligible to participate in the Legal Assistance Plan.

Accessing Legal Plan Services

Access to the Legal Assistance Plan is available through Hyatt Legal's website or by calling the Legal Assistance Plan's Client Service Center. Once enrolled in the Legal Assistance Plan, Hyatt Legal will provide you with a membership number that you and your family will need to access services from the Legal Assistance Plan.

Note: If you receive services from an out-of-network attorney, you may not use an in-network attorney for the same matter.

Network Services

If you choose an attorney included in the Hyatt Legal network, certain covered services will be performed free of charge. This includes unlimited telephone and office consultations for covered services.

To find a network attorney online:

- Log on to www.metlife.com/mybenefits.
- Enter your membership number and ZIP code.
- Click on *Covered Service* to confirm that your legal matter is covered (your network attorney will make the final determination).
- Click on *Attorney Locator* to find a list of convenient network attorney offices.
- Click on *Obtain Case Number* to get the case number your network attorney will need to provide service. You will need a new case number for each new legal matter.

You may also contact the Client Service Center for assistance.

- The Legal Assistance Plan's Client Service Center can be reached at 800-821-6400, Monday-Friday, 8 a.m. to 7 p.m. ET.
- You will need to provide your membership numberto the Client Service Center.
- The Client Service representative will confirm your eligibility and make an initial determination of whether and to what extent your legal matter is covered (your network attorney will make the final determination).
- The Client Service representative will provide you with the phone numbers for several convenient network attorney offices in your area.
- You will also receive a case number for your network attorney. You will need a new Case Number for each new legal matter.

Evening and Saturday appointments may be available. When making your appointment, indicate that you are a new client and a member of the Legal Assistance Plan (administered by Hyatt Legal). You will need to provide both your membership number and case number when making the appointment.

Out-of-Network Services

If you choose, you may select your own attorney. The Legal Assistance Plan will reimburse you for your out-of-network attorneys' fees based on the *Hyatt Legal Plans Out-of-Network Fee Reimbursement Schedule* on page 159.

For out-of-network services to be covered:

- Contact the Legal Assistance Plan's Client Service Center at 800-821-6400, Monday-Friday, 8 a.m. to 7 p.m. ET.
- You will need to provide Client Services with your membership number.
- You must obtain a claim form and case number from the Legal Assistance Plan's Client Service Center.
- The Client Service representative will confirm your eligibility and send you a claim form as well as a current fee reimbursement schedule, upon your request.

Note: U.S. expatriates or U.S. benefits-eligible international employees who receive pay from a U.S. dollar-based Payroll may use the out-of-network option for services provided by an overseas attorney. Reimbursement checks will be in U.S. dollars and any necessary currency conversions are made as of the date of the attorney's invoice.

Covered Legal Services

The Legal Assistance Plan offers access to a host of personal legal services within the Hyatt network to you, your spouse or domestic partner and dependent children.

For in- or out-of-network services to be covered, you or your eligible dependents must receive a case number or claim form, and retain an attorney who begins work on the covered legal matter while you are an eligible participant in the Legal Assistance Plan.

Most common legal matters are covered as described below. However, certain exclusions apply; please refer to the *Exclusions* section on pages 156 for more information.

Consultation and Advice

Office Consultation and Telephone Advice

With the Legal Assistance Plan, you have the opportunity to discuss your personal legal issues with a network attorney. The attorney will explain your rights, point out your options and recommend a course of action. The attorney will identify any further coverage available under the Legal Assistance Plan and represent you if you so choose. If representation is covered by the Legal Assistance Plan, you will generally not be charged

for the attorney's services. If representation is recommended, but not covered by the Legal Assistance Plan, the attorney will provide a written fee statement in advance. You may then choose to retain the attorney at your own expense, seek other counsel or do nothing.

There are no restrictions on the number of times per year you may use this service. However, for a noncovered legal matter, this service is not intended to provide you with continuing access to a network attorney so that you may seek advice and undertake your own representation.

Consumer Protection

Consumer Protection Matters

If you bring a complaint to court, the Legal Assistance Plan provides you and your eligible family members with representation, up to and including trial. These disputes must be over consumer goods and services, and exceed the limits available through small claims court. You must have written evidence about your dispute, such as a sales receipt, contract, note or warranty. This service does not include disputes over real estate, construction, insurance or collection activities after a judgment.

Personal Property Protection

This service covers counseling about personal property issues, such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements for you and your eligible family members over the phone or in person.. Counseling on how to pursue or defend small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits and demand letters.

Small Claims Assistance

If you have a small claims issue, the Legal Assistance Plan provides you and your eligible family members with counseling on how to prosecute the small claims action; helps you prepare documents; advises you on evidence, documentation and witnesses; and prepares you for trial. The service does not include the network attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to postjudgement actions.

Debt Matters

Debt Collection Defense

A network attorney can help with debt collection defense for you and your eligible family members by negotiating with creditors for a repayment schedule and limiting creditor harassment. The network attorney may also represent you and your eligible family members in defense of any action for personal debt collection, foreclosure, repossession or garnishment, up to and including trial. It includes a motion to vacate a default judgment. It does not include counter-, cross- or third-party claims; any action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with Morgan Stanley, Hyatt Legal or their affiliates.

Identity Theft Defense

This benefit provides you and your eligible family members with attorney consultations about potential creditor actions resulting from identity theft. Attorney services will be provided as needed to contact creditors, credit bureaus and financial institutions, as well as to provide defense services for specific creditor actions over disputed accounts. Defense services include limiting creditor harassment and representing you and your eligible family members in defense of any action that arises out of identity theft, such as foreclosure, repossession or garnishment, up to and including trial. The service also provides you and your eligible family members with online help and information about identity theft and prevention through the Hyatt Legal website. It does not include counterclaims, cross-claims, any action arising out of divorce or post-decree matters, or any matter where the creditor is affiliated with Morgan Stanley, Hyatt Legal or their affiliates.

Identity Management Services

This service provides the participant with access to LifeStages Identity Management Services provided by CyberScout, formerly known as IDT911 LLC. These services include both proactive when the participant believes their personal data has been compromised, as well as resolution services to

assist the participant in recovering from account takeover or identity theft with unlimited assistance to fix issues, handle notifications, and provide victims with credit and fraud monitoring. Theft Support, Fraud Support, Recovery and Replacement theft support, fraud support, recovery and replacement services are covered by this service. For more information on identity theft protection, please visit www.legalplans-idtheft.com/.

Personal Bankruptcy or Wage Earner Plan

This service covers the Plan member and their spouse in prebankruptcy planning, the preparation and filing of a personal bankruptcy or wage earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with the sponsor or employer, even if the Plan member or spouse chooses to reaffirm that specific debt.

Tax Audits

This service includes reviewing tax returns and answering questions the IRS or a state or local tax authority has concerning your or your eligible family members' tax return; negotiating with the agency; advising you and your eligible family members on necessary documentation; and attending an IRS, state or local tax audit. The service does not include prosecuting a claim for the return of overpaid taxes, or the preparation of tax returns.

Defense of Civil Lawsuits

Administrative Hearing Representation

The Legal Assistance Plan covers your and your eligible family members' defense at an administrative hearing, which generally does not take place in a courtroom. Administrative hearings include civil proceedings before a municipal, county, state or federal administrative board, agency or commission, including a hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or provided through an insurance policy. Additionally, it does not include divorce or post-decree matters, paternity, support or custody matters, or litigation of a job-related incident.

Civil Litigation Defense

This benefit covers your and your eligible family members' defense in arbitration or civil proceedings before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided through an insurance policy. Additionally, it does not include divorce or post-decree matters; paternity, support or custody matters; or litigation of a job-related incident. Services do not include bringing counterclaims, third-party claims or cross claims.

Incompetency Defense

This service covers your and your eligible family members' defense of any incompetency action, including court hearings when there is a proceeding to find you or your eligible family member incompetent (excluding job-related incompetence actions).

Document Preparation

Document Review

The Legal Assistance Plan provides review of your and your eligible family members' personal legal documents, such as letters, leases or purchase agreements.

Elder Law Matters

This service covers counseling over the phone or in person on any personal issue relating to you or your eligible family members' parents as it affects you.

The service includes reviewing your parents' documents and their impact to you. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. The service also includes preparing deeds for your parents when you are either the grantor or the grantee, and preparing promissory notes for your parents when you are the payer or the payee.

Affidavits

The Legal Assistance Plan covers the preparation of any affidavit in which you and your eligible family members are the person making the statement.

Deeds

This benefit covers the preparation of any deed for which you and your eligible family members are either the grantor or grantee.

Demand Letters

The Legal Assistance Plan covers the preparation of letters that demand money, property or another property interest, unless it is an excluded service. It also covers mailing the letters to the addressee and forwarding and explaining any response to you. Negotiations and representation in litigation are not included.

Mortgages

The Legal Assistance Plan covers the preparation of any mortgage or deed of trust for which you and your eligible family members are the mortgagor.

This service does not include documents pertaining to business, commercial or rental properties.

Notes

This benefit provides for the preparation of any promissory note for which you and your eligible family members are the payor or payee.

Family Law

Name Change

The Legal Assistance Plan covers all necessary pleadings and court hearings for your and your eligible family members' legal name change.

Prenuptial Agreement (Employee Only)

This service includes the preparation of an agreement by you and your fiancé/domestic partner prior to your marriage or civil union, outlining how property is to be divided in the event of separation, divorce or death. Representation is provided only to you. Your fiancé/domestic partner must have separate counsel or waive representation.

Protection From Domestic Violence (Employee Only)

The Legal Assistance Plan covers you only, not your spouse, domestic partner or dependents, as the victim of domestic violence. It provides you with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action or representation for the offender.

Adoption and Legitimization (Contested and Uncontested)

This service covers all legal services and court work in a state or federal court for an adoption for the Plan member and spouse/domestic partner. Legitimization of a child for the Plan member and spouse/domestic partner, including reformation of a birth certificate, is also covered.

Guardianship or Conservatorship (Contested and Uncontested)

This service covers establishing a guardianship or conservatorship over a person and their estate when the Plan member or spouse is appointed as guardian or conservator. It includes obtaining a guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting.

Immigration

Immigration Assistance

The Legal Assistance Plan includes advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents, and helping you and your eligible family members prepare for hearings.

Personal Injury

Personal Injury

Network attorneys will handle personal injury matters in which you and your eligible family members are the plaintiff, at a maximum fee of 25% of the gross award. It is your responsibility to pay this fee and all costs directly to the network attorney. This service is subject to all applicable law and court rules.

Real Estate Matters

Boundary or Title Disputes (Primary Residence)

This benefit covers negotiations and litigation arising from boundary or title disputes involving you and your eligible family member's primary residence, where coverage is not available under your or your eligible family member's homeowner or title insurance policies. The service includes filing to remove a mechanic's lien.

Eviction and Tenant Problems (Primary Residence—Tenant Only)

The Legal Assistance Plan covers you and your eligible family members as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord or an action for return of a security deposit.

Home Equity Loans (Primary Residence)

This service covers the review or preparation of a home equity loan for you and your eligible family members' primary residence.

Home Equity Loans (Second or Vacation Home)

This service covers the review or preparation of a home equity loan on the participant's second or vacation home.

Property Tax Assessment (Primary Residence)

The Legal Assistance Plan covers review and advice on a property tax assessment for your and your eligible family members' primary residence. It also includes filing the paperwork, gathering the evidence, negotiating a settlement and attending the hearing necessary to seek a reduction of the assessment.

Refinancing of Home (Primary Residence, Second or Vacation Home)

With this benefit, an attorney will review or prepare all relevant documents (including the mortgage and deed, and documents pertaining to title, insurance, recordation and taxation) involved in the refinancing of or in obtaining a home equity loan for your and your eligible family member's primary residence, second home or vacation home. This service also includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment or income purposes.

Sale or Purchase of Home (Primary Residence, Second or Vacation Home)

An attorney will review or prepare all relevant documents (including the construction documents for a new home, second home or vacation home; the purchase agreement; mortgage and deed; and documents pertaining to title, insurance, recordation and taxation) involved in the purchase or sale of your and your eligible family member's primary residence, second home or vacation home, or of a vacant property to be used for building a primary residence, second home or vacation home. The service also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home or vacation home held for rental purposes, business, investment or income, or leases with an option to buy.

Security Deposit Assistance (Primary Residence — Tenant Only)

This service covers counseling for you and your eligible family members as a tenant in recovering a security deposit from your residential landlord for your primary residence, reviewing the lease and other relevant documents, and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting you and your eligible family members in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing you and your eligible family members for the small claims trial. This service does not include an attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to postjudgement actions.

Zoning Applications

This service provides you and your eligible family members with the services of a lawyer to help get a zoning change or variance for your or your eligible family member's primary residence.

Services include reviewing the law and surveys, advising you or your eligible family member throughout the process, preparing applications, and preparing for and attending the hearing to change zoning.

Traffic and Criminal Matters

Juvenile Court Defense

The Legal Assistance Plan includes the defense of your eligible dependent child in any juvenile court matter, provided there is no conflict of interest between you and the child. In that event, this service provides an attorney for the participating employee only, including services for parental responsibility.

Restoration of Driving Privileges

The Legal Assistance Plan provides you and your eligible family members with representation in proceedings to restore your driver's license.

Traffic Defense (No DUI or Vehicular Homicide)

This service covers representation for you and your eligible family members in defense of any traffic ticket, including misdemeanor traffic defenses, except driving under the influence or vehicular homicide. It also includes court hearings, negotiation with the prosecutor and trial.

Wills and Estate Planning

Living Trusts

This service covers the preparation of revocable and irrevocable trusts for you and your eligible family members. It does not include tax planning or services associated with funding the trust after it is created.

Living Wills

The Legal Assistance Plan includes the preparation of a living will for you and your eligible family members.

Powers of Attorney

The Legal Assistance Plan includes the preparation of any power of attorney when you and your eligible family members are granting the power.

Probate

Network attorneys will handle probate matters at a reduced fee of 10% less than the network attorney's normal fee for you and your eligible family members. It is your responsibility to pay this reduced fee and all costs. This service is subject to all applicable law and court rules.

Wills and Codicils

This benefit includes will preparation, codicils and will amendments for you and your eligible family members, in addition to the creation of any testamentary trust. It does not include tax planning.

Plus Parents Plan

This optional coverage is available as an additional buy-up to the basic enrollment in the Legal Assistance Plan. It covers the member's parents, stepparents and parents-in-law, and includes the following coverages:

Consultation and Advice

Office Consultation and Telephone Advice

With the Legal Assistance Plan, you or your covered family member have the opportunity to discuss your personal legal issues with a network attorney. The attorney will explain your covered family member's rights and options and recommend a course of action. The attorney will identify any further coverage available under the Legal Assistance Plan and represent your family member if they choose. If representation is covered by the Legal Assistance Plan, your covered family member will generally not be charged for the attorney's services. If representation is recommended, but not covered by the Legal Assistance Plan, the attorney will provide a written fee statement in advance. Your covered family member may then choose to retain the attorney at your family member's own expense, seek other counsel or do nothing.

There are no restrictions on the number of times per year your covered family member may use this

service. However, for a noncovered legal matter, this service is not intended to provide your family member with continuing access to a network attorney so that they may seek advice and undertake their own representation.

Debt Matters

Identity Management Services

This service provides the participant with access to LifeStages Identity Management Services provided by CyberScout, formerly known as IDT911 LLC. These services include both proactive services when the participant believes their personal data has been compromised, as well as resolution services to assist the participant in recovering from account takeover or identity theft with unlimited assistance to fix issues, handle notifications, and provide victims with credit and fraud monitoring. Theft support, fraud support, recovery and replacement services are covered by this service. For more information on identity theft protection, please visit www.legalplans-idtheft.com/.

Document Preparation

Document Review

The Legal Assistance Plan provides review of your and your eligible family members' personal legal documents, such as letters, leases or purchase agreements.

Affidavits

The Legal Assistance Plan covers the preparation of any affidavit in which you and your eligible family members are the person making the statement.

Deeds

This benefit covers the preparation of any deed for which you and your eligible family members are either the grantor or grantee.

Demand Letters

The Legal Assistance Plan covers the preparation of letters that demand money, property or another property interest, unless it is an excluded service. It also covers mailing the letters to the addressee and forwarding and explaining any response to you. Negotiations and representation in litigation are not included.

Mortgages

The Legal Assistance Plan covers the preparation of any mortgage or deed of trust for which you and your eligible family members are the mortgagor.

This service does not include documents pertaining to business, commercial or rental properties.

Notes

This benefit provides for the preparation of any promissory note for which you and your eligible family members are the payor or payee.

Wills and Estate Planning

Living Wills

The Legal Assistance Plan includes the preparation of a living will for you and your eligible family members.

Powers of Attorney

The Legal Assistance Plan includes the preparation of any power of attorney when you and your eligible family members are granting the power.

