Benefits Handbook Date July 1, 2009

Administrative Information
MMC

Administrative Information

This section provides administrative details about how the benefits plans are administered including:

- *plan funding and claims administration*
- *how to obtain plan documents*
- *the claims review and appeal process*
- *your rights under ERISA (the Employee Retirement Income Security Act of 1974)*
- *other important facts about the plans.*

Included in this document is information about the Benefits Handbook itself (such as the plans for which the Benefits Handbook serves as the summary plan description and the official plan document), description of certain laws that apply to the benefit plans, and your rights under those laws.

In addition, this section describes the claims and appeals processes for some of the benefits.

In This Section See Page

How the Benefits Handbook Is Used

Claims Administrators (or Account Administrator or Plan Administrator, as applicable)

The Claims Administrator (or Account Administrator or Plan Administrator, as applicable) for each plan described in the Benefits Handbook uses the description of the applicable plan in the Benefits Handbook to make determinations on claims for benefits under the plan. (Should any plan provision described become invalid or unenforceable, it will not affect the validity or enforceability of any other plan provision.) When necessary, the Claims Administrators may also refer to their internal guidelines in making claims/benefits determinations. The Claims Administrator (or Account Administrator or Plan Administrator, as applicable) has full discretion and authority to make all such claims/benefits determinations.

Headings, Navigation Menus, Tables of Contents, Etc.

Note that the various headings and sub-headings in the Benefits Handbook (which produce the website navigation menus and the tables of contents in the printed version) are provided for your convenience and in no way define, limit, or otherwise describe the scope or intent of the plans.

Administrative Details about the Plans

The following are administrative facts about the benefits described in the Benefits Handbook.

The Basic Life Insurance Plan

Plan Name

Marsh & McLennan Companies Basic Life Insurance Plan

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator (described below) to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Basic Life Insurance
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 1098400.

Source of Benefits Funding

The Basic Life Insurance Plan is insured through contracts with the Claims Administrator, who administers claims for this plan and is solely responsible for providing benefits.

Contributions are made solely by the Company. These contributions are held in the Marsh & McLennan Companies Employer Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

Claims Administrator

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166

(Be sure to check your claim form for the address of the claims processing office.)

Contacts

For filing a claim:

Met Life
Group Life Claims
P.O. Box 3016
Utica, NY 13504

For appealing a claim:

Met Life
Group Life Claims
P.O. Box 3016
Utica, NY 13504

For converting your coverage:

Metropolitan Life Insurance Company
Phone: (877) ASK MET7

E-mail: solutions@metlife.com

The Basic Long Term Disability Plan

Plan Name

Marsh & McLennan Companies Basic Long Term Disability Plan

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

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- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Basic Long Term Disability
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 83082035.

Source of Benefits Funding

The Basic Long Term Disability Plan is self-insured by the Company through contributions made solely by the Company. These contributions are held in the Marsh & McLennan Companies Employer-Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator who is responsible for processing claims for this self-insured plan.

Claims Administrator

The Hartford Life Insurance Companies
P.O. Box 946710
Maitland, FL 32794-6710
Phone: (800) 303-9744
Fax: (407) 919-6329

Contacts

For filing a claim:

A claim form will automatically be sent to your home address. If you have been disabled for more than four months, and you have not received the forms, you can contact your Human Resources Representative.

For appealing a claim:

The Hartford Life Insurance Companies
Group Benefits
P.O. Box 946710
Maitland, FL 32794-6710
Phone: (800) 303-9744

The Business Travel Accident Insurance Plan

Plan Name

Marsh & McLennan Companies Business Travel Accident Insurance Plan

Plan Number

502

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

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- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Business Travel Accident Insurance
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is GTP 8060935

Source of Benefits Funding

The Business Travel Accident Insurance is insured through contracts with the Claims Administrator, who administers claims for this plan and is solely responsible for providing benefits.

Claims Administrator

American International Life Assurance Company of New York (AIG)
AIG Claims Services, Inc.
A&H Claims Department
P.O. Box 15701
Wilmington, DE 19850-5701
Phone: (800) 551-0824

(Be sure to check your claim form for the address of the claims processing office.)

Contacts

For filing a claim:

American International Life Assurance Company of New York (AIG)
AIG Claims Services, Inc.
A&H Claims Department
P.O. Box 15701
Wilmington, DE 19850-5701
Phone: (800) 551-0824

For appealing a claim:

American International Life Assurance Company of New York (AIG)
AIG Claims Services, Inc.
A&H Claims Department
P.O. Box 15701
Wilmington, DE 19850-5701
Phone: (800) 551-0824

The Comprehensive Medical Plan (CMP)

Plan Name

Marsh & McLennan Companies Comprehensive Medical Plan.

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030

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- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Comprehensive Medical Plan
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 98400.

Source of Benefits Funding

The Comprehensive Medical Plan is self insured by the Company through contributions made jointly by the Company and participating employees. These contributions are held in the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan.

Claims Administrator

United Healthcare
P.O. Box 740800
Atlanta, GA 30374-0800
Phone: 800-645-6555

(Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For filing a medical claim:

United Healthcare
P.O. Box 740800
Atlanta, GA 30374-0800
Phone: 800-645-6555

For precertification:

United Healthcare
Phone: 800-645-6555

For filing a retail prescription drug claim:

Medco Health Solutions
P.O. Box 2187
Lee's Summit, MO 64063-2187
Phone: 800-987-8360

For filing a mail-order prescription drug claim

Medco Health Solutions
P.O. Box 2187
Lee's Summit, MO 64063-2187
Phone: 800-987-8360

For appealing a medical claim:

United Healthcare Appeals
P.O. Box 3043
Salt Lake City, UT 84130-0432
Phone: 800-645-6555

For appealing a prescription drug claim:

Medco Health Solutions
8111 Royal Ridge Parkway
Irving, TX 75063
Attn: Coverage Appeals

For COBRA coverage:

Ceridian
Phone: (800) 877-7994

The Consumer Directed Health Plan ("CDHP")

Plan Name

Marsh & McLennan Companies Consumer Directed Health Plan.

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

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- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – CDHP
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 876230.

Source of Benefits Funding

The CDHP is self insured by the Company through contributions made jointly by the Company and by the participating employees. These contributions are held in the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
One Cabot Road
Medford, MA 02149-5159

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan.

Claims Administrator

Aetna
P.O. Box 843
Blue Bell, PA 19422-0843
Phone: 866-210-7858

(Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For filing a medical claim:

Aetna
P.O. Box 981109
El Paso, TX 79998-1109
Phone: 866-210-7858

For precertification:

Aetna
Phone: 800-333-4432

For filing a retail prescription drug claim:

Aetna Pharmacy Management
P.O. Box 398106
Minneapolis, MN 55439-8106
Phone: 800-238-6279
Fax: 952-594-6500

For filing a mail-order prescription drug claim:

Aetna Pharmacy Management Home Delivery
P.O. Box 398106
Minneapolis, MN 55439-8106
Phone: 866-612-3862

For appealing a medical or prescription drug claim:

Aetna
Appeals Resolution Team
P.O. Box 14463
Lexington, KY 40512

For COBRA coverage:

Ceridian
Phone: (800) 877-7994

Dental Plan

Plan Name

Marsh & McLennan Companies Dental Plan

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

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- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Dental Plan
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 302176.

Source of Benefits Funding

The Dental Plan is self insured by the Company through contributions made jointly by the Company and participating employees. These contributions are held in the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, shown below, who is responsible for processing claims for this self-insured plan.

Claims Administrator

Metropolitan Life Insurance Company (MetLife)
One Madison Avenue
New York, NY 10010

(Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For filing a claim:

Metlife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282
Phone: (800) 942-0854

For appealing a claim:

Metlife

Group Claim Review
P.O. Box 14589
Lexington, KY 40512

For COBRA coverage:

Ceridian
Phone: (800) 877-7994

For a copy of participating dentists:

www.MetLife.com/dental
Phone: (800) 942-0854

The Dependent Care Flexible Spending Account Plan ("DCFSA")

Plan Name

Marsh & McLennan Companies Dependent Care Flexible Spending Account

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator –DCFSA
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 886147.

Source of Benefits Funding

The DCFSA is self insured by the Company through contributions made solely by participating employees. These contributions are held in the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
One Cabot Road
Medford, MA 02155-5159

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan.

Claims Administrator

Aetna FSA
P.O. Box 400
Richmond, KY 40476-4000
Phone: (888) 238-6226

(Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For sending a completed claim:

Aetna FSA
P.O. Box 4000
Richmond, KY 40476-4000
Phone: (888) 238-6226
Fax: (888) 238-3539

For appealing a claim:

Aetna FSA
P.O. Box 4000
Richmond, KY 40476-4000
Phone: (888) 238-6226
Fax: (888) 238-3539

The Dependent Children Life Insurance Plan

Plan Name

Marsh & McLennan Companies Dependent Children Life Insurance Plan

Plan Number

508

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

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- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Dependent Children Life Insurance
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 0100212.

Source of Benefits Funding

Dependent Children Life Insurance is insured through contracts with the Claims Administrator, who administers claims for this plan and is solely responsible for providing benefits.

Contributions are made solely by participating employees.

The Company has engaged the services of a Claims Administrator for processing claims of this fully insured plan.

Claims Administrator

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166

Contacts

For filing a claim:

Met Life
Group Life Claims
P.O. Box 3016
Utica, NY 13504

For appealing a claim:

Met Life
Group Life Claims
P.O. Box 3016
Utica, NY 13504

For converting your coverage:

Metropolitan Life Insurance Company
Phone: (877) ASK MET7
E-mail: solutions@metlife.com

The Employee Assistance Program (EAP)

Plan Name

Marsh & McLennan Companies Employee Assistance Program

Plan Number

N/A

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

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- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Marsh and McLennan Companies, Inc. – Employee Assistance Program
c/o Global Benefits, 6th Floor
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

N/A.