Wills and Codicils

This benefit includes will preparation, codicils and will amendments for you and your eligible family members, in addition to the creation of any testamentary trust. It does not include tax planning.

Exclusions

No services, not even a consultation, will be provided for the following matters:

- Employment-related matters, including company or statutory benefits, even for your eligible dependents
- Matters involving Morgan Stanley and affiliates, MetLife and affiliates, and network attorneys
- Matters in which there is a conflict of interest between the participating employee and spouse, domestic partner or dependents; in such cases, services are excluded for the spouse, domestic partner and dependents (services are provided only to the participating employee)
- Appeals and class actions

- Farm and business matters, including rental issues when you are the landlord
- Patent, trademark and copyright matters
- Costs or fines
- Frivolous or unethical matters, as determined by Hyatt Legal in its sole discretion
- Matters for which an attorney-client relationship exists before you become eligible for Plan benefits

Important Information About the Legal Assistance Plan

Plan Confidentiality, Ethics and Independent Judgment

Use of the Legal Assistance Plan and the legal services provided is confidential. The network attorney is directed by Hyatt Legal to maintain strict confidentiality of the traditional lawyer-client relationship. Morgan Stanley will not receive any identifiable information about your legal matters or the services you use under the Legal Assistance Plan. Morgan Stanley will have access only to limited, anonymous statistical information for administration of the Legal Assistance Plan.

Hyatt Legal and Morgan Stanley will not interfere with the network attorney's independent exercise of professional judgment when representing you. All network attorneys' services provided under the Legal Assistance Plan are subject to ethical rules established by the courts for lawyers. The network attorney will adhere to the rules of the Legal Assistance Plan and will not receive any further instructions, direction or interference from anyone else connected with the Legal Assistance Plan.

The network attorney's relationship and obligation is exclusively with you. Hyatt Legal or the law firm providing services under the Legal Assistance Plan is responsible for all services provided by their attorneys. Morgan Stanley and the Legal Assistance Plan are not responsible for any advice or services provided by Hyatt Legal, any network attorney or any out-of-network attorney.

The Legal Assistance Plan has no liability for the conduct of any attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Legal Assistance Plan.

You have the right to retain, at your own expense, any attorney authorized to practice law in your state of residence.

Network attorneys will refuse to provide services if they determine in their discretion that the matter is clearly without merit, frivolous or for the purpose of harassing another person. If you have a complaint about the legal services or the conduct of a network attorney, contact Hyatt Legal at 800-821-6400. Your complaint will be reviewed, and you will receive a response, usually within two business days.

Special Plan Provisions

In addition to the coverages and exclusions listed, there are certain rules for special situations.

Other Coverage Is Available to You

If you are entitled to receive legal representation provided by any other organization, such as an insurance company or a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under the Legal Assistance Plan. However, if you are eligible for legal aid or public defender services, you will still be eligible for benefits under the Legal Assistance Plan, so long as you meet the eligibility requirements.

You Are Involved in a Legal Dispute With Your Dependents

You may need legal help with a problem involving your spouse, domestic partner or children. In some cases, both you and your child may need an attorney. It would be improper for one attorney to represent both you and your dependent. Only you will be entitled to representation under the Legal Assistance Plan; your dependent will not be covered under the Legal Assistance Plan.

You Are Involved in a Legal Dispute With Another Employee

If you or your dependents are involved in a dispute with another Morgan Stanley participating employee or that employee's dependents, the Legal Assistance Plan will arrange for legal representation with independent and separate counsel for both parties.

The Court Awards Attorneys' Fees as Part of a Settlement

If you are awarded attorneys' fees as a part of a court settlement, the Legal Assistance Plan must be repaid from this award for the total fees it paid your attorney. This is called "subrogation." Please contact Hyatt Legal directly if you have any questions.

Termination of Coverage

Legal Assistance Plan coverage will end:

- On your employment termination date
- On the date you lose benefits eligibility
- In the event of your death, or
- On account of certain QLEs

The Legal Assistance Plan will cover eligible legal fees for covered services through matter completion that were open and pending prior to your termination of coverage.

Continuation of Coverage Under the Legal Assistance Plan

If you are an eligible employee enrolled in the Legal Assistance Plan and you terminate your employment or lose benefits eligibility due to a status change, you may continue coverage in the Legal Assistance Plan at your own expense for a set portability period, currently 30 months. To continue coverage, contact the Hyatt Legal Plans' Client Service Center within 31 days of your loss of coverage. You will be required to pay Hyatt Legal Plans an upfront fee equal to the monthly group legal plan rate multiplied by the number of months coverage is available. Please note that to continue coverage, you must choose to be covered for the full portability period (currently 30 months), but the length of the portability period may be subject to change.

Hyatt Legal Plans Out-of-Network Fee Reimbursement Schedule

COVERED LEGAL SERVICES	REIMBURSEMENT
Advice and Consultationp	
Telephone Advice and Office Consultation (if no further covered services are provided)	$70
Consumer Protection	
Consumer Protection Matters	
Excludes disputes over real estate, construction or insurance. Disputed amount exceeds small claims limit and is evidenced by writing.	
• Correspondence and Negotiation	$500
• Filing of Suit—Including suit, ending in settlement or judgment	$2,000
– Plus Trial Supplement[1]	
Personal Property Protection	
Counseling, Document Review and Assistance	$125
Small Claims Assistance	
Counseling on preparing complaint and trial preparation	$200
Debt Matters	
Debt Collection Defense (Consumer Debts)	
Excludes defense of matters arising from divorce or post-decree actions. Includes repossession and garnishment.	
• Negotiation and Settlement	$350
• Negotiation and Settlement after Complaint and Answer Filed	$600
• Trial	$1,050
– Plus Trial Supplement[1]	
• Identity Theft—Correspondence/notice to creditors	$250
Debt Collection Defense (Foreclosures)	
Excludes defense of matters arising from divorce or post-decree actions. Includes repossession and garnishment.	
• Negotiation and Settlement	$500
• Negotiation and Settlement after Complaint and Answer filed	$850
• Trial	
– Plus Trial Supplement[1]	$1,500
Identity Theft—Correspondence/notice to creditors	
Tax Audits	
• Negotiation and Settlement	$500
• Audit Hearing—Includes Negotiation and Settlement	$1,200

[1] In addition to fees indicated, Hyatt Legal will pay one-half of the attorney's hourly rate for representation in trial after the second day of the trial, for a maximum of $800 per day, up to $10,000 total trial supplement.

Hyatt Legal Plans Out-of-Network Fee Reimbursement Schedule (continued)

COVERED LEGAL SERVICES	REIMBURSEMENT
Defense of Civil Lawsuits	
Administrative Hearing Representation and Incompetency Defense Excludes defense of matters arising from divorce, post-decree actions or other family law matters. • Negotiation and Settlement • Trial – Plus Trial Supplement[1]	 $500 $1,800
Civil Litigation Defense Excludes defense of matters arising from divorce, post-decree actions or other family law matters. • Negotiation and Settlement • Filing Answer, Litigation Finding in Settlement or Judgment – Plus Trial Supplement[1]	 $650 $2,000
Document Preparation	
Document Review	$100
Elder Law Matters Counseling and document review only of documents pertaining to the participating employee or eligible family members' parents as it affects the participating employee or eligible family member.	$140
Affidavits	$75
Deeds	$100
Demand Letters	$75
Mortgages	$70
Notes	$70
Family Law	
Name Change	$400
Prenuptial Agreement (available to participating employee only)	$750
Protection From Domestic Violence (available to participating employee only) Preparation of paperwork and attendance at hearing	 $425
Adoption and Legitimization • Uncontested • Contested – Plus Trial Supplement[1]	 $650 $1,500
Guardianship or Conservatorship • Uncontested • Contested – Plus Trial Supplement[1]	 $650 $1,500

[1] In addition to fees indicated, Hyatt Legal will pay one-half of the attorney's hourly rate for representation in trial after the second day of trial, for a maximum of $800 per day, up to $10,000 total trial supplement maximum.

Hyatt Legal Plans Out-of-Network Fee Reimbursement Schedule (continued)

COVERED LEGAL SERVICES	REIMBURSEMENT
Immigration	
Immigration Assistance	
Counseling on preparing forms and hearing preparation	$500
Real Estate Matters	
Boundary or Title Disputes (Primary Residence)	
• Negotiation and Settlement	$500
• Trial	$1,500
– Plus Trial Supplement[1]	
Eviction and Tenant Problems (Primary Residence—Tenant Only)	
• Correspondence and Negotiations	$280
• Eviction Trial Defense	$840
– Plus Trial Supplement[1]	
Home Equity Loan (Primary Residence)	
Applies only to the attorney who represents the participating employee or eligible family member, not the lending institution	$350
Home Equity Loan (Second or Vacation Home)	
Applies only to the attorney who represents the plan member, not the attorney representing the lending institution	$350
Property Tax Assessments (Primary Residence)	
• Negotiation and Settlement	$270
• File Request for Hearing With Attendance at Hearing	$620
– Plus Trial Supplement[1]	
Refinancing of Home (Primary Residence)	
Applies only to the attorney who represents the participating employee or eligible family member, not the lending institution	$350
Refinancing of Home (Second or Vacation Home)	
Applies only to the attorney who represents the plan member, not the attorney representing the lending institution	$350
Sale or Purchase of Home (Primary Residence)	
Applies only to the attorney who represents the participating employee or eligible family member, not the lending institution	$500
Sale or Purchase of Home (Second or Vacation Home)	
Applies only to the attorney who represents the plan member, not the attorney representing the lending institution	$500
Security Deposit Assistance (Primary Residence—Tenant Only)	
• Demand Letter/Negotiations	$250
• Counseling or Preparing Small Claims Complaint and Trial Preparation	$150
Zoning Applications	
• Preparation of Documentation	$250
• Documentation/Attending Hearing	$500

[1] In addition to fees indicated, Hyatt Legal will pay one-half of the attorney's hourly rate for representation in trial after the second day of trial, for a maximum of $800 per day, up to $10,000 total trial supplement maximum.

Hyatt Legal Plans Out-of-Network Fee Reimbursement Schedule (continued)

COVERED LEGAL SERVICES	REIMBURSEMENT
Traffic and Criminal Matters	
Driving Privileges/Restoration of Suspended License	$385
Juvenile Court Defense	
• Negotiation and Settlement	$500
• Trial	$1,200
– Plus Trial Supplement[1]	
Traffic Defense (No DUI)	
• Plea or Trial at Court for Minor Moving Violations	$250
• Plea or Trial at Court for Serious Moving Violations Resulting in Jail Time or License Suspension	$500
– Plus Trial Supplement[1]	
Will and Estate Matters	
Living Wills	
• Individual	$75
• Participating Employee and Spouse or Domestic Partner	$80
Powers of Attorney	
• Individual	$65
• Participating Employee and Spouse or Domestic Partner	$75
Trusts (Revocable and Irrevocable Living Trusts)	
• Individual	$325
• Participating Employee and Spouse or Domestic Partner	$450
Wills and Codicils	
• Individual	$150
• Participating Employee and Spouse or Domestic Partner	$200

[1] In addition to fees indicated, Hyatt Legal will pay one-half of the attorney's hourly rate for representation in trial after the second day of trial, for a maximum of $800 per day, up to $10,000 total trial supplement maximum.

Long-Term Care Insurance

The Morgan Stanley Long-Term Care (LTC) Insurance Plan is designed to help you and your covered family members pay for certain expenses should you no longer be able to care for yourself due to aging, illness or injury.

There were formerly three components of the Morgan Stanley LTC Insurance Plan:

- Prudential LTC Program
- MetLife LTC Program
- Individual LTC Program through John Hancock

These three programs are closed to new entrants. For complete terms and conditions, consult the individual insurance policy that was issued to you upon enrollment or discontinuation of your Program, or contact the administrator below.

- If you enrolled in the Prudential Group LTC Program between January 1, 2012, and June 30, 2013, please contact Prudential at 800-732-0416 for more information.
- If you enrolled in the MetLife Group LTC Plan prior to November 1, 2011, please contact MetLife at 800-984-8650 for more information.
- If you enrolled in the Individual LTC Program prior to November 23, 2016, please contact LTCI Partners at 855-889-5535 for more information.

MassMutual LTC Program

A discounted Long-Term Care policy with MassMutual may be available to you and your family members over 40 years of age. Each policy is customizable with additional buy-up options to meet your (or covered family members') lifestyle and financial needs. Lenox Advisors can provide additional information about the LTC Program. To learn more and receive a quote, call a Lenox Advisor at 1-800-344-6365.

Your (or your family members') application is subject to medical underwriting, which means that you must furnish acceptable health information to MassMutual, the LTC's insurer, to qualify for coverage. Upon approval of your (or your family members') enrollment application. MassMutual will provide you with a policy that contains details about the terms of coverage. Your (or your family members') LTC coverage becomes effective the date MassMutual issues your policy. Premium rates, eligibility and coverage provisions of the LTC insurance policies may differ depending on the state in which the policy is issued. Costs and terms may change from time to time.

Guaranteed Renewable

Your (or your family members') coverage will not be cancelled as long as the premiums continue to be paid and all requirements stated in your LTC insurance policy are met. Your LTC insurance policy is owned by you and you pay your premium payments directly to MassMutual; accordingly, you may continue your LTC coverage after your employment with Morgan Stanley ends, to the extent permitted by your policy.

Evidence of Insurability

All applications are subject to medical underwriting, which means that applicants must furnish acceptable health information to MassMutual to qualify for coverage. All inquiries and claims are handled solely by MassMutual.

Coverage Options

When you apply for LTC coverage, generally, you will able to elect:

- A daily benefit amount
- A benefit period
- Inflation protection

Monthly Facility Benefit

A facility benefit amount is the maximum amount of daily coverage available for nursing home, assisted living/residential care facilities, hospice care and respite care. Amounts available to you will vary in the state in which the policy is issued.

Home health care and adult day care are generally covered at 100% of the daily facility benefit amount.

Total Benefit Amount

The Total Benefit Amount available over the life of the policy is determined by your choice of benefit period (two, three, four, five or six years) and the daily benefit amount (DBA). The Total Benefit Amount is equal to 365 times the number of years in the benefit period times the DBA.

Inflation Protection

The LTC Program offers an optional compound inflation protection feature. Under this feature, your monthly facility benefit amount increases automatically by 3% or 5% each year with no increase to your premium.

Receiving Individual LTC Program Benefits

You will be considered eligible for benefits when MassMutual has determined that you are chronically ill, which is defined as:

- Being unable to perform at least two out of six of the following activities of daily living without substantial assistance from another individual for a period that is expected to last for at least 90 consecutive days
  - Bathing
  - Dressing
  - Toileting
  - Continence
  - Eating
  - Transferring; or
- Requiring substantial supervision to protect you from threats to health and safety due to a severe cognitive impairment for a period that is expected to last 90 consecutive days.

LTC benefits are typically paid for services included in a plan of care prescribed by a licensed health care practitioner. A plan of care identifies ways of meeting the qualified LTC services needs of a chronically ill person.

Please refer to your LTC policy for details about receiving benefits.

Waiver of Premium

Premiums will not be due once MassMutual begins paying, and for as long as MassMutual continues to pay, benefits for Facility Services or Home Care Services under the Policy. MassMutual will return any unearned premium to you on a pro rata basis. Premiums will again become due when MassMutual is no longer paying you because the Insured is no longer receiving Facility Services or Home Care Services at least once every week.

Changing Your Coverage Options

You may request a change in your coverage at any time (except during the 90-day Waiting Period and while you are receiving LTC benefits).

Changes in coverage are granted by MassMutual in its sole discretion and may require underwriting.

Any change in the cost of coverage will generally become effective on the first day of the month after MassMutual approves your request. If the change increases your coverage, the cost for the incremental increase will be based on your age on the date the change is effective. If your coverage is decreased, your new cost is based on the age used to determine your previous coverage.

Covered Services

LTC Program policy provisions will vary by the state in which your policy is issued.

Accordingly, the covered services described below may not apply to all policies. For more detailed information, consult your LTC insurance policy provided by MassMutual at the time of issue:

- Adult Day Care Center
- Alternate Plan of Care
- Assisted Living Facility
- Bed Reservation Benefit
- Home Care
- Hospice Care
- Personal Care Advisor
- Nursing Home
- Respite Care
- Caregiver Training

Exclusions

Please see your LTC Insurance policy for specific exclusions that may apply to you.

Termination of Coverage

You may cancel your Individual LTC Program coverage at any time. Individual LTC Program coverage typically will end on the earliest of the date:

- You notify MassMutual that you wish to terminate your coverage,

- MassMutual receives your last premium payment (not applicable if the premium is being waived in accordance with the Premium Waiver section)
- You reach your Total Benefit Amount, or
- You die.

For complete details on termination of coverage, please consult your Individual LTC insurance policy.

Accident, Critical Illness and Hospital Indemnity Insurance Plans

The Morgan Stanley Accident, Critical Illness and Hospital Indemnity Insurance plans provide limited supplemental accident and/or Critical Illness, and/or hospital indemnity coverage through insurance certificate(s) issued by **Continental American Insurance Company ("Aflac").**

The benefits available are described in detail in the Aflac Certificates. The official Certificate constitutes the formal Plan document for the Aflac accident, critical illness and/or hospital indemnity coverage you elect. If there is any conflict between this summary and a Certificate or other insurance document from Aflac, the Certificate or other insurance document governs.

Aflac will make all determinations about your Accident, Critical Illness and/or Hospital Indemnity Insurance benefits. No benefits are payable outside the Aflac plan issued to you, and Morgan Stanley has no authority to make any Accident, Critical Illness or Hospital Indemnity Insurance benefits decisions or determinations. Be sure to review your Certificates. For questions about covered benefits and services, please call Aflac at 855-730-4944. Please note, however, that information obtained during calls to Aflac does not waive any provision or limitation of your Certificates or the Plan.

Accident, Critical Illness and Hospital Indemnity Insurance Participation

Eligibility

To be eligible for Accident, Critical Illness and/or Hospital Indemnity Insurance benefits, Aflac must first determine that you satisfy the applicable plan's underwriting requirements. If you have a pre-existing condition and/or have previously been diagnosed with a disease, your application for coverage may be limited or denied. Aflac sets and imposes all requirements for and limits on coverage. For information on applicable underwriting requirements, consult your Accident, Critical Illness or Hospital Indemnity Insurance enrollment application.

If you are an eligible employee, coverage may also be available for your spouse or domestic partner and/or dependent children. The availability of dependent coverage (and definition of an eligible dependent) is subject to underwriting requirements set by Aflac, and may vary based on the coverage you select. Dependent coverage may be limited or denied if a dependent has a pre-existing condition or has previously been diagnosed with a disease. For information, consult your Accident, Critical Illness or Hospital Indemnity Insurance Certificate.

Enrollment

You may apply for or change coverage elections during:

- Annual Enrollment
- Within 31 days of your hire date or date you are eligible for benefits for an effective date of your date of hire or benefits eligibility
- Within 31 days of certain Qualified Life Events (QLE). See the *Qualified Life Events* section on page 18 for more details. Please note that any changes, including an increase in benefits or addition of coverage, made due to a QLE, **will not result in the retroactive application of an effective date** or in the retroactive payment of a benefit not otherwise covered on the date of loss. The effective date will be within 30-60 days following the month of the application date.

Applications for Accident, Critical Illness and Hospital Indemnity Insurance Plans are handled by Aflac. Coverage will not be effective until Aflac approves and processes your enrollment application. In certain cases, underwriting requirements may cause you to be ineligible for coverage.

Read your certificate carefully for exact terms and conditions. You may request a full copy of the plan certificate by contacting Aflac's Customer Service Center at 800-433-3036.

Your coverage becomes effective on the date Aflac issues your Certificate, or any later date specified in your Certificate.

Accident, Critical Illness and Hospital Indemnity Insurance coverage will automatically roll over from year to year if you do not take action during Annual Enrollment.

Coverage Options

The Accident Insurance coverage provides indemnity benefits for certain specified accidental occurrences detailed in your Certificate.

The Critical Illness Insurance coverage generally pays a fixed amount for cancer and certain Critical Illnesses described in your Certificate.

The Hospital Indemnity Insurance coverage generally pays a fixed daily amount for hospital admissions and confinements.

For information on key limitations and exclusions, consult your Certificates. All Accident, Critical Illness and Hospital Indemnity Insurance benefits will be determined by Aflac in its sole discretion.

Accident Insurance coverage is generally available for an eligible employee, an employee plus spouse/domestic partner, employee plus dependent children or family.

Critical Illness Insurance coverage is generally available for an eligible employee and/or spouse/domestic partner. Dependent children may be covered at no additional cost at a reduced benefit amount equal to 50% of the employee's coverage.

Hospital Indemnity Insurance Plan coverage is generally available for an eligible employee, employee plus spouse/domestic partner, employee plus dependent children or family.

Filing a Claim

Claims must be filed directly with Aflac on an Aflac claim form. Specific instructions for filing a claim are included in your Certificate.

Aflac reserves the right to deny your request for benefits if you do not meet the terms and conditions as identified in the Certificate or if a limitation or exclusion identified in the Certificate applies. All claim determinations are made solely by Aflac. Morgan Stanley has no authority to make any Accident, Critical Illness or Hospital Indemnity Insurance decisions.

Rehired Employees and Leaves of Absence

To continue your coverage while on any unpaid leave of absence, you must make timely payment of premiums to HR Services. If you stop making payments during your leave, your coverage may lapse. You may contact Aflac to have your coverage reinstated. However, your certificate will not cover events that occurred during the period coverage pursuant to the Certificate had lapsed.

If you did not continue to make payments on your Certificate and return to work without reinstating your coverage, you must make a new election and satisfy any new waiting period during the next Annual Enrollment or within 31 days of experiencing a Qualified Life Event.

If you are on leave of absence governed by the Family and Medical Leave Act or military leave, you may be entitled to have your coverage reinstated upon your return to work to the extent required by applicable federal law.

Covered Occurrences

Accident Insurance

The Accident Insurance plan will generally pay benefits for the following occurrences, subject to all terms, conditions, definitions, limitations and exclusions included in your Certificate. If there is any conflict between your Certificate and this document, your Certificate will prevail. For more detailed information about benefits, consult your Certificate provided by Aflac at the time of enrollment:

Accident Benefits

- Accident follow-up treatment (max. six follow-ups per accident)
- Accidental common-carrier death
- Accidental death
- Air ambulance service
- Ambulance service
- Appliances
- Blood/plasma service
- Burns (second degree and above)
- Coma

- Concussion
- Dislocation
- Dismemberment
- Emergency dental work
- Emergency room observation
- Emergency room treatment
- Exploratory surgery
- Eye injury
- Family member lodging (max. 30 nights)
- Fracture
- Hospital admission (once per calendar year)
- Hospital confinement (max. 365 days)
- Hospital intensive care (max. 30 days)
- Internal injuries
- Laceration
- Major diagnostic exams
- Medical fees
- Paralysis
- Physical therapy (max. six treatments per accident)
- Post-traumatic stress disorder
- Prosthesis
- Rehabilitation unit
- Ruptured disc
- Tendon/ligament
- Torn knee cartilage
- Transportation (train, plane, bus)
- Wellness (once per 12-month period)

Accident Exclusions

Aflac will not pay Accident benefits for Injury, Total Disability or death contributed to, caused by or resulting from:

- War – participating in war or any act of war, declared or not; participating in the armed forces of, or contracting with, any country or international authority. Aflac will return the prorated premium for any period not covered by the Certificate when the insured is in such service.
- Suicide – committing or attempting to commit suicide while sane or insane.
- Sickness – having any disease or bodily/mental illness or degenerative process. Aflac also will not pay benefits for any related medical/surgical treatment or diagnostic procedures for the illness.
- Self-Inflicted Injuries – injuring or attempting to injure yourself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test.
- Intoxication – being legally intoxicated or being under the influence of any narcotic, unless taken under the direction of a doctor. (Legally intoxicated means that condition as defined by the law of the jurisdiction in which the accident occurred.)
- Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job.
- Sports – participating in any organized sport—professional or semiprofessional.
- Cosmetic Surgery – having cosmetic surgery or other elective procedures that are not medically necessary or having dental treatment except as a result of a covered accident.

Termination of Coverage

Your coverage and your dependents' coverage may terminate when the plan is terminated; the 31st day after the premium due date if the premium has not been paid; or the date you no longer belong to an eligible class, including when you are no longer an eligible dependent. If your coverage terminates, Aflac will provide benefits for valid claims that arose while your coverage was in force.

For complete details on termination of coverage, please consult your Aflac Certificate.

You have 31 days from the termination of coverage to port your coverage. Contact Alfac directly at 800-433-3036 for information.

Critical Illness Insurance

The Critical Illness plan will generally pay benefits for the following occurrences, subject to all terms, conditions, definitions, limitations and exclusions included in your Certificate. If there is any conflict between your Certificate and this or any other document, your Certificate will prevail. For more detailed information about benefits, consult your Certificate provided by Aflac at the time of enrollment:

Critical Illness Benefits

- Bone marrow transplant (Stem cell transplant)
- Cancer
- Heart attack (Myocardial Infarction)
- Kidney failure (End-stage renal failure)
- Major organ transplant
- Stroke
- Sudden cardiac arrest

Critical Illness Partial Benefits

- Noninvasive cancer
- Coronary artery bypass surgery

Critical Illness Additional Benefits

- Health screening benefit
- Skin cancer
- Waiver of premium

Critical IllnessBenefits

- Coma
- Loss of sight, speech or hearing
- Severe burn
- Paralysis

Critical Illness Optional Benefits Rider

- Advanced Alzheimer's Disease
- Advanced Parkinson's Disease
- Benign brain tumor

Cancer Diagnosis Limitation

Benefits are payable for Cancer and/or Noninvasive Cancer as long as the insured:

- Is treatment-free from cancer for at least 12 months before the diagnosis date; and
- Is in complete remission prior to the date of a subsequent diagnosis, as evidenced by the absence of all clinical, radiological, biological and biochemical proof of the presence of the cancer.

Critical Illness Exclusions

Aflac will not pay for loss due to any of the following:

- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally or taking action that causes oneself to become injured.
- Suicide – committing or attempting to commit suicide while sane or insane.
- Illegal Acts – participating or attempting to participate in an illegal activity, or working at an illegal job.
- Participation in Aggressive Conflict of any kind, including:
  - War (declared or undeclared) or military conflicts
  - Insurrection or riot
  - Civil commotion or civil state of belligerence
- Illegal Substance Abuse:
  - Abuse of legally obtained prescription medication
  - Illegal use of nonprescription drugs

Diagnosis, treatment, testing and confinement must be in the United States or its territories. All benefits under the plan, including benefits for diagnoses, treatment, confinement and covered tests, are payable only while coverage is in force.

Hospital Indemnity Insurance

The Hospital Indemnity Insurance plan will generally pay benefits for the following occurrences, subject to all terms, conditions, definitions, limitations and exclusions included in your Certificate. If there is any conflict between your Certificate and this or any other document, your Certificate will prevail. For more detailed information about benefits, consult your Certificate.

Hospital Indemnity Benefits

- Hospital admission
- Hospital confinement
- Hospital intensive care
- Hospital intensive care step-down unit

Hospital Indemnity Limitations and Exclusions

Aflac will not pay for loss due to:

- War – voluntarily participating in war, any act of war, or military conflicts, declared or undeclared, or voluntarily participating or serving in the military, armed forces or an auxiliary unit thereto, or contracting with any country or international authority. (We will return the prorated premium for any period not covered by the certificate when the insured is in such service.) War also includes voluntary participation in an insurrection, riot, civil commotion or civil state of belligerence. War does not include acts of terrorism.
- Suicide – committing or attempting to commit suicide while sane or insane.
- Self-Inflicted Injuries – injuring or attempting to injure oneself intentionally.
- Racing – riding in or driving any motor-driven vehicle in a race, stunt show or speed test in a professional or semiprofessional capacity.
- Illegal Occupation – voluntarily participating in, committing, or attempting to commit, a felony or illegal act or activity, or voluntarily working at, or being engaged in, an illegal occupation or job.
- Professional or Semiprofessional Sports – participating in any organized sport in a professional or semiprofessional capacity.
- Custodial Care – This is nonmedical care that helps individuals with the basic tasks of everyday life, the preparation of special diets, and the self-administration of medication, which does not require the constant attention of medical personnel. Treatment for being overweight, gastric bypass or stapling, intestinal bypass and any related procedures, including any resulting complications.
- Services performed by a family member.
- Services related to sex or gender change, sterilization, in vitro fertilization, vasectomy or reversal of a vasectomy, or tubal ligation.
- Elective Abortion – an abortion for any reason other than to preserve the life of the person upon whom the abortion is performed.
- Dental Services or Treatment.
- Cosmetic Surgery, except when due to:
  - Reconstructive surgery, when the service is related to or follows surgery resulting from a Covered Accidental Injury or a Covered Sickness, or is related to or results from a congenital disease or anomaly of a covered dependent child; or
  - Congenital defects in newborns

Payment of Benefits

You must submit an application for payment of benefits under a Plan within 180 days of the event or services giving rise to your application for benefits, unless a different time is specified in this SPD.

To receive reimbursement for Eligible Expenses, you may be required to complete and submit claim forms to the appropriate Plan Claims Administrator. Detailed below are reimbursement instructions for each of the plans. Claim forms for the Medical, Dental, Vision, HSA and FSA Plans are available on the Benefit Center website. Claim forms must be submitted as directed on each form.

Medical Plan

If you receive care from a Medical Plan in-network provider, there are generally no claim forms to file. If you receive care from an out-of-network provider, you must submit a claim form to have any Eligible Expenses reimbursed.

To request payment of benefits, you must submit a claim form within 180 days of the date the expense is incurred. If it is not possible to submit the claim form within 180 days, additional time will be allowed up to a maximum of one year from the original service date. No claim forms will be accepted that are submitted more than one year after the date the service was incurred.

Notice on UHC Reimbursement Policies

UHC develops its reimbursement policy guidelines, in its sole discretion, in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).

- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determinations that UHC accepts.

Following evaluation and validation of certain provider billings (e.g., error, abuse and fraud reviews), UHC's reimbursement policies are applied to provider billings. UHC shares its reimbursement policies with Physicians and other providers in UHC's Network through UHC's provider website. Network Physicians and providers may not bill you for the difference between their contract rate (as may be modified by UHC's reimbursement policies) and the billed charge. However, non-Network providers are not subject to this prohibition and may bill you for any amounts the Plan does not pay, including amounts that are denied because one of UHC's reimbursement policies does not reimburse (in whole or in part) for the service billed. You may obtain copies of UHC's reimbursement policies for yourself or to share with your non-Network Physician or provider by going to www.myuhc.com or by calling the telephone number on your ID card.

Dental Plan

To be reimbursed for eligible dental expenses, you will likely be required to submit a claim form.

However, if you use a PDP dentist and identify yourself as a participant in the MetLife PDP program, or if you are a Delta Dental participant using a network dentist, the dentist may submit the claim form on your behalf. When using a MetLife non-PDP dentist or an out-of-network Delta Dental dentist, or if you participate in the Cigna Global Health Dental Plan, you should bring a claim form with you when you visit the dentist.

To request payment of benefits, you must submit a claim form within 90 days of the date the expense is incurred. If it is not possible to submit the claim form within 90 days, additional time will be allowed up to a maximum of one year from the original service date. No claim forms will be accepted that are submitted more than one year after the date the service was incurred.

You can view your request for payment status on your Dental Plan Administrator's website (see the *Your Important Contacts* section on page 207 for all contact information).

Vision Plan

When you receive services from a VSP Vision Care network doctor, claim forms are not required. When you receive services from an out-of-network provider, you must pay the provider directly for all charges and request payment of benefits by submitting a claim form, including itemized receipts, to VSP. You may log in to vsp.com with your user ID and password to complete the claim form and upload your receipts. You may also print the form and send it with your receipts to: VSP, P.O. Box 385018, Birmingham, AL 35238-5018. Requests for payment must be submitted within one year of the date of service.

Note: U.S. benefits-eligible expatriates and international employees may log in to vsp.com with their user ID and password to complete the claim form, upload their receipts, or fax their claim forms to 916-858-4985. Any claim forms received in foreign currency will be converted to U.S. dollars using conversion rates effective as of the date services were rendered.

Life and Accident Insurance

To request payment of Life or Accident Insurance benefits, you or your beneficiary must contact HR Services and submit a certified copy of the death certificate or accident report (or other supporting documentation, as required). In most cases, HR Services can assist you or your beneficiary with requesting payment of benefits by completing claim forms and submitting them to the insurance company.

The full amount of your Life and Accident Insurance coverage is payable to your named beneficiaries. If the benefit amount payable to a beneficiary is $5,000 or more, the claim may be paid by the establishment of a Total Control Account (TCA). The TCA is a settlement option or method used to pay claims in full. MetLife establishes an interest-bearing account that

provides your beneficiary with immediate access to the entire amount of the insurance proceeds.

MetLife pays interest on the balance in the TCA from the date the TCA is established, and the account provides for a guaranteed minimum rate. Your beneficiary can access the TCA balance at any time, without charge or penalty, simply by writing drafts in an amount of $250 or more. Your beneficiary may withdraw the entire amount of the benefit payment immediately. Please note the TCA is not a bank, checking, savings or money market account.

BTA benefits will be paid to your beneficiary on file with Cigna. All other benefits will be paid to you, if living, or, if not, your beneficiary or estate. BTA claims will be paid as soon as Cigna receives satisfactory proof of loss. If a claim covers benefits for more than four weeks, Cigna will pay all amounts due at the end of each four weeks. If there are any benefits due at the end of the period claimed, Cigna will pay them upon receipt of satisfactory proof of loss.