Source of Benefits Funding

The Employee Assistance Program is insured through contracts with the Claims Administrator, who administers claims for this plan and is solely responsible for paying benefits.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this insured plan.

Claims Administrator

CIGNA Behavioral Health
3636 Nobel Drive Suite 150
San Diego, CA 92122
Phone: (800)-382-3432

Contacts

For filing a claim:

CIGNA Behavioral Health
3636 Nobel Drive Suite 150
San Diego, CA 92122
Phone: (800) 382-3432

For appealing a claim:

CIGNA Behavioral Health
3636 Nobel Drive Suite 150
San Diego, CA 92122
Phone: (800) 382-3432

For COBRA coverage:

Ceridian
Phone: (800) 877-7994

The Exclusive Provider Organization Plan (“EPO”)

Administered by Empire BlueCross BlueShield (BCBS) or UnitedHealthcare (UHC)

Plan Name

Marsh & McLennan Companies Exclusive Provider Organization Plan

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – EPO
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

BCBS - The group contract number is 295648.

UHC - The group contract number is 098400.

Source of Benefits Funding

The EPO is self insured by the Company through contributions made jointly by the Company and participating employees. These contributions are held in the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
One Cabot Road
Medford, MA 02155-5153

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan.

Claims Administrator

For BCBS:

Empire BlueCross BlueShield
P.O. Box 5076
Middletown, N.Y. 10940
Phone: 866-219-8695

(Be sure to check your claim form or instructions for the address of the claims processing office.)

For UHC:

UnitedHealthcare
P.O. Box 740800
Atlanta, GA. 30374-0800
Phone: 866-540-5954

(Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For filing a medical claim:

For BCBS:

Empire BlueCross BlueShield
Attn: Claims
P.O. Box 5076
Middletown, N.Y. 10940
Phone: 866-219-8695

For precertification:

Empire BlueCross BlueShield
Phone: 866-219-8695

For filing a retail prescription drug claim:

Medco Health Solutions
P.O. Box 2187
Lee's Summit, MO 64063-2187
Phone: 800-987-8360

For filing a mail-order prescription drug claim

Medco Health Solutions
P.O. Box 2187
Lee's Summit, MO 64063-2187
Phone: 800-987-8360

For appealing a medical claim:

Empire BlueCross BlueShield
Attn: Appeals
P.O. Box 5076
Middletown, N.Y. 10940
Phone: 866-219-8695

For appealing a prescription drug claim:

Medco Health Solutions
8111 Royal Ridge Parkway
Irving, TX 75063
Attn: Coverage Appeals

For COBRA coverage:

Ceridian
Phone: (800) 877-7994

For UHC:

For filing a medical claim:

United Healthcare
P.O. Box 740800
Atlanta, GA 30374-0800
Phone: 866-540-5954

For precertification:

UnitedHealthcare
Phone: 866-540-5954, prompt 2

For filing a retail prescription drug claim:

Medco Health Solutions
P.O. Box 2187
Lee's Summit, MO 64063-2187
Phone: 800-987-8360

For filing a mail-order prescription drug claim

Medco Health Solutions
P.O. Box 2187
Lee's Summit, MO 64063-2187
Phone: 800-987-8360

For appealing a medical claim:

UnitedHealthcare
P.O. Box 3041
Salt Lake City, UT 84130-0432
Phone: 866-540-5954

For appealing a prescription drug claim:

Medco Health Solutions
8111 Royal Ridge Parkway
Irving, TX 75063
Attn: Coverage Appeals

For COBRA coverage:

Ceridian
Phone: (800) 877-7994

Hawaii - HMSA's Health Plan Hawaii Plus ("HMO")

Plan Name

Marsh & McLennan Companies HMSA's Health Plan Hawaii Plus HMO

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – HMSA HMO
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract numbers are 96770-1 & 96770-3 (COBRA).

Source of Benefits Funding

The plan is fully insured through the HMO which administers claims for this plan and is solely responsible for providing medical benefits and determinations.

Contributions are made jointly by the Company and participating employees. These contributions are held in the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Premium payments to the HMO are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this fully-insured plan.

Claims Administrator

HMSA
Health Plan Hawaii
Honolulu, HI 96808-0860
Phone: (808) 948-6372

(Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For appealing a medical or prescription drug claim:

HMSA - HPH
Attention: Appeals Coordinator
P.O. Box 1958
Honolulu, HI 96805-1958
Phone: (800) 462-2085
Fax: (808) 952-7546

For COBRA coverage:

Ceridian
Phone: (800) 877-7994

Hawaii - HMSA's Preferred Provider Plan ("PPP")

Plan Name

Marsh & McLennan Companies HMSA's Preferred Provider Plan

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – HMSA PPP
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract numbers are 96770-1 & 96770-3 (COBRA).

Source of Benefits Funding

The plan is fully insured through the PPP which administers claims for this plan and is solely responsible for providing medical benefits and determinations.

Contributions are made jointly by the Company and participating employees. These contributions are held in the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Premium payments to the PPP are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan.

Claims Administrator

HMSA
Honolulu, HI 96808-0860
Phone: (808) 948-6111

(Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For appealing a medical or prescription drug claim:

HMSA - HPH

Attention: Appeals Coordinator

P.O. Box 1958
Honolulu, HI 96805-1958

Phone: (800) 462-2085
Fax: (808) 952-7546

For COBRA coverage:

Ceridian
Phone: (800) 877-7994

The Health Care Flexible Spending Account Plan ("HCFSA")

Plan Name

Marsh & McLennan Companies Health Care Flexible Spending Account Plan

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – HCFSA
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 886147.

Source of Benefits Funding

The HCFSA is self insured by the Company through contributions made by participating employees. These contributions are held in the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
One Cabot Road
Medford, MA 02155-5159

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan.

Claims Administrator

Aetna FSA
P.O. Box 4000
Richmond, KY 40476-4000
Phone: (888) 238-6226

(Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For sending a completed claim:

Aetna FSA
P.O. Box 4000
Richmond, KY 40476-4000
Phone: (888) 238-6226
Fax: (888) 238-3539

For appealing a claim:

Aetna FSA
P.O. Box 4000
Richmond, KY 40476-4000
Phone: (888) 238-6226
Fax: (888) 238-3539

For COBRA coverage:

Ceridian
Phone: (800) 877-7994

The Health Savings Account ("HSA")

Plan Name

Marsh & McLennan Companies Health Savings Account Plan

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – HSA
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 876230.

Source of Benefits Funding

The HSA is self insured by the Company through contributions made by participating employees. These contributions are held in the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan.

Claims Administrator

Aetna HSA
P.O. Box 30207
Tampa, FL 33630-3207
Phone: (888) 238-6226

(Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For sending a completed claim:

Aetna HSA
P.O. Box 30207
Tampa, FL 33630-3207
Phone: (888) 238-6226
Fax: (888) 238-3539

For appealing a claim:

Aetna HSA
P.O. Box 30207
Tampa, FL 33630-3207
Phone: (888) 238-6226
Fax: (888) 238-3539

For COBRA coverage:

Ceridian
Phone: (800) 877-7994

The Kaiser Foundation Health Plan, California – North & South ("HMO")

Plan Name

Marsh & McLennan Companies Kaiser Permanente – Northern & Southern California

Plan Number

501.

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 – December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Kaiser Foundation Health Plan, California - North & South ("HMO")
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

California - North group contract number is 8656.

California - South group contract number is 102756.

Source of Benefits Funding

The plan is fully insured through the HMO who administers claims for this plan and is solely responsible for providing vision benefits and determinations.

Contributions are made by the participating employees. These contributions are held in the Marsh & McLennan Companies Employer-Funded Welfare Benefit Trust by the trustees;

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Premium payments are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan.

Claims Administrator

Kaiser Permanente
393 East Walnut Street
Pasadena, CA 91188

(Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For appealing a claim:

Kaiser Permanente
393 East Walnut Street
Pasadena, CA 91188

For COBRA coverage:

Ceridian
Phone: 800-877-7994

The Legal Assistance Plan

Plan Name

Marsh & McLennan Companies Legal Assistance Plan

Plan Number

511

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Legal Assistance Plan
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 130.

Source of Benefits Funding

The Legal Assistance Plan is provided through contracts with the Claims Administrator, who administers claims for this plan and is solely responsible for providing benefits.

The Company has engaged the services of the Claims Administrator for processing claims for this fully-insured plan.

Contributions are made solely by participating employees.

Delaware Law

Except where preempted by ERISA or other U.S. laws, the validity of the plan and any of its provisions will be determined under the laws of Delaware without giving effect to principles of conflict of laws.

Claims Administrator

Hyatt Legal Plans, Inc.
1111 Superior Avenue
Cleveland, OH 44114-2507

(This is the main business address for the Administrator. Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For filing a claim:

Hyatt Legal Plans, Inc.
1111 Superior Avenue
Cleveland, OH 44114-2507

For appealing a claim:

Hyatt Legal Plans, Inc.
1111 Superior Avenue
Cleveland, OH 44114-2507

For converting your coverage:

Hyatt Legal Plans, Inc.
Phone: (800) 821-6400
Website: legalplans.com

The Limited Purpose Health Care Flexible Spending Account Plan (“LPHCFSA”)

Plan Name

Marsh & McLennan Companies Limited Purpose Health Care Flexible Spending Account Plan

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Limited Purpose HCFSA
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 818926.

Source of Benefits Funding

The Limited Purpose HCFSA is self insured by the Company through contributions made by participating employees. These contributions are held in the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan.

Claims Administrator

Aetna FSA
P.O. Box 4000
Richmond, KY 40476-4000
Phone: (888) 238-6226

(Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For sending a completed claim:

Aetna FSA
P.O. Box 4000
Richmond, KY 40476-4000
Phone: (888) 238-6226
Fax: (888) 238-3539

For appealing a claim:

Aetna FSA
P.O. Box 4000
Richmond, KY 40476-4000
Phone: (888) 238-6226
Fax: (888) 238-3539

For COBRA coverage:

Ceridian
Phone: (800) 877-7994

Long Term Care Insurance Plan

Plan Name

Marsh & McLennan Companies Long Term Care Insurance Plan

Plan Number

510

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Long Term Care Insurance
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 105231-G.

Source of Benefits Funding

The Long Term Care Insurance Plan is insured through contracts with the following insurance company, who also administers claims for this plan and is solely responsible for providing benefits:

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166

Contributions are made solely by participating employees.

Claims Administrator

Metropolitan Life Insurance Company
Long Term Care Group
P.O. Box 937
Westport, CT 06881-0937

Contacts

For filing a claim:

Metropolitan Life Insurance Company
Long Term Care Group
P.O. Box 937
Westport, CT 06881-0937

For appealing a claim:

Metropolitan Life Insurance Company
Long Term Care Group
P.O. Box 937
Westport, CT 06881-0937

Long Term Disability Bonus Income Plan

Plan Name

Marsh & McLennan Companies Long Term Disability Bonus Income Plan

Plan Number

511

Plan Type

This is a welfare plan.

Plan Year

The plan year is July 1 - June 30.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Long Term Disability Bonus Income Plan
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 83082036.

Source of Benefits Funding

The Long Term Disability Bonus Income Plan is fully insured through The Hartford who administers claims for this plan and is solely responsible for providing disability benefits and determinations.

Contributions are made by the participating employees. These contributions are held in the Marsh & McLennan Companies Employer-Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
135 Santilli Highway
Everett, MA 02149

The Company has engaged the services of the Claims Administrator who is responsible for processing claims for this self-insured plan.

Claims Administrator

The Hartford Life Insurance Companies
LTD Benefit Management Services
P.O. Box 946710
Maitland, FL 32794-6710
Phone: (800) 303-9744
Fax: (407) 919-6329

Contacts

For filing a claim:

A claim form will automatically be sent to your home address. If you have been disabled for more than four months, and you have not received the forms, you can contact your Human Resources Representative.

For appealing a claim:

The Hartford Life Insurance Companies
Group Benefits
P.O. Box 946710
Maitland, FL 32794-6710

Phone: (800) 303-9744

The Mercer HR Services Retirement Plan

Plan Name

Mercer HR Services Retirement Plan

Plan Number

004

Plan Type

This a defined contribution plan under which accounts are maintained for each participant.

Plan Year

The Plan year is January 1-December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
1166 Avenue of the Americas
New York, NY 10036-2774

You are eligible to participate in the Plan if you are classified on the payroll as a U.S. salaried employee of Mercer HR Services.

Your service with Mercer HR Services includes service with Mercer, Putnam Investments (if you were employed by Mercer HR Services as of August 3, 2007), and Marsh & McLennan Companies, Inc. and all affiliated companies, as well as service with acquired companies that was recognized as service under the Marsh & McLennan Companies Retirement Plan.

Please note that certain former Mercer DBAS employees were given the opportunity to elect to participate in this Plan or continue participation in the Marsh & McLennan Companies Retirement Plan. Eligibility to make this election was based on age and service. If you were in this group and you elected to continue your participation in the Marsh & McLennan Companies Retirement Plan or you did not make an election, you are not eligible to participate in this Plan.

Plan Administrator

The Plan provides for administration by a Committee (consisting of three or more persons appointed by Marsh & McLennan Companies' Chief Executive Officer or Board of Directors). The Committee members may be removed at any time with or without cause. The Committee has full power and authority to administer the plan in its complete discretion.

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administration — Mercer HR Services Retirement Plan
c/o MMC Global Benefits Department, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of the Plan.

Source of Benefits Funding

The Mercer HR Services Retirement Plan is funded through Company contributions. The assets under the Mercer HR Services Retirement Plan are held in a tax-exempt trust by the following:

Northern Trust Company
801 South Canal Street
Chicago, IL 60607

The investment options currently available for investment are listed in the Mercer HR Services Retirement Plan section, in this Benefits Handbook,

The Plan provides that certain expenses of investment and administration, including fees of third-party service providers, may be paid out of Plan assets. Refunds of Section 12b-1 and other similar fees may be applied towards these expenses. The Plan Administrator will determine how to reasonably allocate these expenses among accounts.

Claims Administration

For filing a claim:

Mercer HR Services Retirement Plan Claims
c/o MMC Global Benefits Department, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River St.
Hoboken, NJ 07030-5794

For appealing a claim

Plan Administration — Mercer HR Services Retirement Plan Claims
c/o MMC Global Benefits Department, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River St.
Hoboken, NJ 07030-5794

The MMC Retirement Plan

Plan Name

Marsh & McLennan Companies Retirement Plan

Plan Number

001

Plan Type

The Retirement Plan is a funded, tax-qualified defined benefit pension plan under which benefits are determined under a formula and contributions are actuarially determined. The Benefit Equalization Plan and Supplemental Retirement Plan are non-qualified defined benefit plans which are excess benefit plans or plans for a select group of management or highly-compensated employees.

Plan Year

The Plan year is January 1-December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
1166 Avenue of the Americas
New York, NY 10036-2774

In addition to eligible employees of Marsh & McLennan Companies, Inc., the employee benefits plan described in this document covers employees classified on payroll as a U.S. salaried employee (including U.S. expatriates) of MMC or any related company that is a participating company in the Plan. Participating companies include MMC and all its subsidiaries and affiliates other than (with some exceptions for grandfathered participants) (i) Kroll, Inc. and its subsidiaries, (ii) CS Stars, LLC (formerly Corporate Systems, Inc.), and (iii) Mercer Human Resource Services, including Mercer HR Outsourcing, LLC and Mercer Trust Company.*

*Certain employees of Mercer HR Services who were formerly Mercer HR Consulting employees were given the opportunity to continue participation in the Plan or to elect participation in the Mercer HR Services Retirement Plan.

Individuals classified on payroll as hourly employees, student interns, employees in Puerto Rico, leased employees, U.S. citizens (or non U.S. citizens working in the U.S.) covered by a Company retirement plan in another country, any employee of a non-participating company who is loaned to a U.S. participating company, or individuals who are compensated as independent contractors are not eligible to participate.

Plan Administrator

The Plan provides for administration by a Committee (consisting of three or more persons appointed by Marsh & McLennan Companies' Chief Executive Officer or Board of Directors). The Committee members may be removed at any time with or without cause. The Committee has full power and authority to administer the plan in its complete discretion.

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – MMC Retirement Plan
c/o MMC Global Benefits Department, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Source of Benefits Funding

The tax qualified Retirement Plan is funded entirely through Company contributions and investment gains. Expenses not paid by the Company may be paid from the trust. The assets under the Retirement Plan are held in a tax-exempt master trust by the following:

The Northern Trust Company of Chicago, Illinois
50 South La Salle Street
Chicago, Illinois 60690

An Investment Committee of 3 or more persons is appointed by the Chief Executive Officer of the Company or the Board to manage and supervise Plan Investments.

Contacts

For filing a claim:

Plan Administrator
c/o MMC Global Benefits Department, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794

For appealing a claim:

Plan Administrator – MMC Retirement Plan
MMC Global Benefits Department, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794

The Optional Life Insurance Plan

Plan Name

Marsh & McLennan Companies Optional Life Insurance Plan

Plan Number

506

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Optional Life Insurance Plan
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 0100212.

Source of Benefits Funding

The Optional Life Insurance Plan is insured through contracts with the Claims Administrator, who administers claims for this plan and is solely responsible for providing benefits.

Contributions are made solely by participating employees. These contributions are held in the Marsh & McLennan Companies Employer Funded Welfare Benefit Trust by the trustees:

Putnam Fiduciary Trust Company
Putnam Place
859 Willard Street
Quincy, MA 02269-9110

and

Mellon Trust
One Cabot Road
Medford, MA 02155-5159

Benefits are payable solely from the trust.

Claims Administrator

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166

Contacts

For filing a claim:

Met Life
Group Life Claims
P.O. Box 3016
Utica, NY 13504

For appealing a claim:

Met Life
Group Life Claims
P.O. Box 3016
Utica, NY 13504

For converting your coverage:

Metropolitan Life Insurance Company
Phone: (877) ASK MET7
E-mail: solutions@metlife.com

For continuing your coverage through portability:

Metropolitan Life Insurance Company
Phone: (866) 492-6983 (from 8 a.m. to 8 p.m. Eastern time)

The Optional Long Term Disability Plan

Plan Name

Marsh McLennan Companies Optional Long Term Disability

Plan Number

506

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Optional Long Term Disability
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 83082035.

Source of Benefits Funding

The Optional Long Term Disability Plan is self-insured by the Company through contributions made by participating employees. These contributions are held in the Marsh & McLennan Companies Employer-Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
135 Santilli Highway
Everett, MA 02149

The Company has engaged the services of the Claims Administrator who is responsible for processing claims for this self-insured plan.

Claims Administrator

The Hartford Life Insurance Companies
P.O. Box 946710
Maitland, FL 32794-6710
Phone: (800) 303-9744
Fax: (407) 919-6329

Contacts

For filing a claim:

A claim form will automatically be sent to your home address. If you have been disabled for more than four months, and you have not received the forms, you can contact your Human Resources Representative.

For appealing a claim:

The Hartford Life Insurance Companies
Group Benefits
P.O. Box 946710
Maitland, FL 32794-6710
Phone: (800) 303-9744

The Personal Accident Insurance Plan

Plan Name

Marsh & McLennan Companies Personal Accident Insurance Plan

Plan Number

504

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Personal Accident Insurance Plan
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number for active employees is PAI 8062110.