You must file a claim for BTA and AD&D benefits within 30 calendar days of the date of the event or your claim may be denied.

STD Benefits

MetLife will also verify certain information with your physician, including:

- That you are under the regular care of a physician who is qualified to treat your type of injury or illness
- The date of your disability
- The cause of your disability
- The extent of your disability, including any restrictions and limitations preventing you from performing your regular occupation, and
- The name and address of any hospital or institution where you received treatment, including all attending physicians.

If the information required by MetLife is not received and a determination is not made within 30 calendar days from your first day absent, you will be placed on an unpaid leave. If your claim is subsequently approved, you will be paid STD benefits retroactively to your first day of approved disability.

If your claim is approved more than 12 months from your first day absent or last day of approved absence, whichever is greater, Morgan Stanley may provide your STD benefit as a one-time cash payment, and any benefit entitlements may be prospective only.

If MetLife does not approve your claim and you do not return to work, your employment may be terminated at Morgan Stanley's discretion.

LTD Plan

If you request STD benefits during your 180-day elimination period, MetLife will:

- Determine your eligibility for LTD benefits based on the information provided by you and your physician during your STD benefit review,
- Request additional information, if needed,
- Either accept or deny the claim, and
- Notify you of its determination in a timely manner.

Any disabilities you incur during your leave will be subject to exclusions under the LTD portion of the Plan. If you become disabled while on an unpaid leave or did not request STD benefits and are participating in the LTD Plan, you must contact MetLife directly to request benefits. You will be required to complete the 180-day elimination period prior to receiving LTD benefits regardless of whether or not you receive STD benefits. You must file a claim for LTD benefits within 90 calendar days following your first day of disability or your claim may be denied. Generally, for employees on STD, MetLife will file your LTD claim on your behalf after the 13th week of your disability. However, it is your responsibility to confirm your claim has been filed and to follow up with any additional information that may be required.

Legal Assistance Plan

In-network attorneys' fees for covered services are fully covered by the Legal Assistance Plan. To request payment of out-of-network attorneys' fees, you must request a claim form prior to receiving service from the out-of-network attorney. Claim forms for reimbursement of eligible out-of-network services are available by calling the Hyatt Legal Plan's Client Service Center at 800-821-6400.

LTC Plan—Prudential

To request LTC benefits from Prudential, you, your physician or an authorized representative must contact Prudential. Prudential must approve the request for benefit eligibility and may also require access to your medical records.

Prudential will pay benefits only upon receipt of written proof approved by Prudential that expenses for covered services were incurred. This written proof of claim must be submitted no later than 90 days after the end of the calendar year in which the expenses were incurred. Failure to submit a proof of claim within 90 days may result in a claim denial, unless it is not possible to provide it within the time period or that the proof of claim was submitted as soon as reasonably possible. Claim forms are available from Prudential. If Prudential approves a request for payment of benefits, Prudential generally will send written notice of the decision no later than 15 business days after all necessary information is received.

After Prudential has approved your request for payment, reimbursement for covered services will be paid directly to you. Payments for most services can be made directly to the provider at your request and at the request of the providers. This does not include payments for the Alternate Plan of Service and/or the Transition Expense Benefit.

The Facility Daily Benefit (FDB) selected by you determines the maximum amount that can be received each day. The amount payable will not exceed the FDB selected for expenses incurred during any day you receive covered services.

Concurrent Review. When you are receiving benefits for covered services, Prudential will review your case from time to time to ensure that the standards for eligibility to receive benefits continue to be met. Prudential may review records and/or contact you, your physician or someone else familiar with your condition. If it is determined that you are no longer eligible to receive benefits, you will be notified by Prudential. All determinations made by Prudential are final.

LTC Plan—MetLife

To request LTC benefits from MetLife, you, your physician or an authorized representative must contact MetLife. MetLife must approve the request for benefit eligibility and may also require access to your medical records.

MetLife will pay benefits only upon receipt of written proof approved by MetLife that expenses for covered services were incurred. This written proof of claim must be submitted no later than 90 days after the end of the calendar year in which the expenses were incurred. Failure to submit a proof of claim within 90 days may result in a claim denial, unless it is not possible to provide it within the time period or that the proof of claim was submitted as soon as reasonably possible. Claim forms are available from MetLife. If MetLife approves a request for payment of benefits, MetLife generally will send written notice of the decision no later than 10 business days after all necessary information is received.

After MetLife has approved your request for payment, reimbursement for covered services will be paid directly to you. Payments for most services can be made directly to the provider at your request and at the request of the provider. This does not include payments for the Alternate Plan of Service and/or the Transition Expense Benefit.

The Daily Benefit Amount (DBA) selected by you determines the maximum amount that can be received each day. The amount payable will not exceed the DBA selected for expenses incurred during any day you receive covered services.

Concurrent Review. When you are receiving benefits for covered services, MetLife will review your case from time to time to ensure that the standards for eligibility to receive benefits continue to be met. MetLife may review records and/or contact you, your physician or someone else familiar with your condition. If it is determined that you are no longer eligible to receive benefits, you will be notified by MetLife. All determinations made by MetLife are final.

LTC Plan—Individual LTC MassMutual Program

To request LTC benefits from MassMutual, you, your physician or an authorized representative must contact MassMutual. MassMutual must approve the request for benefit eligibility and may also require access to your medical records.

MassMutual will pay benefits only upon receipt of written proof approved by MassMutual that expenses for covered services were incurred. This written proof of claim must be submitted no later than 90 days after the end of the calendar year in which the expenses were incurred. Failure to submit a proof of claim within 90 days may result in a claim denial, unless it is not possible to provide it within the time period or that the proof of claim was submitted as soon as reasonably possible. Claim forms are available from MassMutual. If MassMutual approves a request for payment of benefits, MassMutual generally will send written notice of the decision no later than 10 business days after all necessary information is received.

After MassMutual has approved your request for payment, reimbursement for covered services will be paid directly to you. Payments for most services can be made directly to the provider at your request and at the request of the provider. This may not include some rider benefits.

The Daily Benefit Amount (DBA) selected by you determines the maximum amount that can be received each day. The amount payable will not exceed the DBA selected for expenses incurred during any day you receive covered services.

Concurrent Review. When you are receiving benefits for covered services, MassMutual will review your case from time to time to ensure that the standards for eligibility to receive benefits continue to be met. MassMutual may review records and/or contact you, your physician or someone else familiar with your condition. If it is determined that you are no longer eligible to receive benefits, you will be notified by MassMutual. All determinations made by MassMutual are final.

LTC Plan—Individual (John Hancock)

To request LTC benefits from John Hancock, you, your physician or an authorized representative must contact John Hancock. John Hancock must approve the request for benefit eligibility and may also require access to your medical records.

John Hancock will pay benefits only upon receipt of written proof approved by John Hancock that expenses for covered services were incurred. This written proof of claim must be submitted no later than 90 days after the end of the calendar year in which the expenses were incurred. Failure to submit a proof of claim within 90 days may result in a claim denial, unless it is not possible to provide it within the time period or that the proof of claim was submitted as soon as reasonably possible. Claim forms are available from John Hancock. If John Hancock approves a request for payment of benefits, John Hancock generally will send written notice of the decision no later than 10 business days after all necessary information is received.

After John Hancock has approved your request for payment, reimbursement for covered services will be paid directly to you. Payments for most services can be made directly to the provider at your request and at the request of the provider. This does not include payments for the Alternate Plan of Service and/or the Transition Expense Benefit.

The Daily Benefit Amount (DBA) selected by you determines the maximum amount that can be received each day. The amount payable will not exceed the DBA selected for expenses incurred during any day you receive covered services.

Concurrent Review. When you are receiving benefits for covered services, John Hancock will review your case from time to time to ensure that the standards for eligibility to receive benefits continue to be met. John Hancock may review records and/or contact you, your physician or someone else familiar with your condition. If it is determined that you are no longer eligible to receive benefits, you will be notified by John Hancock. All determinations made by John Hancock are final.

Accident, Critical Illness and Hospital Indemnity Insurance

Claims for benefits must be filed directly with Aflac on an Aflac claim form. Specific instructions for filing a claim with Aflac are included in your Welcome Packet you will receive once coverage is approved.

Aflac reserves the right to deny your request for benefits if you do not meet the terms and conditions as identified in the Certificates or if a limitation or exclusion identified in the Certificates applies. All claim determinations are made solely by Aflac. Morgan Stanley has no authority to make any Accident, Critical Illness or Hospital Indemnity Insurance benefit decisions.

If Benefits Are Not Paid

If your or your dependent's request for payment under any of the plans is denied, you or your dependent can file a claim (first review level) and appeal (if the claim is denied). Certain health plans also offer a Voluntary Third Level of Review.

Information about filing claims and appeals, including applicable time frames, is included in the *Claims and Appeals Process Under the Morgan Stanley Benefit Plans* section on page 174.

Claims and Appeals Process Under the Morgan Stanley Benefit Plans

The following is a general summary of the claims and appeals process for all Morgan Stanley benefit plans, including frequently asked questions.

In most cases, benefits to which you are entitled are paid upon your request. Depending on the plan, you may request payment by sending a written claim form to the plan's administrator or insurer (a "claims administrator," such as UHC or MetLife) or to HR Services. Forms are available on the Benefit Center website or from the claims administrator.

The appropriate claims administrator will either:

- Make the payments you request,
- Advise Morgan Stanley to make the payments, or
- Notify you in writing why your request for payment is denied.

If you disagree with the outcome, you may file a claim.

- A "claim" is your first request for a review of the denial.
- An "appeal" is your second request for review of the denial if your claim is denied.

Frequently Asked Questions

If my initial request for payment is denied, how do I file a claim for benefits?

If you have a question or concern, you should first contact HR Services or the appropriate claims administrator's member services department. If HR Services or the claims administrator's member services department cannot resolve the issue to your satisfaction, you or an authorized representative (including your spouse or adult child, or a person authorized by you) has the right to file a claim. Your claim must be in writing.

When submitting a claim, you should include all relevant documentation and a statement of why you believe your claim should be granted. This information should be sent to the appropriate Claim Reviewer listed on the following chart. If the Morgan Stanley Benefit Plan Claims Committee is the Claim Reviewer, send your claim to HR Services. If you are not satisfied with the Claim Reviewer's decision, you have the right to file an appeal.

Who reviews my claim or appeal?

The person or entity that reviews your claim or appeal, called the "Reviewer," depends on the plan involved, the type of request for review, the amount involved and whether it is a claim (your first level of review) or an appeal.

The following chart shows the claim and appeal Reviewers for each of the Morgan Stanley benefit plans listed. If the amount involved is $40,000 or less, and the Claim Reviewer is the Morgan Stanley Benefit Plan Claims Committee, your claim may be decided by Morgan Stanley's Global Head of Compensation, Director of Executive Compensation Services and Operations, or Director of Retirement Benefits for retirement benefits, or Morgan Stanley's Chief Medical Officer and Head of HR Data & Analytics, or Head of HR Benefits for health and insurance benefits (or any person in an equivalent position without regard to title), or delegate.

Claims and Appeals Process Chart

PLAN	TYPE OF REVIEW REQUESTED	CLAIM REVIEWER (FIRST-LEVEL REVIEW)	APPEAL REVIEWER (SECOND-LEVEL REVIEW)	APPEAL REVIEWER[1] (THIRD-LEVEL REVIEW)
Medical Plan:				
Cigna Options A and B (includes prescription drug coverage)	Type or amount of benefits payable	Cigna or Express Scripts	Cigna or Express Scripts	Independent third party administered through Cigna or Express Scripts
Cigna Option C (includes prescription drug coverage)	Type or amount of benefits payable	Cigna	Cigna	Independent third- -party administered through Cigna
UHC Options A, B and C (includes prescription drug coverage)	Type or amount of benefits payable	UHC or Express Scripts	UHC or Express Scripts	Independent third party administered through UHC or Express Scripts
HMSA Medical Plan	Type or amount of benefits payable	HMSA	HMSA	Independent third party administered through HMSA
Kaiser Permanente HMO	Type or amount of benefits payable	Kaiser Permanente	Kaiser Permanente	Independent third party administered through Kaiser Permanente
Cigna Global Health Medical Plan and Cigna Global Health Dental Plan	Type or amount of benefits payable	Cigna Global Medical Plan or Cigna Global Dental Plan	Cigna Global Medical Plan or Cigna Global Dental Plan	Independent third party administered through Cigna Global Medical Plan or Cigna Global Dental Plan
Dental Plan:				
MetLife Options A and B	Type or amount of benefits payable	MetLife	MetLife	Not applicable
Delta Dental	Type or amount of benefits payable	Delta Dental	Delta Dental	Not applicable

[1] Certain health plans offer a voluntary Third-Level Review. Contact HR Services for more information.

Claims and Appeals Process Chart (continued)

PLAN	TYPE OF REVIEW REQUESTED	CLAIM REVIEWER (FIRST-LEVEL REVIEW)	APPEAL REVIEWER (SECOND-LEVEL REVIEW)
Vision Plan:			
VSP Vision Plan	Type or amount of benefits payable	VSP	VSP
Disability Plan:			
STD[1]	All	MetLife	MetLife
LTD	All	MetLife	MetLife
Life Insurance and Accident Plans:			
Life Insurance	All	MetLife	MetLife
AD&D Insurance	All	MetLife	MetLife
BTA Insurance Plan	All	Cigna	Cigna
Other Plans:			
LTC Insurance—Prudential	All	Prudential	Prudential
LTC Insurance—MetLife	All	MetLife	MetLife
LTC Insurance—Individual Insurance Program	All	John Hancock	John Hancock
LTC Insurance—MassMutual	All	MassMutual	MassMutual
HCFSA and DDCFSA	Type or amount of benefits payable	UHC	UHC
LPFSA	Type or amount of benefits payable	YSA	YSA
Legal Assistance Plan	Type or amount of benefits payable	Hyatt Legal Plans	Hyatt Legal Plans
Accident, Critical Illness and Hospital Indemnity Insurance	All	Aflac	Aflac
Medical, Dental, Vision, STD, FSAs, Legal Assistance	Eligibility for coverage, premiums and certain other matters	Morgan Stanley Benefit Plan Claims Committee	Morgan Stanley Benefit Plan Appeals Committee
Employees Retirement Plan, 401(k) Plan, EAP, Severance Pay Plan[1]	All	Morgan Stanley Benefit Plan Claims Committee	Morgan Stanley Benefit Plan Appeals Committee

[1] The claims process described for the STD, Employees Retirement Plan and Severance Pay Plan does not apply to Saxon Employees.

When must I file a claim?

You must file your claim within 180 days following the date your initial request for benefits is denied, unless otherwise specified.

If you wish to file an appeal, you must do so within 180 days following the denial of your claim. Certain insured programs require that appeals be made within shorter time frames. Please be sure to check with the appropriate Plan Administrator for more information about its claims review process and timelines.

You may not bring a lawsuit to recover benefits under a benefit plan until you have exhausted the plan's administrative process described in this SPD. If your appeal is denied, you have the right to file a lawsuit under ERISA, if it is within the earliest of:

- Six months following the date your appeal is denied,
- Three years following the date the services you are appealing are performed, or
- The end of any other applicable statutory limitation period.

Coronavirus Update

Due to the coronavirus pandemic and Declaration of a National Emergency on March 13, 2020, the U.S. Department of Labor (DOL) issued a notification of relief, extending deadlines for individuals to take certain plan actions, including filing an initial claim and appeal of an adverse claim determination. Deadlines for filing claims or appeals occurring on or after March 1, 2020, will be extended until the date that is 60 days after the announced end of the national emergency (date currently unknown), or later as may be determined by appropriate federal agencies. Although this extension will be taken into account in determining your deadline, please do not delay in submitting your claim or appeal. Please contact the appropriate Claims Administrator for the current claim or appeals filing deadlines. Given the evolving nature of the pandemic and related legislation, the benefits enhancements may be temporary and are subject to change at any time and without notice or your consent.

When will I receive a decision on my claim or appeal?

Deadlines differ depending on the plan involved, the nature of the review requested and whether it is a claim or an appeal. Generally, claims will be decided within 90 days of receipt, but a 90-day extension is allowed if the Claim Reviewer needs additional time for processing. Appeals will be decided within 60 days of receipt, but a 60-day extension is allowed if the Appeal Reviewer needs additional time due to special circumstances.

Please contact the Plan Administrator for specific details about its claims review process and timelines.

Claim Types and Review Deadlines:

- **Urgent Care Review:** A claim that requires expedited notification or authorization for medical treatment because a longer time period could seriously jeopardize your life, health or ability to regain maximum function, or would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the requested treatment.
- Urgent Care Reviews are decided within 72 hours. Urgent Care Reviews may be requested orally, and all necessary information, including the decision on appeal, will be sent to you by telephone, fax or another expeditious method. If you do not provide sufficient information to determine if your claim is covered, you will be notified within 24 hours of the specific information needed to complete the claim. You will have at least 48 hours to provide this information. If you do not follow the plan's procedures for filing an urgent care claim, you will be contacted and advised of the proper procedures within 24 hours.
- **Pre-Service Review:** A claim for treatment where prior plan approval or notification is required to cover the cost of the treatment or benefit. If you fail to submit the necessary information, you will receive an extension notice outlining the information required, and you will have 45 days to provide it. If you do not follow the plan's procedures for filing a Pre-Service claim, you will be notified within five days.

- **Concurrent Care Review:** May occur when the plan has approved treatment to be provided over a period of time or a certain number of treatments. A reduction or termination by the plan (except by a plan amendment or termination) of the course of treatment before the end of the originally approved period of time or number of treatments is considered a claim denial. If the plan has approved a course of treatment and subsequently reduces or terminates that approval, you will be given enough advance notice to appeal the decision before it takes effect.

If a course of treatment involves urgent care, your claim will be decided as soon as possible but within 24 hours after the plan receives your request, as long as your request is made at least 24 hours before the end of the course of treatment. If your request is not made at least 24 hours before the end of the course of treatment, it will be treated as a new urgent care claim and decided within 72 hours. If a course of treatment does not involve urgent care, your request to extend it will be treated as a new claim and decided within the time periods that apply to the type of claim.

- **Post-Service Review:** A claim for which you do not need prior approval to have the benefit or treatment covered. A request for payment for medical care already received by you is a Post-Service claim. If a decision is not made within 30 days because you fail to submit the necessary information, you will have an additional 45 days to provide it. If your review is not for Urgent Care, Pre-Service or Concurrent Care, it will be treated as a Post-Service Review.

Claim Types and Review Deadlines

PLAN	AMOUNT OF TIME TO REVIEW CLAIM (FIRST-LEVEL REVIEW)	AMOUNT OF TIME TO REVIEW APPEAL (SECOND-LEVEL REVIEW)	AMOUNT OF TIME TO REVIEW APPEAL (THIRD-LEVEL REVIEW*)[1]
Urgent Care Review:			
Medical, Dental and Vision Plans	• Immediately or within 72 hours of receipt • 48-hour extension after Reviewer receives any additional information	• Immediately or within 72 hours of receipt	• Check with the health Plan Administrator for specific details
Pre-Service Review:			
Medical, Dental and Vision Plans	• Up to 15 days • 15-day extension	• 30 days	• Check with the health plan administrator for specific details
Concurrent Care Review:			
Medical, Dental and Vision Plans	• Varies based on claim type	• Varies based on claim type	• Check with the health Plan Administrator for specific details
Post-Service Review:			
Medical, Dental and Vision Plans	• 30 days • 15-day extension	• 60 days	• Check with the health Plan Administrator for specific details
FSAs	• 30 days • 15-day extension	• 60 days	• Not applicable
STD	• 45 days • 45-day extension	• 45 days • 45-day extension	• Not applicable
LTD	• 45 days • 45-day extension	• 45 days • 45-day extension	• Not applicable
LTC	• 10 days • No extension	• 60 days • 60-day extension	• Not applicable
Accident, Critical Illness and Hospital Indemnity Insurance	• 30 days (Critical Illness and Hospital Indemnity) • 45 days (Accident) • 15-day extension (Critical Illness and Hospital Indemnity); Two 30-day extensions (Accident)	• 60 days (Critical Illness and Hospital Indemnity) • 45 days (Accident) • 45-day extension (Accident only)	• Not applicable

[1]* Certain health plans offer a voluntary Third-Level Review. Contact HR Services for more information.

What happens if my claim is denied?

If your claim is denied, in whole or in part, you will receive a written or an electronic notice containing the following information (for Urgent Care Medical Review, you may receive oral notice followed by a written or electronic notice within three business days):

- The specific reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A description of any additional material or information that you must provide in order to complete your claim and an explanation of why such material or information is necessary; incomplete claims will be treated as part of the request for information and extension process and not as a denial, unless you do not respond to the request for information within the required time period
- Instructions and deadlines for making an appeal, including a statement of your right to file a lawsuit under ERISA if your appeal is denied

For urgent care claims under the health plans, your notice will also include a description of the expedited review process for these types of claims.

For claims under the disability plan, your notice will also include the following**:**

- A discussion of the decision, including an explanation of the basis for not agreeing with the views presented by you of a determination of disability regarding you made by the Social Security Administration, health care providers treating you, or vocational professionals who evaluated you
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse determination, without regard to whether the advice was relied on in making the benefit determination

For all claims, your notice will also include the following:

- A free copy of any internal rule, guideline, protocol or other similar criterion relied on in denying your claim or a statement that such documents do not exist
- A statement that you are entitled to receive, upon request and without charge, access to and copies of all documents, records and other information relevant to your claim under applicable legal standards
- If the denial was based on medical necessity or experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your medical circumstances, or a statement that a free explanation will be provided to you upon request

How do I make an appeal if my claim is denied?

Your appeal must be in writing. Send a statement of why you believe your appeal should be granted, along with all documentation that you consider relevant, to the Appeal Reviewer. You will be provided, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your claim under applicable legal standards. If the Morgan Stanley Benefit Plan Appeals Committee is the Appeal Reviewer, send your documentation to HR Services. If another person or entity is the Appeal Reviewer, see the *How do I contact the appropriate Claim and Appeal Reviewers* section of the Morgan Stanley Health Benefits and Insurance SPD (for Health Benefits and Insurance Plans), or call HR Services for the appropriate address.

- **For Health Care and Disability Plans:** The Appeal Reviewer will be someone other than the Claim Reviewer or its subordinate. The Appeal Reviewer will not give deference to the denial of your claim. If your claim was denied based on a medical judgment, the Appeal Reviewer will consult with a health care professional who has appropriate training and experience in the relevant field of medicine (and who was not consulted in connection with the denial of your first claim). The Appeal Reviewer also will identify, at your request, any medical or

vocational expert consulted in connection with the denial of your claim. Prior to a decision of your appeal, to the extent required by law, you will be provided, free of charge, a copy of any new or additional evidence considered, relied upon or generated by (or at the direction of) the relevant plan in connection with your claim, and you will have a reasonable opportunity to respond to any new or additional evidence or rationale.

What happens if my appeal is denied?

If your appeal is denied, in whole or in part, you will receive a written or electronic notice containing the following information:

- The specific reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your claim under applicable legal standards
- A statement describing any Voluntary Third Level of Review procedures, if any, offered by the plan, and your right to obtain information about these procedures
- A statement of your right to file a lawsuit under ERISA

For appeals under the disability plan, your notice will also include the following:

- A discussion of the decision, including an explanation of the basis for not agreeing with the views presented by you of a determination of disability regarding you made by the Social Security Administration, health care providers treating you, or vocational professionals who evaluated you
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse determination, without regard to whether the advice was relied on in making the benefit determination
- The deadline for filing a lawsuit under ERISA and the specific date by which the lawsuit must be filed to be considered timely

For appeals under the health and disability plans, your notice will also include the following:

- A free copy of any internal rule, guideline, protocol or other similar criterion relied on in denying your appeal or a statement that such rules, guidelines, protocols, standards or other similar criteria do not exist
- If the denial was based on a medical necessity or experimental treatment, or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination applying the terms of the plan to your medical circumstances, or a statement that a free explanation will be provided to you on request

May I have my appeal reheard?

Certain Medical, Dental and Vision Plan Administrators offer a voluntary rehearing of your **appeal by an independent third party. It is called a "Voluntary Third Level of Review" and is not conducted by Morgan Stanley.** Each individual administrator will provide you details on how this process works. Not all health Plan Administrators offer the Voluntary Third Level of Review. Check with your health Plan Administrator for more information.

Third Level of Review may be made only after your claim and appeal have both been denied.

Your decision whether to submit an appeal to the Voluntary Third Level of Review will not affect any other rights you may have under the plan. There is no charge for filing a Voluntary Third Level of Review.

You do not have to ask for a Voluntary Third Level of Review to take legal action, even if the Voluntary Third Level of Review is made available. The period of time in which your Voluntary Third Level of Review is processed will not be counted against you in determining the timelines of any later legal action you may bring. Contact your health Plan Administrator for more information about the Voluntary Third Level of Review.

All decisions of the Appeal Reviewer (or Third Level of Review Reviewer, if applicable) are final, conclusive and binding. If, however, you believe that the Appeal Reviewer did not follow the terms of the plan or has violated the law, you may bring a legal action under ERISA. See the *Your ERISA Rights* section for details.

How do I contact the appropriate Claim and Appeal Reviewers?

Send all correspondence and documents for the Claims Committee, Appeals Committee, Director of Retirement Benefits, Director of Health and Insurance Benefits or HR Services to:

Regular Mail

Morgan Stanley HR Services:
Claims Group
P.O. Box 7105
Rantoul, IL 61866-7105
877-MSHR-411 (877-674-7411)
Fax: 1-847-554-1306

Overnight Mail

Morgan Stanley HR Services
Attn: Claims and Appeals Management
9501 Lakeside Boulevard
The Woodlands, TX 77381

877-MSHR-411 (877-674-7411)

Send all correspondence directly to the other Claim Reviewers or Appeal Reviewers at the address listed in the relevant plan's summary plan description.

What else should I know about how the Reviewers make decisions?

The administrators and fiduciaries of Morgan Stanley's benefit plans, including the Reviewers, have discretionary authority to interpret and make determinations under the Plans. Any decision made will be effective unless the review is found to be arbitrary or capricious. See the *Administrative Information* section on page 195 for more information.

Legal Notices and Other Important Information

This section includes important information about your legal rights under the plans in addition to other plan details.

Your ERISA Rights

As a participant in any of the Morgan Stanley benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and other locations, such as work sites, all documents governing the plan, including insurance contracts and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for these copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may be able to continue health care coverage for a period of time for yourself, your spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for this coverage. For more information, see the *Continuation* Coverage Rights Under COBRA section on page 184.

Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan.

You should be provided a certificate of creditable coverage, without charge, from your group health plan or health insurance issuer when:

- You lose coverage under the plan,
- You become entitled to elect COBRA continuation coverage,
- Your COBRA continuation coverage ceases,
- If you request it before losing coverage, or
- If you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a Pre-Existing Condition exclusion for 12 months (18 months for late enrollees) after you enroll in your coverage.

Prudent Action by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan ("fiduciaries") have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit to which you are entitled under the Plan or by exercising your rights under ERISA.

Enforce Your Rights

If your claim for a health or insurance benefit (which includes benefits in the event of sickness, accident, disability, death or unemployment) is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time frames.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in the federal court designated below. The court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in the state or federal court designated below. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court.

If Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court designated below. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Except as otherwise provided in a certificate of coverage, our insured benefits, any action in connection with the plan (plans), including, but not limited to, any claims brought under ERISA for benefits or to enforce fiduciary duties, must be filed in the United States District Court for the Southern District of New York located in the City and State of New York.

Assistance With Your Questions

If you have any questions about the Plan, contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory; or write the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

Nondiscrimination Notice:

Morgan Stanley complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

Morgan Stanley:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact HR Services at 877-MSHR-411 (877-674-7411)

If you believe that Morgan Stanley has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Morgan Stanley Domestic Holdings, Inc.
c/o HR Services
1585 Broadway

18th Floor - Benefits Department
New York, NY 10036
877-MSHR-411 (877-674-7411)

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at https://www.hhs.gov/ocr/office/file/index.html.

Continuation Coverage Rights Under COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Medical, Dental, Vision Plans, the Employee Assistance Plan (Lyra Mental Health Benefit) and the HCFSA (collectively, the "Group Health Plans"). **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage under the Group Health Plans. It can also become available to other members of your family who are covered under the Group Health Plans when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Group Health Plans and under federal law, you should review this SPD or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Group Health Plan coverage when coverage would otherwise end because of a qualifying event (listed below). After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse and your dependent children could become qualified beneficiaries if coverage under the Group Health Plans is lost because of the qualifying event. (Please note that domestic partners are not eligible for COBRA continuation coverage, but Morgan Stanley makes COBRA-like coverage available to domestic partners and their dependents). Under the Group Health Plans, qualified beneficiaries who elect COBRA continuation coverage must pay the full cost for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Group Health Plans because one of the following qualifying events happens:

- Your hours of employment are reduced,
- Your employment ends after 31 days of employment for any reason other than your gross misconduct,
- Your employment ends within 31 days from the date you became U.S. Benefits-eligible due to your voluntary termination, or
- You become ineligible for U.S. Benefits due to the transfer to a non-U.S. Benefits program and international work location.

Note: If your employment is involuntarily terminated or you are released within your first 31 days of employment (for example, due to untruthful statements on your employment application), you are not eligible for continuation coverage through COBRA.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Group Health Plans because any of the following qualifying events happens:

- Your spouse dies,
- Your spouse's hours of employment are reduced,
- Your spouse's employment ends for any reason other than gross misconduct,
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B or both),
- You become divorced or legally separated from your spouse, or
- Your spouse/domestic partner becomes ineligible for U.S. Benefits due to the transfer to a non-U.S. Benefits program and international work location.

Your dependent children will become qualified beneficiaries if they lose coverage under the Group Health Plans because any of the following qualifying events happens:

- The parent-employee dies,
- The parent-employee's hours of employment are reduced,
- The parent-employee's employment ends for any reason other than gross misconduct,
- The parent-employee becomes entitled to Medicare benefits (under Part A, Part B or both),
- The parents become divorced or legally separated, or
- The child stops being eligible for coverage under the Group Health Plans as a dependent child.

Sometimes, filing a proceeding in bankruptcy under Title 11 of the U.S. Code can be a qualifying event. If bankruptcy is filed with respect to Morgan Stanley, and that bankruptcy results in the loss of coverage of any retired employee covered under the Group Health Plans, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Group Health Plans.

When Is COBRA Coverage Available?

COBRA continuation coverage will be offered to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee becoming entitled to Medicare benefits (under Part A, Part B or both), the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For other qualifying events (divorce or legal separation of the employee and spouse or a dependent child losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. Note that this period may be extended due to recent coronavirus-related legislation. Given the evolving nature of the pandemic and related legislation, the benefits enhancements may be temporary and are subject to change at any time and without notice or your consent. For more information on whether the notification and enrollment period extensions apply to you, please contact HR Services. You must provide notice of the qualifying event to:

Morgan Stanley HR Services
877-674-7411 (toll-free)
www.morganstanley.com/benefits

When Is COBRA Coverage No Longer Available?

COBRA coverage will end on the earliest of the following dates:

- At the end of the applicable 18, 29 or 36 months of coverage continuation,
- The last day of the month for which a premium payment is received. This period may be extended due to recent legislation,
- The date the COBRA participant becomes covered by any other group health plan, if the new plan does not exclude or limit your coverage for pre-existing conditions as a result of employment, reemployment or marriage, or
- When your COBRA coverage was extended due to disability and there is a final determination that you are no longer disabled.

What Happens to My COBRA Coverage When I Become Eligible to Enroll in Medicare?

When you become entitled to Medicare (regardless of whether you are enrolled), your coverage through COBRA automatically becomes secondary coverage on that date (unless you are entitled to Medicare because of end stage renal disease (ESRD) or kidney failure). This means your current coverage will pay as if you first received Medicare payments, regardless of whether you actually enroll in Medicare.

If you are eligible for retiree medical coverage under the Exchange, you must enroll in retiree medical coverage. Your covered spouse or domestic partner and covered eligible dependents may continue their COBRA coverage for up to 36 months.

If you become Medicare-eligible while receiving COBRA coverage, you should enroll in Medicare Parts A and B immediately since you are not entitled to a Special Enrollment Period and COBRA automatically becomes secondary coverage. This means your current coverage will pay as if you first received Medicare payments, regardless of whether you actually enroll in Medicare. Additionally, you may receive a late enrollment penalty from Medicare if you enroll in Part B after your Initial Enrollment Period.

If you already have Medicare (or are eligible for Medicare) when you become eligible for COBRA, you may still enroll in COBRA. Medicare acts as the primary payer and COBRA pays as the secondary payer, so, for maximum benefits, you should stay enrolled in Medicare Part B. COBRA, as a secondary payer, may help fill the gaps in Medicare (if any) and offer benefits that are not available under Medicare, such as prescription drug coverage. Alternatively, if you are eligible for subsidized retiree medical coverage through an Exchange, it may be more cost-effective to enroll in that option. Contact HR Services for more information.

How Is COBRA Coverage Provided?

Once the plan administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children. The election of COBRA must be made within 60 days following the date the qualified beneficiary's active coverage ends or by the date specified in the offer of COBRA coverage, whichever is later.

COBRA continuation coverage is a temporary continuation of coverage and may last for up to a total of 36 months when the qualifying life event is:

- Death of the employee,
- Employee becoming entitled to Medicare benefits (Part A, Part B or both),
- Your divorce or legal separation, or
- A dependent child's losing eligibility as a dependent child.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement.