The group contract number for retired employees is PAI 8062289.

Source of Benefits Funding

The Personal Accident Insurance Plan is insured through contracts with the Claims Administrator, who administers claims for this plan and is solely responsible for providing benefits.

Contributions are made solely by participating employees and retirees.

Claims Administrator

American International Life Assurance Company of New York (AIG)
AIG Claims Services, Inc.
A&H Claims Department
P.O. Box 15701
Wilmington, DE 19850-5701
Phone: (800) 551-0824

(Be sure to check your claim form for the address of the claims processing office.)

Contacts

For filing a claim:

American International Life Assurance Company of New York (AIG)
AIG Claims Services, Inc.
A&H Claims Department
P.O. Box 15701
Wilmington, DE 19850-5701
Phone: (800) 551-0824

For appealing a claim

American International Life Assurance Company of New York (AIG)
AIG Claims Services, Inc.
A&H Claims Department
P.O. Box 15701
Wilmington, DE 19850-5701
Phone: (800) 551-0824

For converting your coverage

American International Life Assurance Company of New York (AIG)
32 Old Slip, 22nd floor
New York, NY 10005
Phone: (646) 857-1585

Personal Life Insurance Plan

Plan Name

Marsh & McLennan Companies Personal Life Insurance Plan

Plan Number

509

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street – Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Personal Life Insurance
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is EGN 7200758.

Source of Benefits Funding

Personal Life Insurance is insured through contracts with the Claims Administrator, who administers claims for this plan and is solely responsible for providing benefits.

Contributions are made by participating employees.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this fully-insured plan.

Claims Administrator

Metropolitan Life Insurance Company
One Madison Avenue
New York, NY 10010

Contacts

For filing a claim:

Metropolitan Life Insurance Company
Claims Office
One Madison Avenue
New York, NY 10010-3690

For appealing a claim:

Metropolitan Life Insurance Company
Claims Office
One Madison Avenue
New York, NY 10010-3690

The Preferred Provider Organization Plan (“PPO”)

Plan Name

Marsh & McLennan Companies Preferred Provider Organization Plan

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – PPO
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 876230.

Source of Benefits Funding

The PPO is self insured by the Company through contributions made jointly by the Company and participating employees. These contributions are held in the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust by the trustees:

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
One Cabot Road
Medford, MA 02155-5159

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan.

Claims Administrator

Aetna
P.O. Box 843
Blue Bell, PA 19422-0843
Phone: 866-210-7858

(Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For filing a medical claim:

Aetna
P.O. Box 981109
El Paso, TX 79998-1109
Phone: 866-210-7858

For precertification:

Aetna
Phone: 800-333-4432

For filing a retail prescription drug claim:

Medco Health Solutions
P.O. Box 2187
Lee’s Summit, MO 64063-2187
Phone: 800-987-8360

For filing a mail-order prescription drug claim

Medco Health Solutions
P.O. Box 2187
Lee's Summit, MO 64063-2187
Phone: 800-987-8360

For appealing a medical claim:

Aetna
Appeals Resolution Team
P.O. Box 14463
Lexington, KY 40512

For appealing a prescription drug claim:

Medco Health Solutions
8111 Royal Ridge Parkway
Irving, TX 75063
Attn: Coverage Appeals

For COBRA coverage:

Ceridian
Phone: (800) 877-7994

The 401(k) Savings & Investment Plan

Plan Name

Marsh & McLennan Companies 401(k) Savings & Investment Plan

Plan Number

003

Plan Type

This is a defined contribution plan under which accounts are maintained for each participant. The plan qualifies as both a stock bonus 401(k) savings plan and an employee stock ownership plan.

Plan Year

The Plan year is January 1-December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
1166 Avenue of the Americas
New York, NY 10036-2774

The Plan covers employees of participating employers who are at least 18 years of age, and classified on payroll as U.S. salaried employees of MMC or any subsidiary or affiliate of MMC (other than Kroll) or classified as a regular employee of Kroll or any subsidiary or affiliate of Kroll.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan-Administrator – 401(k) Plan
c/o MMC Global Benefits Department, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of the plan.

Source of Benefits Funding

The 401(k) Savings & Investment Plan is funded through Company and employee contributions. The assets under the 401(k) Savings & Investment Plan are held in a tax-exempt trust by the following:

The Northern Trust Company
801 South Canal Street
Chicago, Illinois 60607

The investment options currently available for investment are listed in the 401(k) Savings & Investment Plan section in this Benefits Handbook. Current prospectuses and certain other financial information about these funds are available on request.

The Plan provides that certain expenses of investment and administration, including fees for third-party service providers, may be paid out of Plan assets. Refunds of Section 12b-1 and other similar fees may be applied towards these expenses. The Plan Administrator will determine how to reasonably allocate these expenses among accounts.

Contacts

For filing a claim:

401(k) Plan Claims
c/o MMC Global Benefits Department, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794

For appealing a claim:

Plan Administrator – 401(k) Plan
c/o MMC Global Benefits Department, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794

The Short Term Disability Benefits Policy

Plan Name

Marsh & McLennan Companies Short Term Disability Benefits Policy

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator can be reached at:

Plan Administrator – Short Term Disability
Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator will serve as the appellate body if an employee disagrees with the determination as to whether he/she comes within the definition of an eligible employee, or the determination as to whether he/she satisfies an eligibility date requirement or otherwise complied with the mandatory claim filing process.

All other matters not covered by the Plan Administrator appeal process should be referred to the Claims Administrator.

The Company has engaged the services of the Claims Administrator who is responsible for processing claims for this benefits policy.

Claims Administrator

The Hartford
P.O. Box 946710
Maitland, FL 32794-6710
Phone: (800) 303-9744

Claims Administrator Appeals should be sent to:

The Hartford-Comprehensive Employee Benefit Services Company
Maitland Claim Appeal Unit
P.O. Box 946710
Maitland, FL 32794
Phone: (800) 303-9744

Contacts

For filing a claim, please refer to the *Filing a Claim* sub-section of the Short Term Disability Benefits Policy.

Spouse Life Insurance Plan

Plan Name

Marsh & McLennan Companies Spouse Life Insurance Plan

Plan Number

507

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan Administrator – Spouse Life Insurance Plan
c/o Global Benefits, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 0100212.

Source of Benefits Funding

Spouse Life Insurance is insured through contracts with the Claims Administrator, who administers claims for this plan and is solely responsible for providing benefits.

Contributions are made by participating employees.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this fully-insured plan.

Claims Administrator

Metropolitan Life Insurance Company
200 Park Avenue
New York, NY 10166

(This is the main business address of the Administrator. Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For filing a claim:

Met Life
Group Life Claims
P.O. Box 3016
Utica, NY 13504

For appealing a claim:

Met Life
Group Life Claims
P.O. Box 3016
Utica, NY 13504

For converting your coverage:

Metropolitan Life
Phone: 877-ASK MET7
E-mail: solutions@metlife.com

The Vision Care Plan

Plan Name

Marsh & McLennan Companies Vision Care Plan

Plan Number

511

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 – December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Eligible employees of Marsh & McLennan Companies, Inc. are covered by the employee benefits plan described in this document, as well as eligible employees of any subsidiary or affiliate which:

- Is designated by the Board of Directors of Marsh & McLennan Companies, Inc. as a participating employer under this plan; and
- Has adopted the plan.

You may write to the Plan Administrator to learn which employers participate in this plan.

Plan Administrator

The Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Plan-Administrator – 401(k) Plan
c/o MMC Global Benefits Department, 6th Floor
Marsh and McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: (201) 284-4000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of the plans except to the extent authority has been granted to the Claims Administrator for adjudication of claims.

Group Contract Number

The group contract number is 12222153.

Source of Benefits Funding

The Vision plan is fully insured through VSP, who administers claims for this plan and is solely responsible for providing vision benefits and determinations.

Contributions are made by participating employees. These contributions are held in the Marsh & McLennan Companies Employer-Funded Welfare Benefit Trust by the trustees;

Mercer Trust Company
Investors Way
Norwood, MA 02062

and

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Premium payments are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan.

Claims Administrator

VSP
3333 Quality Drive
Rancho Cordova, CA 95670

(Be sure to check your claim form or instructions for the address of the claims processing office.)

Contacts

For filing an out-of-network claim:

VSP
P.O. Box 997100
Sacramento, CA 95899

For appealing a claim:

VSP
3333 Quality Drive
Rancho Cordova, CA 95670
Phone: 800-877-7195

For COBRA coverage:

Ceridian
Phone: 800-877-7994

Other Administrative Details

Employer Identification Number (EIN)

As Plan Sponsor, the Company files benefit plan reports with the Federal Government under Employer Identification Number:

36-2668272

Agent for Legal Process

We hope you never feel you need to resort to legal action to enforce your rights. However, if you feel you have cause for legal action after you have exhausted the plan's claims appeal process, a timely complaint may be served on the Claims Administrator (or Plan Administrator, as applicable), shown below, or the Company's General Counsel at:

Marsh & McLennan Companies, Inc.
1166 Avenue of the Americas
New York, NY 10036

Service of legal process may be made upon the Plan Administrator or a Plan trustee as well.

Remember, actions generally must be brought within three years of the date your benefit was denied (or the date your cause of action first arose, if earlier) unless a shorter period is allowed, or a longer period is required, by applicable state insurance law but only if such state insurance law is not pre-empted by ERISA.

California State Law

Except where pre-empted by ERISA or other U.S. laws, the validity of the Kaiser HMO plan and any of its provisions will be determined under the laws of the State of California without giving effect to principles of conflict of laws.