For example, if a covered employee becomes entitled to Medicare eight months before the date on which his/her employment terminates, COBRA continuation coverage for his/her spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts up to a total of 18 months. There are several ways in which this 18-month period of COBRA continuation coverage can be extended, as described below. In all cases, COBRA continuation coverage ceases when the qualified beneficiary becomes eligible for Medicare.

1. **Disability Extension of 18-Month COBRA Period**

If you or anyone in your family covered under the Group Health Plans is determined to be disabled by the Social Security Administration and you notify the plan administrator in a timely manner within the 18-month period, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must begin before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

2. **Second Qualifying Event Extension of 18-Month COBRA Period**

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your spouse and dependent children may receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Group Health Plans. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (Part A, Part B or both), gets divorced or legally separated, or if the dependent child becomes ineligible under the Group Health Plans as a dependent child, but only if the event would have caused the spouse or dependent child to lose coverage under the Group Health Plans had the first qualifying event not occurred.

3. **Cal-COBRA (Medical Only)**

If you live in the state of California and receive medical coverage under the Kaiser HMO, you may be able to continue your employer-sponsored health coverage for 18 months through Cal-COBRA. However, if you meet Social Security's rules of disability, Cal-COBRA can generally be extended to provide medical coverage for a maximum of 29 months. You will be responsible for 110 percent of the total health insurance premium. For more information and to arrange coverage, contact the Kaiser HMO.

Domestic Partner Coverage

COBRA does not provide continuation coverage for your domestic partner and his/her dependents, but Morgan Stanley offers similar coverage. Contact HR Services for more information.

Retiree Medical Coverage for Those Under Age 65

If you or any covered dependent are eligible to receive retiree medical coverage when you retire prior to the time you reach Medicare eligibility, you may defer retiree medical coverage and first elect continuation coverage under COBRA instead. When your COBRA coverage expires, you may elect to begin coverage for yourself and any covered dependent under the Retiree Medical Plan. Coverage must be continuous. If you waive retiree medical coverage for a reason other than electing COBRA coverage, you will not be able to elect it at a later date. In addition, you must be continuously covered under Morgan Stanley's COBRA coverage in order to elect Morgan Stanley retiree medical coverage when COBRA expires.

If You Have Questions

Questions about the Group Health Plans or your COBRA continuation coverage rights should be addressed to the Group Health Plans contact listed below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the nearest Regional or District

Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plans Informed of Address Changes

In order to protect your family's rights, you should keep the plan administrators informed of any changes to the addresses of your family members. You should also keep a copy of any notices you send to the plan administrator for your records.

Group Health Plans Contact Information

Morgan Stanley HR Services

PO BOX 7110

Rantoul, IL 61866-7110

877-MSHR-411 (877-674-7411) (toll-free)

Your Rights to Health Insurance Portability Under HIPAA

If you terminate participation in the Medical Plan, including terminating COBRA coverage, federal law may affect your medical coverage if you later enroll or become eligible to enroll in medical coverage that excludes coverage for pre-existing medical conditions.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be denied or excluded for medical conditions that you experienced or sought treatment for during the six months prior to the time you enroll in a Group Health Plan (known as a "Pre-Existing Condition"). Under the law, a Pre-Existing Condition exclusion generally may not be imposed for more than 12 months, or 18 months for a late enrollee. This means that you will receive treatment under the new plan for conditions unrelated to your Pre-Existing Condition, but benefits may be denied or excluded for your Pre-Existing Condition until the end of the 12- or 18-month waiting period. However, the 12- or 18-month exclusion period is reduced by the length of time for which you were covered under a prior health plan, provided you had coverage within the preceding 63 days.

You are entitled to a certificate that shows evidence of the length of your prior medical coverage under this plan. If you buy medical insurance other than through an employer group medical plan, a certificate of prior coverage may also help you obtain credit against a Pre-Existing Condition exclusion period. Contact your state insurance department for further information.

A certificate of prior coverage or certificate of creditable coverage will automatically be provided by HR Services to you and to each of your dependents participating in the Morgan Stanley Medical Plan at the time your participation ends. If you are beginning employment with a new employer or purchasing individual coverage, check with the new plan administrator to see if it excludes coverage for pre-existing conditions.

Your Privacy Rights

Notice of Privacy Practices

It is the Plans' policy to protect your medical information to the extent required by any applicable law, including HIPAA.

However, the Plans may share your medical information with other Morgan Stanley Group Health Plans; with Morgan Stanley; and with others for the purposes of treatment, payment and health care operations and for certain other legally permitted purposes. To the extent required by law, Morgan Stanley will not use any medical information about you to make employment-related decisions.

The Plans will make reasonable efforts to use, share or request only the minimum amount of information necessary to accomplish the intended purpose. You also have certain privacy related rights, including the right to access, request restrictions on and request amendments to your health records. Details about the Plans' privacy policies, including your privacy rights, are found in the *Notice of Privacy Practices* available on the Benefit Center website or by contacting HR Services.

Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay for childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean section. However, federal law generally does not prohibit the mother or her newborn being discharged earlier than 48 hours (or 96 hours, as applicable) if the attending physician and mother choose this option. In either case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or insurance issuer for prescribing a length of stay up to 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

The Women's Health and Cancer Rights Act of 1998 (WHCRA) requires that the Morgan Stanley Medical Plan provide benefits for mastectomy-related services. If you have a mastectomy, you may be entitled to certain benefits under the WHCRA. For individuals receiving mastectomy-related benefits, coverage will be provided for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedema in a manner determined in consultation with the attending physician and the patient

These benefits will be subject to the same deductibles and coinsurance or copays applicable to other benefits provided under the Morgan Stanley Medical Plan and described in this SPD. If you would like more information on WHCRA benefits, call HR Services or your Medical Plan option's member services department.

Creditable Prescription Drug Coverage Notice

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Morgan Stanley and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare prescription drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. The end of the notice includes resources to help you make decisions about your prescription drug coverage.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage. Read this notice carefully—it explains your options.

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare prescription drug plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. Morgan Stanley has determined all of the options available under its Medical Plan are, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and are therefore considered to provide Creditable Coverage.

Because the Morgan Stanley prescription drug coverage options provide Creditable Coverage, you can keep this coverage and you will not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join a Medicare Drug Plan?

You can join a Medicare prescription drug plan when you first become Medicare eligible and each year from October 15 through December 7.

If you lose your current creditable prescription drug coverage through no fault of your own, you will

also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Creditable Coverage If You Decide to Join a Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Morgan Stanley coverage will be affected.

The result depends on whether you are an Active Employee or a Retiree (see below).

If You Are an Active Employee:

Your Morgan Stanley coverage pays for other medical expenses in addition to prescription drugs. This coverage provides benefits before Medicare coverage. You and your covered family members who join a Medicare prescription drug plan will be eligible to continue receiving prescription drug coverage and these other medical benefits.

Medicare prescription drug coverage will be secondary for you or the covered family members who join a Medicare prescription drug plan.

If you decide to join a Medicare drug plan and voluntarily drop your Morgan Stanley prescription drug coverage, you and your dependents may not be able to get this coverage back.

If You Are a Retiree:

Your Morgan Stanley coverage pays for other medical expenses in addition to prescription drugs. You or your covered family members who join a Medicare prescription drug plan will be eligible to continue receiving prescription drug coverage and these other medical benefits.

Morgan Stanley prescription drug coverage will become secondary for you or your covered family members who join a Medicare prescription drug plan. When Morgan Stanley drug coverage becomes secondary, it will not pay out as much as the Medicare prescription drug plan. The Medicare prescription drug plan coverage will pay primary, which means that you or your covered family member will receive most prescription drug benefits from the Medicare prescription drug plan.

If you or any covered dependents decide to join a Medicare drug plan, be aware that you and/or your dependents will not be able to get primary prescription drug coverage from Morgan Stanley again until Medicare prescription drug coverage is dropped.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

If you drop or lose your current coverage with Morgan Stanley and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1 percent of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19 percent higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following enrollment period (usually October) to join.

For More Information

Contact HR Services at 877-MSHR-411 (877-674-7411) (toll-free). **NOTE:** You will receive this notice each year. You will also receive it before the next period you can join a Medicare drug plan and if this coverage through Morgan Stanley changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage

Detailed information about Medicare plans that offer prescription drug coverage is available in the *Medicare & You* handbook. You will receive a copy of the handbook every year from Medicare. You may also be contacted directly by Medicare prescription drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the *Medicare & You* handbook for their telephone number) for personalized help.
- Call 800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call 800-772-1213 (TTY 800-325-0778).

Remember to keep this notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

Coronavirus Update

In response to the coronavirus pandemic and related legislation, the special enrollment period (within 60 days of being determined eligible for premium assistance) may be extended until the date that is 60 days after the announced end of the national emergency (date currently unknown), or a different date announced by the agencies. Given the evolving nature of the pandemic and related legislation, the benefits enhancements may be temporary and are subject to change at any time and without notice or your consent.Contact HR Services for up-to-date information on enrollment periods.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of July 31, 2020. Contact your State for more information on eligibility.

ALABAMA – MEDICAID

Website: http://myalhipp.com/
Phone: 1-855-692-5447

ALASKA – MEDICAID

The AK Health Insurance Premium Payment Program
Website: http://myakhipp.com/
Phone: 1-866-251-4861
Email: CustomerService@MyAKHIPP.com
Medicaid Eligibility:
http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx

ARKANSAS – MEDICAID

Website: http://myarhipp.com/
Phone: 1-855-MyARHIPP (855-692-7447)

CALIFORNIA – MEDICAID

Website:
https://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx
Phone: 1-800-541-5555

COLORADO – HEALTH FIRST COLORADO (COLORADO'S MEDICAID PROGRAM & CHILD HEALTH PLAN PLUS (CHP+)

Health First Colorado Website:
https://www.healthfirstcolorado.com/
Health First Colorado Member Contact Center:
1-800-221-3943/ State Relay 711
CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus
CHP+ Customer Service: 1-800-359-1991/
State Relay 711

FLORIDA – MEDICAID

Website: http://flmedicaidtplrecovery.com/hipp/
Phone: 1-877-357-3268

GEORGIA – MEDICAID

Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp
Phone: 678-564-1162 ext 2131

INDIANA – MEDICAID

Healthy Indiana Plan for low-income adults 19-64
Website: http://www.in.gov/fssa/hip/
Phone: 1-877-438-4479
All other Medicaid
Website: http://www.indianamedicaid.com
Phone 1-800-403-0864

IOWA – MEDICAID AND CHIP (HAWKI)

Medicaid Website:
https://dhs.iowa.gov/ime/members
Medicaid Phone: 1-800-338-8366
Hawki Website:
http://dhs.iowa.gov/Hawki
Hawki Phone: 1-800-257-8563

KANSAS – MEDICAID

Website: http://www.kdheks.gov/hcf/default.htm
Phone: 1-800-792-4884

KENTUCKY – MEDICAID

Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:
https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx
Phone: 1-855-459-6328
Email: KIHIPP.PROGRAM@ky.gov

KCHIP Website:
https://kidshealth.ky.gov/Pages/index.aspx
Phone: 1-877-524-4718

Kentucky Medicaid Website: https://chfs.ky.gov

LOUISIANA – MEDICAID

Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp
Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP)

MAINE – MEDICAID

Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-442-6003
TTY: Maine relay 711

MASSACHUSETTS – MEDICAID AND CHIP

Website:
http://www.mass.gov/eohhs/gov/departments/masshealth/
Phone: 1-800-862-4840

MINNESOTA – MEDICAID

Website:
https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/medical-assistance.jsp [Under ELIGIBILITY tab, see "what if I have other health insurance?"]
Phone: 1-800-657-3739

MISSOURI – MEDICAID

Website:
http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 573-751-2005

MONTANA – MEDICAID

Website:
http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP
Phone: 1-800-694-3084

NEBRASKA – MEDICAID

Website: http://www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633
Lincoln: 402-473-7000
Omaha: 402-595-1178

NEVADA – MEDICAID

Medicaid Website: http://dhcfp.nv.gov
Medicaid Phone: 1-800-992-0900

NEW HAMPSHIRE – MEDICAID

Website: https://www.dhhs.nh.gov/oii/hipp.htm
Phone: 603-271-5218
Toll free number for the HIPP program: 1-800-852-3345, ext 5218

NEW JERSEY – MEDICAID AND CHIP

Medicaid Website:
http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW YORK – MEDICAID

Website: https://www.health.ny.gov/health_care/medicaid/
Phone: 1-800-541-2831

NORTH CAROLINA – MEDICAID

Website: https://medicaid.ncdhhs.gov/
Phone: 919-855-4100

NORTH DAKOTA – MEDICAID

Website:
http://www.nd.gov/dhs/services/medicalserv/medicaid/
Phone: 1-844-854-4825

OKLAHOMA – MEDICAID AND CHIP

Website: http://www.insureoklahoma.org
Phone: 1-888-365-3742

OREGON – MEDICAID

Website: http://healthcare.oregon.gov/Pages/index.aspx
http://www.oregonhealthcare.gov/index-es.html
Phone: 1-800-699-9075

PENNSYLVANIA – MEDICAID

Website:
https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx
Phone: 1-800-692-7462

RHODE ISLAND – MEDICAID AND CHIP

Website: http://www.eohhs.ri.gov/
Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line)

SOUTH CAROLINA – MEDICAID

Website: https://www.scdhhs.gov
Phone: 1-888-549-0820

SOUTH DAKOTA – MEDICAID

Website: http://dss.sd.gov
Phone: 1-888-828-0059

TEXAS – MEDICAID

Website: http://gethipptexas.com/
Phone: 1-800-440-0493

UTAH – MEDICAID AND CHIP

Medicaid Website: https://medicaid.utah.gov/
CHIP Website: http://health.utah.gov/chip
Phone: 1-877-543-7669

VERMONT – MEDICAID

Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA – MEDICAID AND CHIP

Website: https://www.coverva.org/hipp/
Medicaid Phone: 1-800-432-5924
CHIP Phone: 1-855-242-8282

WASHINGTON – MEDICAID

Website: https://www.hca.wa.gov/
Phone: 1-800-562-3022

WEST VIRGINIA – MEDICAID

Website: http://mywvhipp.com/
Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447)

WISCONSIN – MEDICAID AND CHIP

Website:
https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf
Phone: 1-800-362-3002

WYOMING – MEDICAID

Website: https://wyequalitycare.acs-inc.com/
Phone: 307-777-7531

To see if any other states have added a premium assistance program since July 31, 2020, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/agencies/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

Paperwork Reduction Act Statement

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210, or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

Administrative Information

Except as otherwise provided herein, the Plans are health and insurance benefit plans subject to ERISA and are sponsored and maintained by Morgan Stanley Domestic Holdings Inc. The Employer Identification Number for Morgan Stanley Domestic Holdings Inc. is 20-8764829.

This SPD, along with any applicable insurance contracts and policies, constitutes the Plan document for each plan.

The Plans' Identification Numbers and the health benefits and insurance provided are as follows:

- Morgan Stanley Health Benefits and Insurance Plan: 501—provides basic and supplemental life insurance benefits, short-term[1] and long-term disability benefits and business travel accident benefits, basic and supplemental accidental death and dismemberment insurance benefits, flexible spending accounts for health care and dependent day care, vision benefits, dental benefits, LTC benefits, legal assistance benefits, and accident, critical illness and hospital indemnity benefits.
- Morgan Stanley Medical Plan: 507—provides medical and prescription drug benefits.
- Morgan Stanley Retiree Medical Plan: 521—provides medical and prescription drug benefits for certain retirees over age 65.
- Morgan Stanley Employee Assistance Plan: 511 employee welfare benefit plan providing employee assistance program benefits.

Note that the HSA is a personal savings account and is not subject to ERISA. All questions, claims and inquiries regarding the HSA should be directed to Morgan Stanley HR Services.

The Accident, Critical Illness and Hospital Indemnity plans are voluntary programs and are not subject to ERISA.

The DDCFSA is not subject to ERISA.

Plan Sponsor

Morgan Stanley Domestic Holdings Inc.
c/o HR Services

1585 Broadway

18th Floor - Benefits Department

New York, NY 10036

877-MSHR-411 (877-674-7411)

Plan Administrator and Named Fiduciary

Morgan Stanley Chief Human Resources Officer
c/o HR Services

1585 Broadway

18th Floor – Benefits Department

New York, NY 10036

877-MSHR-411 (877-674-7411)

Agent for Service of Legal Process

The designated agent for the service of legal process is:

Legal and Compliance Division
Attn: Chief Legal Officer Morgan Stanley

1585 Broadway

New York, NY 10036

Service of legal process also may be made on the plan administrator.

Participating Employers

All majority-owned U.S. subsidiaries and affiliates of Morgan Stanley (including Morgan Stanley Domestic Holdings Inc.) with U.S. employees participate in the plans, except for certain affiliates acquired after January 1, 2006.

A complete list of employers participating in the Plans may be obtained by sending a written request to the plan administrator at the address shown. Plan participants and beneficiaries may also request information about whether a particular employer participates in the Plans and its address.

Plan Funding

Certain benefits under the Morgan Stanley Medical Plan and prescription drug programs are self-funded. Morgan Stanley pays administrative fees

[1] Excludes STD benefits for Saxon employees of the U.S. Residential Mortgage Business.

to Cigna, UHC and Express Scripts, and funds benefit payments from general assets and employee contributions.

Certain benefits under the Morgan Stanley Medical Plan and prescription drug programs are insured through insurance policies.

Morgan Stanley pays insurance premiums to Cigna Global Health Medical Plan, Cigna Global Health Dental Plan, HMSA and Kaiser Permanente from general assets and employee contributions.

Dental benefits through MetLife and Delta Dental are self-funded. Morgan Stanley pays administrative fees to MetLife and Delta Dental, and funds certain benefit payments from general assets and employee contributions. Dental benefits for expatriate employees through Cigna Global Health Dental Plan are funded through a fully insured policy with Cigna Global Health. Morgan Stanley pays premiums to Cigna Global Health from general assets and employee contributions.

The Employee Assistance Plan is an unfunded plan. All premiums for active employees and their eligible dependents are paid by Morgan Stanley from its general assets.

Benefits under the Vision Plan are funded by a fully insured policy with Eastern Vision Service Plan Inc. (VSP). Morgan Stanley pays insurance premiums to VSP from employee contributions.

The Cafeteria Plan is an unfunded plan. All payments are made from Morgan Stanley's general assets. Your "contributions," as described in this SPD, are your salary deferrals, credited to your accounts under the FSA. Your HCFSA and LPFSA are credited with the full amount of your election at the beginning of the year, and you may make a claim from your HCFSA or LPFSA during the year, whether or not your salary has been reduced by the amount of your claim. Your DDCFSA is credited with the amount of your salary reductions as they are made, and you may make a claim from your DDCFSA to the extent your account has a positive balance. Except for the optional carry-over of up to $500 in your HCFSA, any amount not claimed by you in a timely manner for Eligible Expenses incurred by December 31 is forfeited from your FSA accounts. Benefits under the FSA are administered by but not insured by UHC.

The Life Insurance Plan is funded through one or more fully insured policies issued by MetLife.

MetLife is responsible for paying benefits only as provided under the terms of the insurance policies. In the event the policies terminate, MetLife will no longer be responsible for benefit payments other than as provided for upon termination of the policy.

AD&D Insurance Plan benefits are funded through one or more fully insured policies issued by MetLife. MetLife is responsible for paying benefits only as provided under the terms of the insurance policies. In the event that the policies terminate, MetLife will no longer be responsible for benefit payments other than as provided for upon the termination of the policies.

BTA Insurance Plan benefits are funded through one or more fully insured policies issued by Life Insurance Company of America (LICONA).

LICONA is responsible for paying benefits only as provided under the terms of the insurance policies. In the event that the policies terminate, LICONA will no longer be responsible for benefit payments other than as provided for upon the termination of the policies.

STD benefits are fully funded through the general assets of Morgan Stanley. Morgan Stanley pays administrative fees to MetLife for the administration of STD. LTD is funded through a group and individual insurance policies with MetLife, Lloyd's of London, The Paul Revere Life Insurance Company, Provident Accident and Casualty Insurance Company, and Provident Life and Accident Insurance Company. The insurers are responsible for paying benefits only as provided under the terms of the insurance policies. In the event that the policies terminate, the insurers will no longer be responsible for benefit payments other than as provided for upon the termination of the policies.

Legal Assistance Plan benefits are funded through an insured contract issued by Hyatt Legal Plans. Morgan Stanley pays premiums for benefits under the Legal Assistance Plan to Hyatt Legal Plans from employee contributions. Hyatt Legal is the claims administrator and assumes responsibility to pay all benefits under the terms of the contract. In

the event the contract terminates, Hyatt Legal Plans will no longer be responsible for benefit payments other than as provided for upon termination of the contract.

The Long-Term Care Plan is funded by fully insured policies with MassMutual, Prudential, MetLife and John Hancock. You pay the full cost of the plan with after-tax premium payments. Benefits are payable under the LTC Plan only to the extent that they are payable by the issuer of your policy under the terms of the applicable insurance policy.

Accident, Critical Illness and Hospital Indemnity Insurance are funded through fully insured policies with Aflac Group. You pay the full cost of your coverage with after-tax premiums. Benefits are payable only to the extent that they are payable by Aflac under the terms of the applicable individual insurance certificates. Aflac (not Morgan Stanley) is solely responsible for paying claims and determining which benefits are payable.

Morgan Stanley pays administrative fees from general assets to Alight for the record keeping and administration of COBRA.

Claims Administrators

Medical Plan

Cigna Healthcare
P.O. Box 5200
Scranton, PA 18505-5200

UnitedHealthcare
450 Columbus Blvd.
Hartford, CT 06103

Express Scripts
Attn: Commercial Claims
P.O. Box 14711
Lexington, KY 40512-4711

Cigna Global Health
P.O. Box 15050
Wilmington, DE 19850-5050

Hawaii Medical Service Association
P.O. Box 860
Honolulu, HI 96814

Kaiser Permanente HMO—Hawaii
711 Kapiolani Blvd., Suite 400
Honolulu, HI 96813

Kaiser Permanente HMO—
Northern California Claims
P.O. Box 12923
Oakland, CA 94604-2923

Kaiser Permanente HMO—
Southern California Claims
P.O. Box 7004
Downey, CA 90242-7004

UnitedHealthcare Insurance Company
(UHC Connector Model)
185 Asylum Street
Hartford, CT 06103-0450

Dental Plan

MetLife
P.O. Box 981282
El Paso, TX 79998-1282

Delta Dental
P.O. Box 2105
Mechanicsburg, PA 17055-2105

Cigna Global Health
P.O. Box 15050
Wilmington, DE 19850-5050

Vision Plan

VSP
3333 Quality Drive
Rancho Cordova, CA 95670

VSP – Out of Network Claims
P.O. Box 385018
Birmingham, AL 35238-5018

Flexible Spending Account Plan

UnitedHealthcare
P.O. Box 981178
El Paso, TX 79998-1178

Morgan Stanley HR Services
P.O. Box 563975
Charlotte, NC 28256-3975

Employee Assistance Plan

Lyra Health
287 Lorton Avenue
Burlingame, CA 94010

Life and Accident Insurance

Basic and Supplemental Life Insurance Plan/Basic and Supplemental AD&D Insurance Plan

Metropolitan Life Insurance Company
Group Life Claims
P.O. Box 6100
Scranton, PA 18505

Business Travel Accident Insurance Plan

Life Insurance Company of North America (Cigna)
1601 Chestnut Street
Philadelphia, PA 19192

Disability Plan

MetLife
P.O. Box 14592
Lexington, KY 40511-4592

Individual Disability Insurance Policies

Lenox Advisors
530 Fifth Avenue
New York, NY 10036

CEDi Policy

Hanleigh Management Inc.
50 Tice Blvd, Suite 122
Woodcliff Lake, NJ 07677
Attn: Matthew Zuba and Graham Southall

BTA Plan

Life Insurance Company of North America (Cigna)
1601 Chestnut Street
Philadelphia, PA 19192

Legal Assistance Plan

Hyatt Legal Plans Inc.
1111 Superior Avenue
Cleveland, OH 44114-2507

Long-Term Care Plan

Massachusetts Mutual Life Company
Long-Term Care Administrative Office
P.O. Box 4243
Woodland Hills, CA 91365-4243

The Prudential Insurance Company of America
Attn: LTC Claims Department
Long-Term Care Customer Service Center
P.O. Box 8526
Philadelphia, PA 19176

MetLife
57 Greens Farm Road
Westport, CT 06880

John Hancock
1 John Hancock Way, Suite 1700
Boston, MA 02217-1700

Accident, Critical Illness and Hospital Indemnity Insurance

Continental American Insurance Company
Aflac Group
Attn: Claims
P.O. Box 427
Columbia, SC 29202

COBRA

Morgan Stanley HR Services
P.O. Box 563975
Charlotte, NC 28256-3975

Health Savings Account[1]

Morgan Stanley HR Services
P.O. Box 563975
Charlotte, NC 28256-3975

Plan Year

The Plan Year for all Plans and programs described in this SPD is from January 1 through December 31.

[1] Note that your Health Savings Account is not a Morgan Stanley Benefit Plan.

If the Plans Are Terminated or Modified

Although Morgan Stanley and its participating affiliates expect to continue the Plans indefinitely, Morgan Stanley Domestic Holdings Inc., by action of its board of directors (or its delegates, the board of directors of Morgan Stanley Services Group Inc. or the Morgan Stanley Chief Human Resources Officer), reserves the right to amend, modify or discontinue any or all of the Plans or any benefits under any of the Plans at any time for any reason, including to curtail benefits for some or all covered individuals, to change the cost of coverage, and to implement changes required by federal, state and local legislation.

Plan Documents Govern

To the extent benefits are provided under an insurance contract, benefits payable to an individual are limited to the coverage of the insurance contracts. No provision in the Plan documents or SPD is intended, or shall be interpreted, to conflict with or supersede any provision of any such insurance contract.

No Guarantee of Employment

Neither this SPD nor participation in any of the Plans is a guarantee of continued employment or any particular level of compensation.

Confirmation of Your Elections

Any elections that you make under the Plans (excluding LTC) will become effective when the election is processed by HR Services (and EOI is approved, if applicable) and you are actively at work (for LTD and Life Insurance). You will receive confirmation of your elections (either electronic or paper), which you should check carefully to ensure it is correct. If it is incorrect, you must call an HR Services Representative within 10 business days of the date on your confirmation. If you do not receive a confirmation within 10 business days, it is your responsibility to call HR Services.

Any election that you make under the LTC Plan will become valid when the election is processed and your EOI is approved by the issuer of your LTC insurance. (It is your responsibility to follow up with Prudential, MetLife or John Hancock, as applicable. Note that the LTC Plan is closed to new entrants. Additionally, it is your responsibility to follow up on any election that requires EOI.

Right to Audit

Morgan Stanley audits the coverage of dependents, including spouses, domestic partners and children, to ensure that no ineligible person is enrolled in any of the Plans. Any person who fails to cooperate or who intentionally provides false or misleading information to the Plans may be subject to legal or disciplinary action by Morgan Stanley, including termination of employment and cancellation of executive compensation, as applicable.

Discretionary Authority of Plan Administrator and Other Plan Fiduciaries

In carrying out their respective responsibilities under the Plans, the plan administrator and other of the Plans' fiduciaries shall have discretionary authority to make any findings necessary or appropriate for any purpose under the Plans, including to interpret the terms of the Plans and to determine eligibility for and entitlement to benefits under the Plans. Any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the determination was arbitrary and capricious.

Indemnification

To the fullest extent permitted by law, Morgan Stanley and its affiliates will indemnify and hold harmless the plan administrator, each member of the Benefit Plan Claims Committee, the Benefit Plan Appeals Committee and each other current or former employee, officer and director of Morgan Stanley or of any member of Morgan Stanley's affiliated group to whom fiduciary responsibilities are delegated under the plans against any cost or expense (including attorneys' fees) or liability (including any sum paid in settlement of a claim with the approval of Morgan Stanley) arising out of any act or omission to act, except in the case of willful misconduct or lack of good faith. This paragraph shall not supersede any separate agreement or contract between Morgan Stanley or an affiliate, the plan administrator, the Benefit Plan Claims Committee or the Benefit Plan Appeals Committee and any other person to whom fiduciary responsibilities are delegated.

Plan Expenses

All fees and expenses incurred in connection with the operation and administration of the Plans, including legal, accounting, actuarial, investment, management, and administrative fees and expenses may be paid out of any assets of the Plans to the extent legally permitted. The Plan Sponsor may advance amounts properly payable by the Plans and then obtain reimbursement from the Plans.

Governing Law

The Plans shall be governed by federal law, and, to the extent not preempted by federal law, including ERISA, the laws of the state of New York, or to the extent provided in any insurance policies or contracts, the laws of the state of issuance of such insurance policies or contracts.

For information about the governing law for your HSA, consult the HSA documentation received from UMB, the bank that holds your account.

Glossary

As you review the details of the Morgan Stanley health care plans, it may be helpful to understand the general terms below.

Actively at Work

Actively at work or active at work means that you are performing all of the usual and customary duties of your job on a full-time basis. This must be done at:

- Morgan Stanley's place of business
- An alternate place approved by Morgan Stanley
- A place where Morgan Stanley's business requires you to travel

You will be deemed to be actively at work during weekends or Morgan Stanley-approved vacations, holidays or business closures if you were actively at work on the last scheduled work day preceding such time off.

Ambulatory Surgical Center

Ambulatory surgical centers are also known as outpatient surgery centers or same-day surgery centers. Ambulatory surgical centers are health care facilities that specialize in providing surgery, including certain pain management and diagnostic (e.g., colonoscopy) services in an outpatient setting. Ambulatory surgical centers' services are often considered procedures that are more intensive than those done in the average doctor's office but not so intensive as to require an overnight hospital stay.

Annual Deductible

An annual deductible is the amount you are required to pay toward covered expenses each year before you receive any reimbursement.

For the Morgan Stanley Medical Plan, an annual deductible applies to most covered in- and out-of-network medical expenses, including hospital charges, doctors' fees and lab tests. Your annual deductible depends on your coverage level (the number of dependents you cover) and your benefits-eligible earnings. Each covered individual must meet the per-person deductible each year before being reimbursed for covered expenses for the remainder of the year. However, when the combined covered expenses of three or more individuals reach the family maximum, each covered member in the family is considered to have met their individual deductible. Annual deductibles do not apply to certain preventive services.

Example

Assume you elect "yourself plus family" coverage and have three dependents. Also assume you have an annual deductible of $500 per person with a family maximum of $1,250 and you visit providers.

- If one family member reaches the $500 annual deductible for the year, that person's expenses alone are eligible for reimbursement at the Medical Plan's coinsurance level.
- If three family members each reach the $500 annual deductible, the $1,250 maximum has been met and the whole family's covered medical expenses through the end of the year are eligible for reimbursement at the Medical Plan's coinsurance level.
- If all four family members have covered expenses of $350, the $1,250 maximum has also been met. All future services for the year are eligible for reimbursement at the Medical Plan's coinsurance level.

For the Dental Plan, the annual deductible applies to most covered dental expenses not received within a Preferred Dentist Program (PDP) network, including restorative and orthodontic services. Your annual deductible depends on your coverage level and the option you elect. Each covered individual must meet the per-person deductible in order to be reimbursed for covered dental expenses for the remainder of the year. However, when the combined covered expenses of three or more covered individuals reach the family maximum, each covered member in the family is considered to have met his or her individual deductible. Annual deductibles generally do not apply to PDP dental expenses or Type A diagnostic and preventive services.

Benefit Maximum

The benefit maximum is the highest amount that the Medical and Dental Plans will pay for eligible medical and dental services. See the *Schedule of Benefits for the Medical Plan—National Coverage Options* chart on page 38 for Medical Plan maximums. For the Dental Plan, there are two benefit maximums:

- An annual benefit maximum for most services
- A lifetime benefit maximum for orthodontic expenses

If you switch Medical or Dental Plan options at any time, any prior amounts credited toward an annual or lifetime maximum (for example, fertility lifetime maximum and orthodontic lifetime maximum) will be applied to your new plan option. You will not receive another full benefit maximum.

Birth Center

A birth center is a specialized health care facility, staffed by nurses, midwives and/or obstetricians, for mothers in labor, who may be assisted by doulas and coaches. Birth centers may be freestanding (separate from a hospital) or located within a hospital. Should additional medical assistance be required, the mother can be transferred to a hospital.

Calendar Year

The calendar year begins January 1 and extends through December 31.

Coinsurance

The percentage of eligible medical and dental expenses that you and your dependents are required to pay for certain services. Your coinsurance is determined based on the type of service received and whether the service was performed by an in-network or out-of-network provider. Your coinsurance is generally limited by your annual coinsurance limit.

Coinsurance Limit

This feature limits the amount you pay toward covered medical expenses in a calendar year. Once your annual deductible (if any) plus your coinsurance amounts reach the annual coinsurance or out-of-pocket limit, Eligible Expenses will be covered for the remainder of the calendar year at 100 percent for in-network services and 100 percent of reasonable and customary (Eligible Expenses) charges for out-of-network services. Certain expenses, such as prescription drug payments, copays, penalties for preauthorization noncompliance and noncovered expenses, do not count toward your annual coinsurance limit. See the *Schedule of Benefits for the Medical Plan—National Coverage Options* chart on page 38 for a complete list of annual coinsurance limit exclusions and maximums. The annual coinsurance limit is applied to each covered individual or family. When the combined expenses of three or more individuals reach the family maximum, you will meet the coinsurance limit, regardless of the number of dependents covered under the Medical Plan.

Comprehensive Outpatient Rehabilitation Facility

An outpatient rehabilitation facility provides comprehensive diagnostic, therapeutic and restorative services on an outpatient basis. All rehabilitation services are provided at a fixed location and under the supervision of a physician.