Hawaii State Law

Except where pre-empted by ERISA or other U.S. laws, the validity of the Hawaii HMO and PPP plans and any of their provisions will be determined under the laws of State of Hawaii without giving effect to principles of conflict of laws.

New York State Law

Except where pre-empted by ERISA or other U.S. laws, the validity of the plans (with the exception of the Kaiser HMO, Hawaii HMO and Hawaii PPP) and any of their provisions will be determined under the laws of New York State without giving effect to principles of conflict of laws.

ERISA, and Your Rights under ERISA

The following plans are subject to the Employee Retirement Income Security Act of 1974 (ERISA):

Health & Welfare Plans

- The Basic Life Insurance Plan
- The Basic Long Term Disability Plan
- The Business Travel Accident Insurance Plan
- The Comprehensive Medical Plan (“CMP”)
- The Consumer Directed Health Plan (“CDHP”)
- The Dental Plan
- The Dependent Care Flexible Spending Account Plan (“DCFSA”)
- The Dependent Children Life Insurance Plan
- The Employee Assistance Plan (“EAP”)
- The Exclusive Provider Organization Plan (“EPO”)

- Hawaii – HMSA's Health Plan Hawaii Plus ("HMO")
- Hawaii – HMSA's Preferred Provider Plan ("PPP")
- The Health Care Flexible Spending Account Plan ("HCFSA")
- The Health Savings Account ("HSA")
- The Kaiser Foundation Health Plan, California – North & South ("HMO")
- The Legal Assistance Plan
- The Limited Purpose Health Care Flexible Spending Account Plan ("LPHCFSA")
- The Long Term Care Insurance Plan
- The Long Term Disability Bonus Income Plan
- The Optional Life Insurance Plan
- The Optional Long Term Disability Plan
- The Personal Accident Insurance Plan
- The Personal Life Insurance Plan
- The Preferred Provider Organization Plan ("PPO")
- The Short Term Disability Benefits Policy
- The Vision Care Plan

Tax-qualified Retirement and Savings Plans

- The Mercer HR Services Retirement Plan
- The MMC Retirement Plan
- The MMC 401(k) Savings & Investment Plan

Your Rights under ERISA

As a participant in a plan subject to ERISA, you are entitled to certain rights and protections under ERISA. ERISA entitles you to:

- Receive information about the plan and your benefits.
- Examine, at the Plan Administrator's office and other specified locations, including work sites, without charge, all plan documents governing the plan. These documents may include insurance contracts, if applicable, and 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 Benefit Security Administration.

- Obtain, after sending a written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, if applicable, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. You may be asked to pay a reasonable charge for the copies of documents which are not part of the prospectus.
- Receive a written summary of the plan's annual financial report. The Plan Administrator is required by law to provide each participant with a copy of this summary annual report. See "Summary Annual Reports" on page 73.
- For applicable plans, obtain a statement telling you whether you have a right to receive a retirement plan benefit at normal retirement age (age 65) and, if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a retirement benefit, the statement will tell you how many more years you have to work to get a right to a benefit. This statement must be requested in writing and is not required to be given more than once every three years in the case of the MMC Retirement Plan, and once every twelve months in the case of the MMC 401(k) Savings & Investment Plan or the Mercer HR Services Retirement Plan. The plan must provide the statement free of charge. Currently, updated monthly statements are available on Total Rewards accessible via MMC PeopleLink (www.mmcpeoplelink.com).
- For applicable plans, continue health care coverage for yourself, spouse, or covered family members if there is a loss of coverage under the plan as a result of a qualifying event. You or your covered family members may have to pay for such coverage. Review the Summary Plan Description and the documents governing the plan on the rules governing your continuation coverage rights under the Consolidated Omnibus Budget Reconciliation Act ("COBRA").
- For applicable plans, the reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when 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 preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties on the people responsible for the operation of the plans. The people who operate these plans, called "fiduciaries", have a duty to do so prudently and in the best interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a benefit under a plan is denied or ignored, in whole or in part, you have a right to know why this was done, including the provision of the plan on which the denial was based, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are several steps you can take to enforce your rights. For instance, under certain circumstances, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, 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 Plan Administrator's control.

If you have a claim for benefits that is denied or ignored, in whole or in part, and you have appealed all adverse determinations, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack of decision about the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court, as applicable. 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 federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about any of these plans, contact the Claims Administrator or the Plan Administrator, as applicable. If you have 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, U.S. Department of Labor, listed in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Summary Plan Descriptions

Plans subject to ERISA, described under "ERISA, and Your Rights under ERISA" on page 68, are required to provide summary plan descriptions (SPDs) for those plans. This Benefits Handbook serves as the summary plan description for the following plans:

Health & Welfare Plans

- The Basic Life Insurance Plan
- The Basic Long Term Disability Plan
- The Business Travel Accident Insurance Plan
- The Comprehensive Medical Plan ("CMP")
- The Consumer Directed Health Plan ("CDHP")
- The Dental Plan
- The Dependent Care Flexible Spending Account Plan ("DCFSA")
- The Dependent Children Life Insurance Plan
- The Employee Assistance Plan ("EAP")
- The Exclusive Provider Organization Plan ("EPO")
- Hawaii – HMSA's Health Plan Hawaii Plus ("HMO")
- Hawaii – HMSA's Preferred Provider Plan ("PPP")
- The Health Care Flexible Spending Account Plan ("HCFSA")
- The Health Savings Account ("HSA")
- The Kaiser Foundation Health Plan, California – North & South ("HMO")
- The Legal Assistance Plan
- The Limited Purpose Health Care Flexible Spending Account Plan ("LPHCFSA")
- The Long Term Care Insurance Plan
- The Long Term Disability Bonus Income Plan
- The Optional Life Insurance Plan
- The Optional Long Term Disability Plan
- The Personal Accident Insurance Plan
- The Personal Life Insurance Plan
- The Preferred Provider Organization Plan ("PPO")
- The Vision Care Plan)

About SPDs

Summary plan descriptions (SPDs) are intended to provide you with easy-to-understand general explanations of the more significant provisions of your benefit plans. If any conflict should arise between the Summary Plan Description and the provisions of the plan, or if any provision is not explained or only partially explained in the Summary Plan Description, your rights will be determined under the provisions of the plan document (which may be changed from time to time), as interpreted by the Claims Administrator or Plan Administrator, as applicable.

Tax-qualified Retirement and Savings Plans

- The Mercer HR Services Retirement Plan
- The MMC Retirement Plan
- The MMC 401(k) Savings & Investment Plan

The information presented in these Summary Plan Descriptions is intended to comply with the disclosure requirements of the regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act of 1974 (ERISA).

Summary Annual Reports

The summary annual report ("SAR") is a written summary of the plan's annual financial report. The Plan Administrator is required by federal law to provide participants with a copy of the summary annual report for certain plans.

The following tables list the current available SARs and provide a link to a PDF file of each SAR.

2007 SARs

SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies 401(k) Savings and Investment Plan	http://mmcbenefits-handbook.mmcpeoplelink.com/Prod/CURR/2007-sar-mmc-sip.pdf	2007	▪ MMC 401(k) Savings and Investment Plan (formerly the MMC Stock Investment Plan)
Marsh & McLennan Companies Retirement Plan	http://mmcbenefits-handbook.mmcpeoplelink.com/Prod/CURR/2007-sar-mmc-retirement-plan.pdf	2007	▪ MMC Retirement Plan
Marsh & McLennan Companies, Inc. Employee Funded Welfare Benefit Trust	http://mmcbenefits-handbook.mmcpeoplelink.com/Prod/CURR/2007-sar-mmc-ees-welfare-ben-plan.pdf	2007	▪ Optional Long-Term Disability Plan ▪ Optional Life Insurance Plan ▪ Long-Term Care Plan

SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust	http://mmcbenefits-handbook.mmcpeoplelink.com/Prod/CURR/2007-sar-mmc-er-welfare-ben-plan.pdf	2007	▪ Aetna PPO ▪ Aetna CDHP ▪ Metlife Dental Plan ▪ Blue Cross Blue Shield EPO ▪ United Healthcare EPO ▪ United Healthcare Comprehensive Medical Plan (“Retiree Medical Plan”) ▪ Medco Pharmacy Plan ▪ Basic Long-Term Disability Plan ▪ Basic Life Insurance Plan ▪ Health Care Flexible Spending Account ▪ Dependent Care Flexible Spending Account ▪ Fully Insured HMO and PPO (Kaiser Plans)
Marsh & McLennan Companies, Inc. Group Benefits	http://mmcbenefits-handbook.mmcpeoplelink.com/Prod/CURR/2007-sar-mmc-group-benefit-plan.pdf	2007	▪ Hyatt Legal Plan ▪ American International Life (Accidental Death and Dismemberment Plan) ▪ Vision Service Plan (VSP) ▪ American International Life (Business Travel Accident Plan) ▪ Connecticut General Life Insurance Company (Employee Assistance Program) ▪ MetLife (Personal Life Insurance Plan)
Mercer HR Services Retirement Plan	http://mmcbenefits-handbook.mmcpeoplelink.com/Prod/CURR/2007-sar-mmc-hr-services-plan.pdf	2007	▪ Mercer HR Services Retirement Plan