Copay

A fixed amount you must pay at the time you receive services.

Covered Health Services

Covered health services are the health services covered by a particular plan. If you obtain services that are not covered, you pay the full cost for those services. Please note that no plan covers everything.

Covered Person

The employee, retiree, employee's or retiree's spouse or domestic partner, and/or dependent who is eligible and enrolled for coverage under the Plans.

Custodial Care

Care that is generally needed for a person's daily living activities, such as dressing, eating or performing other personal needs.

Designated Transplant Facility, Supplies or Equipment

A facility designated by the health plan administrator to provide the necessary services and supplies for qualified transplant procedures under the Medical Plan.

Eligible Expenses

For covered health services, incurred while the Plan is in effect, Eligible Expenses are determined by UHC and Cigna.

Eligible expenses are determined solely in accordance with UHC's and Cigna's reimbursement policy guidelines.

UHC develops the reimbursement policy guidelines, in UHC's discretion, following evaluation and validation of all provider billings in accordance with one or more of the following methodologies:

- As indicated in the most recent edition of the Current Procedural Terminology (CPT), a publication of the American Medical Association, and/or the Centers for Medicare and Medicaid Services (CMS).
- As reported by generally recognized professionals or publications.
- As used for Medicare.
- As determined by medical staff and outside medical consultants pursuant to other appropriate sources or determination that UHC accepts.

Cigna's policy for payments made to health care professionals not participating in Cigna's network are determined based on the lesser of: the health care professional's normal charge for a similar service or supply, or a percentile of charges made by health care professionals of such service or supply in the geographic area where it is received. The health care professional may bill the customer the difference between the health care professional's normal charge and the maximum reimbursable charge as determined by the benefit plan, in addition to applicable deductibles, co-payments and coinsurance.

Emergency Care

Medical care and treatment provided after the sudden onset of a medical condition that is severe enough that the lack of immediate medical attention could reasonably be expected to result in serious injury or death.

Experimental, Investigational or Unproven Services

This refers to a procedure, device or pharmaceutical agent that is still undergoing pre-clinical or clinical evaluation, and/or has not yet received regulatory approval. In its discretion, the health plan administrator may deem an experimental, investigational or unproven service covered under the Medical Plan for treating a life-threatening sickness or condition if it is proved to be safe with promising efficacy, provided in a clinically controlled research setting, and uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.

Health Plan Administrator

A company that administers the provisions of the Medical, Dental or Vision Plans, including paying claims.

- The health plan administrators for the Medical Plan are:
  - UHC
  - Cigna
  - Cigna Global Health
  - Hawaii Medical Service Association (HMSA)
  - Kaiser Permanente HMO—Hawaii
  - Kaiser Permanente HMO—California

- The health plan administrators for prescription drugs are:
  - Cigna Global Health
  - Express ScriptsCigna Pharmacy
  - Hawaii Medical Service Association (HMSA)
  - Kaiser Permanente HMO—Hawaii
  - Kaiser Permanente HMO—California
- The health plan administrators for the Dental Plan are:
  - MetLife
  - Delta Dental
  - Cigna Global Health
- The health plan administrator for the Vision Plan is VSP.

Home Health Care Services

Services performed by an agency or organization that provides a program of skilled home health care, provided on a part-time intermittent schedule of services:

- Medical and surgical nursing care
- Nursing care
- Rehabilitation care and therapies
- Hospice care
- Social services and counseling on health-related issues

Home Health Care Visit

The maximum number of hours per day is limited to 16 hours. Multiple visits can occur in one day. A visit is defined as a period of two hours or less (e.g., maximum of eight visits per day).

Hospice

A hospice is a program of medical and emotional care for the terminally ill. Considered to be the model for quality, compassionate care for people facing a life-limiting illness or injury, hospice and palliative care involves a team-oriented approach to expert medical care, pain management, and emotional and spiritual support expressly tailored to the person's needs and wishes.

Hospital

An institution where sick or injured people receive medical or surgical care on an inpatient basis. A hospital must be accredited by the Joint Commission on Accreditation of Healthcare Organizations and approved by Medicare.

Involuntary Termination (Other Than Release)

Termination of employment for cause or that is otherwise initiated by Morgan Stanley and not in connection with a release.

Lifetime Maximum

The most that will be paid by a plan for covered services for a plan member. Not all plans apply a lifetime maximum and some plans have different lifetime maximums for both in-network and out-of-network care. Once you reach the lifetime maximum, you pay all future expenses over that amount.

Medically Necessary

Those covered services or supplies that are determined by the health plan administrator (in its sole discretion) to be:

- Provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease
- Not for experimental, investigational or cosmetic purposes
- Necessary for and appropriate to the diagnosis, treatment, cure or relief of a health condition, illness, injury, disease or its symptoms
- Within generally accepted standards of medical care in the community
- Not solely for the convenience of the employee, the employee's family or the provider

Medicare

The Health Insurance for the Aged and Disabled Program under Title XVIII of the Social Security Act. For more information, see the *Medicare* section on page 83.

Mental Disorder Treatment

Treatment of:

- Any disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence or addiction to alcohol, psychiatric drugs or medications,

regardless of any underlying physical or organic cause, and

- Any disorder where the treatment is primarily the use of psychotherapy or other psychotherapist methods.

All inpatient services, including room and board, given by a mental health facility or area of a hospital that provides mental health or substance abuse treatment for a disorder identified in the DSM are considered mental disorder treatment. Prescription drugs are not considered mental disorder treatment.

Network

Used to describe a plan's network of doctors, hospitals and other health care providers. Different health plan administrators have different networks. The Cigna plans offer the Cigna Open Access Plus network, and the UHC plans offer the UHC Choice Plus network.

Nurse Midwife

A person who is licensed or certified to practice as a nurse midwife, and is both licensed by a board of nursing as an RN, and has completed a program approved by the state for the preparation of nurse midwives.

Nurse Practitioner

A person who is licensed or certified to practice as a nurse practitioner, and is both licensed by a board of nursing as an RN, and has completed a program approved by the state for the preparation of nurse practitioners.

Outpatient Facility

An institution where sick or injured people receive medical or surgical care on an outpatient basis. The facility must be licensed in the state in which it is doing business.

Out-of-Network Hospital

A hospital that does not participate in a health plan administrator's network.

Out-of-Network Provider

A provider that does not participate in a health plan administrator's network.

Out-of-Pocket Maximum

The most you would have to pay out of your own pocket for Eligible Expenses. With a plan that has an out-of-pocket maximum, once you reach the maximum for a given year, the plan pays all Eligible Expenses for covered services until any lifetime maximum benefit is reached. Not all expenses count toward an out-of-pocket maximum.

Physician

- A person licensed to practice medicine in the jurisdiction where such services are performed; or
- Any other person whose services, according to applicable law, must be treated as physician's services for purposes of the group policy. Each such person must be licensed in the jurisdiction where he performs the service and must act within the scope of that license. He must also be certified and/or registered if required by such jurisdiction.

The term does not include:

- You;
- Your spouse; or
- any member of your immediate family including your and/or your spouse's:
- parents;
- children (natural, step or adopted);
- siblings;
- grandparents; or
- grandchildren.

Preauthorization

Preauthorization helps ensure that you obtain the most appropriate care for your condition, in the most appropriate setting and that health care costs are managed. You are required to contact your health plan administrator prior to receiving certain treatments or services so that the treatment or service can be preauthorized. Failure to receive preauthorization from your health plan administrator, when required, will result in penalties or no benefits being paid.

Primary Care Physician (PCP)

With some plans, you may choose a PCP to be the personal doctor for each family member.

Private Duty Nursing

The planning of care and care of patients by a nurse, whether a registered nurse or licensed practical nurse.

Rehabilitation Facility

A facility accredited as a rehabilitation facility by the Commission on Accreditation of Rehabilitation Facilities.

Release

Termination of employment that is not for cause and that is initiated by Morgan Stanley, at its sole discretion, in connection with a staff reduction, elimination of position, sale of business, transfer to a joint venture, office closing, outsourcing or reorganization.

Whether a termination of employment is a release, is determined by Morgan Stanley's Chief Human Resources Officer, in their sole discretion.

Review or Review Process

A review and determination of whether services and supplies provided by a health care provider are considered covered health services.

Room and Board

Room, board, general duty nursing, intensive nursing care and any other services regularly furnished by a hospital when receiving services as an inpatient.

Shared Savings Program

A program through UHC may obtain a discount to an out-of-network provider's billed charges. This discount is usually based on a schedule previously agreed to by the out-of-network provider. When this happens, you may experience lower out-of-pocket amounts. Plan coinsurance and deductibles would still apply to the reduced charge. Sometimes Plan provisions or administrative practices conflict with the scheduled rate, and a different rate is determined by UHC. In this case the out-of-network provider may bill you for the difference between the billed amount and the rate determined by UHC. If this happens, you should call the number on your ID card. Shared Savings Program providers are out-of-network providers and are not credentialed by UHC.

Sickness

Physical illness, disease or pregnancy. The term sickness as used in this SPD does not include mental illness or substance abuse, regardless of the cause or origin of the mental illness or substance abuse.

Skilled Nursing Facility

A hospital or nursing facility that is licensed and operated as a skilled nursing facility under an applicable state or federal law.

Temporomandibular Joint (TMJ) Services:

The Medical Plan covers services for the evaluation and treatment of temporomandibular joint syndrome (TMJ) and associated muscles.

Diagnosis: Examination, radiographs and applicable imaging studies and consultation.

Nonsurgical treatment, including clinical examinations, arthrocentesis and trigger point injections.

Benefits are provided for surgical treatment if the following criteria are met:

- There is clearly demonstrated radiographic evidence of significant joint abnormality.
- Nonsurgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

Benefits for surgical services include arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations.

Benefits for surgical services also include FDA-approved TMJ prosthetic replacements when all other treatment has failed.

Urgent Care Center

A facility dedicated to the delivery of ambulatory care outside of a hospital emergency department.

Your Important Contacts

PROGRAM	WEBSITE OR EMAIL	GROUP NUMBER	PHONE NUMBER
All Benefit Plans	For transactions, www.morganstanley.com/benefits For news and resources, type mybenefits in your intranet browser		1-877-MSHR-411 (1-877-674-7411)
ConnectOne (for your Citigroup benefits information, if applicable)	N/A		1-800-881-3938
General Human Resources Inquiries	Contact Your HR Representative		1-877-MSHR-411 (1-877-674-7411)
General HR and FA Compensation Inquiries—FSG Desk (for MSSB employees)	N/A		1-888-FSG-9999 (1-888-374-9999)
Health Care			
Benefits Advocates	Type **benefitsadvocates** in your intranet browser		From office: 1-877-MSHR-411 (1-877-674-7411) From home: 1-800-555-7187
Cigna (Options A, B and C)	www.mycigna.com	3327984	1-800-CIGNA24 (1-800-244-6224)
Cigna Global Health Medical and Dental	www.cignaenvoy.com	00519A	1-800-441-2668 (in the U.S.) 1-302-797-3100 (collect—outside of the U.S.)
Delta Dental	www.deltadentalins.com	NY05703	1-800-932-0783
Flexible Spending Accounts (Health Care and Dependent Day Care)	www.myuhc.com www.irs.gov (for a list of Eligible Expenses)	202942	1-888-332-8891 1-800-TAX-FORM (1-800-829-3676)
Health Savings Account	For transactions, visit www.morganstanley.com/benefits For information, visit www.mybenefits.morganstanley.com		1-877-MSHR-411 (1-877-674-7411)
HMSA Medical (Hawaii)	www.hmsa.com	Employees: 98643-1 COBRA: 98643-3	1-808-948-6111
Kaiser Permanente (Northern and Southern California and Hawaii)	www.kaiserpermanente.org	8488 (N CA) 102045 (S CA) 1340 (HI)	1-800-464-4000 (CA) 1-800-966-5955 (HI)

PROGRAM	WEBSITE OR EMAIL	GROUP NUMBER	PHONE NUMBER
Limited Purpose Flexible Spending Account	For transactions, visit www.morganstanley.com/benefits For information, visit mybenefits.morganstanley.com		1-877-MSHR-411 (1-877-674-7411)
Lyra Health	www.lyrahealth.com/morganstanley		1-866-926-2648
MetLife Dental (Options A and B)	www.metlife.com/mybenefits	Standard Plan: 308228 Premier Plan: 308229	1-800-474-7371
Express Scripts Prescription Drugs	www.express-scripts.com	MSG	800-753-2851
Second Opinion Services (Firm Provided)	www.2nd.md/morganstanley		1-866-841-2575
Telemedicine: Cigna Telehealth Connection	www.mycigna.com		N/A
Telemedicine: UHC Virtual Visits	www.myuhc.com		N/A
UnitedHealthcare (Options A, B and C)	www.myuhc.com	182019	1-888-332-8891
VSP Vision Plan (Option A and B)	www.vsp.com	12290137	1-800-877-7195
Incentive and FA Compensation Plans			
Common Book Accounts	N/A		1-800-622-2393 1-201-680-6578
Executive Compensation	Use the *Contact Us* feature on the Executive Compensation website Current employees: http://execcomp.ms.com (through the Morgan Stanley intranet) Former employees: www.morganstanley.com/excomp		N/A
Deferred Cash Plan Administrator (EWM)	questions@ewmglobal.com		1-203-972-6900 +41-44-913-1914
FA Compensation	me@MS		1-212-276-5300
Leaves and Disability			
Dye & Eskin Inc. (CEDi)	N/A		1-888-556-8767
Hanleigh Management Inc. (CEDi)	N/A		1-201-505-1050
Lenox Advisors (Individual Disability Insurance)	mdonalds@lenoxadvisors.com www.lenoxadvisors.com		1-212-536-8782
MetLife (Leave Initiation, STD and LTD)	www.metlife.com/mybenefits	STD and FMLA: 308160 LTD: 143274	1-800-498-5306 1-800-638-6420 prompt 1 (EOI)

PROGRAM	WEBSITE OR EMAIL	GROUP NUMBER	PHONE NUMBER
Insurance			
Aflac (Accident, Critical Illness and Hospital Indemnity)	N/A		1-855-730-4944
Cigna (Business Travel Accident Insurance)	N/A		1-800-238-2125 (Claims) 1-201-533-4911
MassMutual (Life Insurance Portability and Conversion)	N/A		1-877-275-6387
MetLife (Life Insurance and Accidental Death and Dismemberment Insurance)	N/A		1-800-753-9021 1-800-638-6420 prompt 1 (EOI)
Payroll and Employment Verification			
Employment Verification	www.theworknumber.com/Employees/		1-800-367-5690 Morgan Stanley Employer Code: 11441; Citigroup Employer Code: 24841 (if you transferred into MSSB from Citigroup, for employment through 2009)
U.S. Payroll	me@MS		1-212-276-5300
MyTime	www.mytime@morganstanley.com		N/A
Other Company Programs			
Adoption Assistance Program	N/A		1-877-MSHR-411 (1-877-674-7411)
CARE.COM	www.morganstanley.care.com		1-855-781-1303
CARE Program (Employment Dispute Resolution Program)	carebox@morganstanley.com		1-866-CARE-123 (1-866-227-3123)
Employee Offers (Commuter Benefits, Group Auto/Home, Group Personal Excess Liability Insurance, College Coach —Educational Assistance)	www.youdecide.com/morganstanley		1-800-864-1539
Diversity and Inclusion (Employee Networking Groups)	Type **diversity** in your browser diversity@morganstanley.com		N/A
HR Policies	me@MS		N/A
Legal Assistance Plan (Hyatt Legal)	www.metlife.com/mybenefits		1-800-821-6400
Onsite Counselor	www.lyrahealth.com/morganstanley		1-866-926-2648
Perks Portfolio	Type **offers** in your browser		N/A
Tuition Reimbursement	On the Policies section at me@MS		1-212-276-5300
Wellness Programs (such as onsite health and fitness centers, health coaching, wellness lectures/events, meditation and discounts)	Type **wellness** in your intranet browser For questions about wellness programs, email wellness@morganstanley.com		N/A

PROGRAM	WEBSITE OR EMAIL	GROUP NUMBER	PHONE NUMBER
Other Helpful Links			
Employee Trading and Activities Helpline	useta@morganstanley.com		1-201-830-7737
New Hire Onboarding	onboarding_newhires@morganstanley.com		1-201-633-4221 (Fax)
Medicare	www.medicare.gov		1-800-633-4227
QDRO/QMCSO	N/A		1-877-MSHR-411 (1-877-674-7411)
Registration (security licensing inquiries)	naregist@morganstanley.com		1-443-627-6300 1-201-633-4214 (Fax)
Social Security	www.socialsecurity.gov		1-800-772-1213
UnitedHealthcare Medicare Solutions	www.myuhcplans.com/morganstanley		1-855-618-1796

Claim Forms: Claim forms are available on the Benefit Center website and from the plan administrator websites listed above.