2006 SARs

SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies 401(k) Savings and Investment Plan	http://mmcbenefits-handbook.mmcpeoplelink.com/Prod/CURR/2006-SAR-MMC-SIP.pdf	2006	▪ MMC 401(k) Savings and Investment Plan (formerly the MMC Stock Investment Plan)
Marsh & McLennan Companies Retirement Plan	http://mmcbenefits-handbook.mmcpeoplelink.com/Prod/CURR/2006-SAR-MMC-Retirement-Plan.pdf	2006	▪ MMC Retirement Plan
Marsh & McLennan Companies, Inc. Employee Funded Welfare Benefit Trust	http://mmcbenefits-handbook.mmcpeoplelink.com/Prod/CURR/2006-SAR-MMC-EEs-Welfare-Ben-Plan.pdf	2006	▪ Optional Long-Term Disability Plan ▪ Optional Life Insurance Plan ▪ Long-Term Care Plan
Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust	http://mmcbenefits-handbook.mmcpeoplelink.com/Prod/CURR/2006-SAR-MMC-Er-Welfare-Benf-Plan.pdf	2006	▪ Aetna PPO ▪ Aetna CDHP ▪ Metlife Dental Plan ▪ Blue Cross Blue Shield EPO ▪ United Healthcare EPO ▪ United Healthcare Comprehensive Medical Plan (“Retiree Medical Plan”) ▪ Medco Pharmacy Plan ▪ Basic Long-Term Disability Plan ▪ Basic Life Insurance Plan ▪ Health Care Flexible Spending Account ▪ Dependent Care Flexible Spending Account ▪ Fully Insured HMO and PPO (Kaiser Plans)

SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Group Benefits	http://mmcbenefits-handbook.mmcpeoplelink.com/Prod/CURR/2006-SAR-MMC-Group-Benefit-Plan.pdf	2006	▪ Hyatt Legal Plan ▪ American International Life (Accidental Death and Dismemberment Plan) ▪ Vision Service Plan (VSP) ▪ American International Life (Business Travel Accident Plan) ▪ Connecticut General Life Insurance Company (Employee Assistance Program) ▪ MetLife (Personal Life Insurance Plan)
Mercer HR Services Retirement Plan	http://mmcbenefits-handbook.mmcpeoplelink.com/Prod/CURR/2006-SAR-MMC-HR-Services-Plan.pdf	2006	▪ Mercer HR Services Retirement Plan

Plan Summaries

This Benefit Handbook also includes plan summaries for non-ERISA plans. This Benefit Handbook includes plan summaries for the following plans:

- The Benefit Equalization Plan
- The Choice Auto and Home Insurance Program
- The Group Umbrella Liability Insurance Program
- The Identity Theft Plan
- The Pet Insurance Program
- The Short Term Disability Benefits Policy
- The Stock Purchase Plan
- The Supplemental Retirement Plan
- The Supplemental Savings & Investment Plan
- The Transportation Reimbursement Incentive Program
- The Vision Discount Program

Official Plan Documents

This Benefits Handbook serves as the official plan document for the following plans:

- The Basic Life Insurance Plan
- The Basic Long Term Disability Plan
- The Business Travel Accident Insurance Plan
- The Comprehensive Medical Plan (“CMP”)
- The Consumer Directed Health Plan (“CDHP”)
- The Dental Plan
- The Dependent Care Flexible Spending Account Plan (“DCFSA”)
- The Dependent Children Life Insurance Plan
- The Employee Assistance Plan (“EAP”)
- The Exclusive Provider Organization Plan (“EPO”)
- Hawaii – HMSA’s Health Plan Hawaii Plus (“HMO”)
- Hawaii – HMSA’s Preferred Provider Plan (“PPP”)
- The Health Care Flexible Spending Account Plan (“HCFSA”)
- The Health Savings Account (“HSA”)
- The Kaiser Foundation Health Plan, California – North & South (“HMO”)
- The Legal Assistance Plan
- The Limited Purpose Health Care Flexible Spending Account Plan (“LPHCFSA”)
- The Long Term Care Insurance Plan
- The Long Term Disability Bonus Income Plan
- The Optional Life Insurance Plan
- The Optional Long Term Disability Plan
- The Personal Accident Insurance Plan
- The Personal Life Insurance Plan
- The Preferred Provider Organization Plan (“PPO”)
- The Short Term Disability Benefits Policy
- The Spouse Life Insurance Plan
- The Vision Care Plan
- The Vision Discount Program

Life and Accident Insurance, Long Term Care Insurance, Legal Assistance and EAP Plans

The Claims Administrators use the Plans' description in the Benefits Handbook to make determinations on claims for benefits under the Plans. (Should any plan provision described become invalid or unenforceable, it will not affect the validity or enforceability of any other plan provision.) When necessary, the Claims Administrators may also refer to their internal guidelines in making claims/benefits determinations. The Claims Administrators have full discretion and authority to make all such claims/benefits determinations.

How to Obtain Plan Documents

Copies of plan documents and certain related documents such as insurance company contracts and trust agreements, (to the extent applicable) are available to review upon written request to the Plan Administrator or Marsh & McLennan Companies, Inc.'s General Counsel. A copy of any of these documents will be furnished to a plan participant or beneficiary (or an authorized representative) upon request at a reasonable charge of 25 cents per page to cover reproduction and handling. Note that this Benefits Handbook constitutes the plan document, as applicable.

Plan Amendments

Health & Welfare Plans

Amendments to any health or welfare plan provision, such as those regarding eligibility for coverage and the benefits provided under these plans, are made by updating this Benefits Handbook and, where applicable, these plans' Guide to Benefits. Any such amendments are communicated to you by revising the Benefits Handbook, or through Marsh & McLennan Companies, Inc.'s internal employee communication channels, and, where applicable, these plans' Guide to Benefits.

Tax-qualified Retirement and Savings Plans

Amendments to any retirement or savings plan provision, including amendments regarding eligibility for participation and the benefits provided under these plan, are made only by written amendments to the applicable plan document. Amendments may be made by the Board of Directors of Marsh & McLennan Companies, Inc. The Board of Directors has in the past delegated to certain officers authority to adopt amendments necessary to keep these plans tax qualified or to make *de minimis* changes. Any material amendments are communicated to you by revising this section of the Benefits Handbook, or through Marsh & McLennan Companies, Inc.'s internal employee communication channels, including the distribution of a Summary of Material Modifications.

Plan Termination

Life and Accident Insurance, Long Term Care Insurance, Legal Assistance and EAP Plans

While the Company intends to continue these benefit plans and programs indefinitely, the Company reserves the right to terminate or amend this plan, in whole or part, at any time and for any reason as it deems advisable, as to any and all employees covered. In fact, as a matter of prudent business planning, the Company periodically evaluates the Benefits Program.

Retirement and Savings Plans

While MMC intends to continue the retirement plans described in the Benefits Handbook indefinitely, MMC reserves the right to terminate or amend any plan or plans, in whole or part, at any time and for any reason as it deems advisable, as to any and all employees covered. In fact, as a matter of prudent business planning, MMC periodically evaluates its benefits programs.

However, if MMC should exercise its right to amend, modify or terminate a retirement plan, you will not be deprived of any benefit you have accrued to the date of such modification, suspension or termination, and you may have preserved rights as to your benefits (such as an account balance in a savings plan) as of the date of the change, although changes may be made retroactively to comply with applicable laws.

For the following retirement plans, if a plan is terminated or if there is a complete discontinuance of contributions, all accounts of affected participants that are not otherwise fully (100%) vested will become 100% vested and will be paid to you under the circumstances and in the manner as determined by MMC's Board of Directors:

- The Mercer HR Services Retirement Plan
- The MMC 401(k) Savings & Investment Plan

Amounts accumulated under these defined contribution plans are not insured by the Pension Benefit Guaranty Corporation (PBGC), a federal agency, if any of these plans terminates.

Your accrued benefits under the MMC Retirement Plan are insured by the PBGC. if the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits under their plan, but some people may lose certain benefits.

The PBGC guarantee generally covers: (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the plan terminates; and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates; (3) benefits that are not vested because you have not worked enough for the Company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

Even if certain of your benefits are not guaranteed, you may still receive some of these benefits from the PBGC depending on how much money your plan has and how much the PBGC collects from employers.

For more information about the PBGC and the benefits it guarantees, ask the Plan Administrator or contact the PBGC's Technical Assistance Division, 1200 K Street N.W., Suite 930, Washington, D.C. 20005-4026 or call 202-326-4000 (not a toll-free number). TTY/TDD users may call the federal relay toll-free at 1-800-877-8339 and ask to be connected to 202-326-4000. Additional information about the PBGC's pension insurance program is available through the PBGC's website on the Internet at www.pbgc.gov.

If it ever becomes necessary to terminate the MMC Retirement Plan, accrued benefits of affected participants will be 100% vested (to the extent funded or guaranteed) and assets will be used to pay out benefits in the form of non-transferable annuity contracts and/or lump sums in accordance with legal requirements. The MMC Retirement Plan provides that, in the event of a complete termination, any excess assets remaining after all liabilities have been satisfied will revert to the Company.

Other qualified plans may be merged into any of the retirement and savings plans, and any of the retirement and savings plans may also be merged, in whole or in part, into or with another plan. However, in no event will your benefit immediately after the transfer or merger (determined as if the plan terminated) be less than your benefit immediately prior to the transfer or merger (determined as if the plan terminated).

Limits on Plan Amendments

Limits on plan amendments, including changes in actuarial factors, options and subsidies

The Internal Revenue Code provides that no plan amendment may retroactively reduce your previously accrued benefit under a tax qualified plan, unless necessary to keep the plan tax qualified. This means, for example, that if the benefit formula is changed in the future by an amendment to the tax-qualified plan, your accrued benefit after the amendment may never be less than your accrued benefit before the amendment. These rules also currently provide that certain changes in the actuarial factors used to calculate your benefits and the options and early retirement subsidiaries available under that plan may not be applied to your accrued benefit prior to the change. In addition to being notified of any future changes in the benefit formula, you will be notified when tax qualified plan assumptions or options are changed if you need to be informed of any rights you have that were protected by law as of the date of the change.

Claims, Reviews, and Appeals

This section describes some general rules about claims and how benefits are paid, and how you can have payment decision reviewed and how you can appeal a claim decision.

Authority over Benefit Determinations and Appeals

Health and Welfare Plans

The Claims Administrator or Plan Administrator, as applicable, and any reviewing committee have full discretion and authority to determine all claims for benefits under the plan. Claims not involving specific benefits, but concerning eligibility or enrollment should be addressed to the Plan Administrator. Any action or determination in this review procedure will be final, conclusive, and binding on the Claims and Plan Administrators, the Company, the plan participant and his or her legal representative, and the participant's family members and their legal representatives. The Claims Administrator's decision is based only on whether or not benefits are available under the plan for the proposed treatment or procedure. The determination as to whether the pending health service is necessary and appropriate is determined by you and your physician.

No action for benefits may be brought by any participant or beneficiary unless the plan's claim review procedure has been exhausted (that is, all appeals of adverse decisions have been made). Any such action must be commenced within three years of the first date by which all essential facts and circumstances which support your claim had arisen, provided that the three year period will never begin later than the date on which the claim arose or a final determination denying your claim, in whole or in part, has been issued under the procedures described below.

Tax-qualified Retirement and Savings Plans

The Claims Administrator of the retirement and savings plans uses the claims procedure described in this section of the Benefits Handbook to make determinations on claims for benefits under a retirement or savings plan. The Claims Administrator has been delegated full discretion and the maximum authority to interpret the applicable plan and make all initial claims/benefits determinations permitted by law.

No action for benefits may be brought by any participant or beneficiary unless the plan's claim review procedure has been exhausted (that is, all appeals of adverse decisions have been made). Any such action must be commenced within three years of the first date by which all essential facts and circumstances which support your claim had arisen, provided that the three year period will never begin later than the date on which the claim arose or a final determination denying your claim, in whole or in part, has been issued under the procedures described below.

Healthcare Plans and Healthcare Flexible Spending Accounts

Refer to the Kaiser HMO's member handbook for information on the benefits determination process including claims and appeals.

Refer to HMSA's "Guide to Benefits" document for information on the benefits determination process including claims and appeal for the Hawaii HMO and PPP plans.

For all other health care plans, see below for information on the benefits determination process including claims and appeals.

Medical and Dental Benefit Determinations

Three types of claims can be made for benefit determinations: pre-service claims, post-service claims, and claims involving urgent care.

- A pre-service claim is any claim for a benefit under a group health plan for which the plan requires approval or notification before medical care is obtained.
- A post-service claim is any claim for a benefit under a group health plan that is not a pre-service claim.
- A claim involving urgent care is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Note, a post-service claim would never constitute a claim involving urgent care.

Claims for benefits and appeals of claims should be directed to the Claims Administrator for the applicable plan. See "Headings, Navigation Menus, Tables of Contents, Etc." on page 1

Note that the various headings and sub-headings in the Benefits Handbook (which produce the website navigation menus and the tables of contents in the printed version) are provided for your convenience and in no way define, limit, or otherwise describe the scope or intent of the plans. See "Administrative Details about the Plans" on page 1 for the name and contact information for the Claims Administrator for each plan.

Vision and EAP Benefit Determinations

The one type of claim that can be made for benefit determinations is a post-service claim.

- A post-service claim is any claim for a benefit under a group health plan that is not a pre-service claim.

Note, a post-service claim would never constitute a claim involving urgent care.

Claims for benefits and appeals of claims should be directed to the Claims Administrator for the applicable plan. See "Headings, Navigation Menus, Tables of Contents, Etc." on page 1

Note that the various headings and sub-headings in the Benefits Handbook (which produce the website navigation menus and the tables of contents in the printed version) are provided for your convenience and in no way define, limit, or otherwise describe the scope or intent of the plans.

See "Administrative Details about the Plans" on page 1 for the name and contact information for the Claims Administrator for each plan.

Timing of Notification of Pre-service Claim Benefit Determination

In the case of a pre-service claim, the Claims Administrator will notify you of the benefit determination (whether adverse or not) no later than 15 days after your claim is received. This period may be extended one time by the Claims Administrator for up to 15 days, provided that the extension is necessary due to matters beyond the control of the Claims Administrator and you are notified prior to the expiration of the initial 15-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within 15 days after the claim was received and may request a one-time extension not longer than 15 days and suspend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day timeframe, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, describe any additional material or information necessary to complete the claim so it may be processed, and provide the claim appeal procedures.

Timing of Notification of Post-service Claim Benefit Determination

In the case of a post-service claim, the Claims Administrator will notify you of the benefit determination (whether adverse or not) no later than 30 days after your claim was received. This period may be extended one time by the Claims Administrator for up to 15 days, provided that the extension is necessary due to matters beyond the control of the Claims Administrator and you are notified prior to the expiration of the initial 30-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If additional information is needed to process the claim, the Claims Administrator will notify you within this 30-day period and may request a one-time extension of not more than 15 days and suspend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day timeframe, the Claims Administrator will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, describe any additional material or information necessary to complete the claim so it may be processed, and provide the claim appeal procedures.

Timing of Notification of Benefit Determinations Involving Urgent Care Claims

In the case of a claim involving urgent care, the Claims Administrator will notify you of the benefit determination (whether adverse or not) no later than 72 hours after your claim is received. If additional information is needed to process the claim, the Claims Administrator will notify you within 24 hours after receipt of your claim of the specific information necessary to complete the claim. Once notified of the extension, you then have 48 hours to provide this information. If all of the needed information is received within the 48-hour timeframe, the Claims Administrator will notify you of the determination within 48 hours after the information is received. If you don't provide the needed information within the 48-hour period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, describe any additional material or information necessary to complete the claim so it may be processed, and provide the claim appeal procedures.

Ongoing Treatment Involving Urgent Care Claims

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and the treatment involves urgent care, your request will be decided within 24 hours, provided your request is made at least 24 hours prior to the end of the approved treatment. The Claims Administrator will make a determination on your request for the extended treatment within 24 hours from receipt of your request. If you do not make a request for extended treatment involving urgent care at least 24 hours prior to the end of the approved treatment, the request will be treated as an urgent care claim and decided according to the urgent care claim benefit determination timeframes, (i.e., no later than 72 hours from receipt of your request).

Ongoing Treatment Not Involving Urgent Care Claims

If a request to extend a course of treatment beyond the period of time or number of treatments previously approved does not involve urgent care, the request will be treated as a new benefit claim and decided within the time frame appropriate to the type of claim (i.e., as a pre-service or post-service claim).

Appeal of Benefit Determinations Not Involving Urgent Care Claims

If you believe your benefits under a plan were denied improperly, you may file a written appeal for the unpaid amount within 180 days of your receipt of notification of the adverse benefit determination. The written appeal should specify the amount of the claim, include any other written comments, documents, records or other information that may be pertinent and should be sent to the Claims Administrator.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 60 days from receipt of the first level appeal decision.

For appeals of a pre-service claim, the first level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted and you will be notified by the Claims Administrator of the decision within 15 days from receipt of a request for review of the first level appeal decision.

For appeals of a post-service claim, the first level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for appeal of a denied claim. The second level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 30 days from receipt of a request for review of the first level appeal decision.

Appeal of Benefit Determinations Involving Urgent Care Claims

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations, the appeal does not need to be submitted in writing. You or your physician should call the Claims Administrator as soon as possible. The Claims Administrator will provide you with a written or electronic determination within 72 hours following receipt of your request for review of the determination taking into account the seriousness of your condition.

Improper Filing of Pre-service Claims and Urgent Care Claims

If you filed a pre-service or urgent care claim improperly, the Claims Administrator will notify you of the improper filing and how to correct it within five days (24 hours in the case of a failure to file a claim involving urgent care) after the pre-service claim was received.

Claims Concerning Eligibility and Enrollment

If your claim concerns whether or not you or a family member is eligible for coverage under the plan or whether you or a family member has properly enrolled in the plan, you may file a claim with the Plan Administrator for coverage. The claim should be in writing and specify the circumstances under which you do not have coverage, why you believe you should have coverage and include any mitigating factors, documents, records or other information that may be pertinent and should be sent to the Plan Administrator. You may file a written appeal with the Plan Administrator within 180 days of your notification of an adverse claim determination. A written appeal of a denied claim should include all the information necessary for the original claim as well as any additional information you would like the plan to consider.

Subrogation

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

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

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

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

Dependent Care Flexible Spending Account Plan

Timing of Notification of Benefits Determination

In the case of a claim, the Claims Administrator will notify you of the benefit determination (whether adverse or not) no later than 90 days after your claim was received. This period may be extended one time by the Claims Administrator for up to 90 days, provided that the extension is necessary due to matters beyond the control of the Claims Administrator and you are notified prior to the expiration of the initial 90- day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If additional information is needed to process the claim, the Claims Administrator will notify you within this 90-day period and may request a one-time extension of not more than 90 days and suspend your claim until all information is received. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, describe any additional material or information necessary to complete the claim so it may be processed, and provide the claim appeal procedures.

Appeal of Benefits Determinations

If you believe your benefits under a plan were denied improperly, you may file a written appeal for the unpaid amount within 60 days of receipt of notification of the adverse benefit determination. The written appeal should specify the amount of the claim, include any other written comments, documents, records or other information that may be pertinent, and should be sent to the Claims Administrator.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 180 days from receipt of the first level appeal decision. The second level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 60 days from receipt of a request for review of the first level appeal decision.

Upon request, you will be provided, free of charge, reasonable access to, and copies of, al documents, funds, and other information relevant to your claim for benefits.

Disability Plans

Timing of Notification of Claim for Disability Benefits Determinations

In the case of a claim for disability benefits, the Claims Administrator will notify you of the benefit determination (whether adverse or not) no later than 45 days after your claim was received. This period may be extended one time by the Claims Administrator for up to 30 days, provided that the extension is necessary due to matters beyond the control of the Claims Administrator and you are notified prior to the expiration of the initial 45-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision. If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within this 45-day period and may request a one-time extension not longer than 45 days and suspend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day timeframe, the Claims Administrator will notify you of the determination within 45 days after the information is received. If you don’t provide the needed information within the 45-day period, your claim will be denied. A denial notice will explain the reason for denial, refer to the part of the Plan on which the denial is based, describe any additional material or information necessary to complete the claim so it may be processed, and provide the claim appeal procedures.

Note, for plans providing disability benefits, a copy of the specific rule, guideline or protocol relied upon or a statement that such rule, guideline or protocol will be provided free of charge to the claimant upon request must be provided.

Timing of Appeal of Claim for Disability Benefits Determinations

If you believe your claim for disability benefits under the plan was denied improperly, you may file a written claim for the unpaid amount within 180 days of receipt of the denial. The written claim should specify the amount of the claim and any other written comments, documents, records or other information that may be pertinent and should be sent to the Claims Administrator.

The first level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 45 days from receipt of a request for appeal of a denied claim. This period may be extended one time by the Claims Administrator for up to 45 days, provided that you are notified prior to the expiration of the initial 45-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator. Your second level appeal request must be submitted to the Claims Administrator within 180 days from receipt of the first level appeal decision. The second level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 45 days from receipt of a request for review of the first level appeal decision.

If you do not file a written request for appeal of a denied claim within 180 days from the date you received your claim denial, your claim will be closed and your right to appeal will terminate. Appeals that are submitted after this timeframe cannot be considered.

Subrogation

To the maximum extent permitted by law, the disability plans are entitled to equitable or other permitted remedies, including a lien or constructive trust, to recover any amounts received as a result of a judgment, settlement or other means of compensation for conditions or injuries which have resulted in the payment of benefits under the disability plans. This shall include, but is not limited to, damages for pain and suffering and lost income. The disability plans are entitled to recover these amounts from the participant, any covered family member or beneficiary, or any other person holding them, up to the amount of all payments made or payable in the future plus costs of recovery. The disability plans have a priority interest in any and all funds recovered in any full or partial recovery, including funds intended to compensate for attorney's fees and other expenses.

As a condition of receiving benefits under the disability plans, you agree that:

1. You will promptly notify the Claims Administrator of any settlement negotiations, settlement, or judgment in any litigation related to an event or condition for which you have received, or expect to receive, benefits under the disability plans; and

2. Future benefits, even for an unrelated event or condition, may be reduced by the amount of any judgment or settlement, or similar compensation which the disability plans would be entitled to under the rules above but is unable to recover.

Life and Accident Insurance Plans

Timing of Notification of Benefits Determination

In the case of a claim, the Claims Administrator will notify you of the benefit determination (whether adverse or not) no later than 90 days after your claim was received. If an extension of time for processing is required, the Claims Administrator will notify you within this 90-day period and may request a one-time extension not longer than 90 days. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, describe any additional material or information necessary to complete the claim so it may be processed, and provide the claim appeal procedures.

Timing of Appeal of Benefits Determination

If you believe your claim benefits under a plan was denied improperly, you may file a written claim for the unpaid amount within 60 days of receipt of the denial. The written claim should specify the amount of the claim and include any other written comments, documents, records or other information that may be pertinent. The claim should be sent to the Claims Administrator. The first level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 60 days from receipt of a request for appeal of a denied claim.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator as the Plan Administrator. Your second level appeal request must be submitted to the Claims Administrator within 180 days from receipt of the first level appeal decision. The second level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 60 days from receipt of a request for review of the first level appeal decision.

Upon request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Accident Insurance and Legal Assistance Plans

Timing of Notification of Benefits Determination

In the case of a claim, the Claims Administrator will notify you of the benefit determination (whether adverse or not) no later than 90 days after your claim was received. This period may be extended one time by the Claims Administrator for up to 90 days, provided that the extension is necessary due to matters beyond the control of the Claims Administrator and you are notified prior to the expiration of the initial 90-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If additional information is needed to process the claim, the Claims Administrator will notify you within this 90-day period and may request a one-time extension of not more than 90 days and suspend your claim until all information is received. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, describe any additional material or information necessary to complete the claim so it may be processed, and provide the claim appeal procedures.

Appeal of Benefits Determination

If you believe your claim benefits under a plan was denied improperly, you may file a written claim for the unpaid amount within 60 days of receipt of the denial. The written claim should specify the amount of the claim and include any other written comments, documents, records or other information that may be pertinent. The claim should be sent to the Claims Administrator. The first level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 60 days from receipt of a request for appeal of a denied claim.

If you are not satisfied with the first level appeal decision of the Claims Administrator, you have the right to request a second level appeal from the Claims Administrator as the Plan Administrator. Your second level appeal request must be submitted to the Claims Administrator within 180 days from receipt of the first level appeal decision. The second level appeal will be conducted, and you will be notified by the Claims Administrator of the decision within 60 days from receipt of a request for review of the first level appeal decision.

Upon request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.

Long Term Care Insurance Plan

Timing of Notification of Benefits Determination

To determine initial eligibility for benefits, you or someone acting on your behalf, must call the Claims Administrator (refer to the number on your identification card) to inform to inform of your request for a determination of eligibility for benefits and the reasons for the request. You will be certified as Chronically Ill (as defined by the Claims Administrator), only if the Claims Administrator is provided with proof, satisfactory to the Licensed Health Care Practitioner employed or retained by the Claims Administrator that you are Chronically Ill. If we require more information: we or a person designated by us may contact you, your representative, your Physician or other persons familiar with your condition; and we or a person designated by the Claims Administrator may need to access your medical records to obtain information about your condition (the Licensed Health Care Practitioner employed or retained by the Claims Administrator cannot certify you as Chronically Ill if we are denied access to your medical records); and we have the right to have you examined, at our expense, by a healthcare provider and to conduct an on-site assessment.

If you are certified as Chronically Ill, you are eligible for benefits. We will send written notice of the certification decision as soon as reasonably possible. We will send this notice no later than 10 business days after we have received all the information we need to assess your condition. The notice will state the date as of which you have been certified as Chronically Ill. When we notify you that you are eligible for benefits, we will provide you or your representative with forms to be used to submit proof of a claim for benefits. Contact the Claims Administrator for the claims submission requirements.

If you are not certified as Chronically Ill, you are not eligible for benefits. The Claims Administrator will send written notice of their decision no later than 10 business days after we have received all the information we need to assess your condition. You or your representative may ask us to more fully explain the denial. Within 60 days of the date the Claims Administrator receives such a written request: (a) the Claims Administrator will provide a written explanation of the reasons for the denial; and (b) make available all information directly relating to such denial.

Appeal of Benefits Determination

If you believe your claim for benefits under the plan was denied improperly, you or your representative may appeal the denial of eligibility for benefits. Contact the Claims Administrator for the “Appeals of Eligibility for Benefits or Claims Decisions” instructions.

Retirement and Savings Plans

Timing of Notification of Benefits Determination

In the case of a claim, the Claims Administrator will notify you of the benefit determination (whether adverse or not) no later than 90 days after your claim was received. This period may be extended one time by the Claims Administrator for up to 90 days, provided that the extension is necessary due to matters beyond the control of the Claims Administrator and you are notified prior to the expiration of the initial 90-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If additional information is needed to process the claim, the Claims Administrator will notify you within this 90-day period and may request a one-time extension of not more than 90 days and suspend your claim until all information is received. A denial notice will explain the reason for denial, refer to the part of the plan on which the denial is based, describe any additional material or information necessary to complete claim so it may be processed, provide the claim appeal procedures, and include a statement of your right to bring a civil action under section 502(a) of ERISA if your appeal is denied.

Appeal of Benefits Determinations

If you believe a benefit under a retirement or savings plan was denied improperly by the Claims Administrator you or your representative may file a written appeal for the unpaid amount within 60 days of receipt of notification of the adverse benefit determination. The written appeal should specify the amount of the claim, include any other written comments, documents, records or other information that may be pertinent and should be sent to the Plan Administrator. A written decision will usually be issued by the Plan Administrator within 60 days of your written appeal. This period may be extended for up to 60 days by the Plan Administrator if the Plan Administrator determines that the extension is necessary. You will be notified prior to the expiration of the initial 60-day period of the circumstances requiring the extension and the date by which the Plan Administrator expects to render a decision. If your appeal is denied, the written decision will explain the reason for denial, refer to the section of the plan on which the denial is based, inform you that, if you request, you are entitled to receive, at no cost, reasonable access and copies of all relevant documents, and include a statement of your right to bring a civil action under section 502(a) of ERISA if your appeal is denied.

Upon request, you will be provided, free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim for benefits.

Conversion Rights

Basic, Optional, Spouse and Dependent Life Insurance Plans

To exercise your conversion rights, you must be enrolled in plan coverage at the time you experience the event that results in the loss of policy. You must contact the Claims Administrator within 31 days to exercise your conversion rights for plan coverage.

You may convert the entire amount of your current plan coverage. Premiums for the converted policy are determined by the Claims Administrator and are based on the amount of coverage.

Personal Accident Insurance Plan

To exercise your conversion rights, you must be enrolled in plan coverage at the time you experience the event that results in the loss of policy. You must contact the Claims Administrator within 31 days to exercise your conversion rights for plan coverage.

You may convert the entire amount of your current plan coverage. Premiums for the converted policy are determined by the Claims Administrator and are based on the amount of coverage.

Legal Assistance Plan

If you are enrolled in the Legal Assistance Plan at the time you experience the event that results in the loss of coverage, you can elect to continue the plan for two years on an individual basis. You (or your approved spouse or domestic partner in the event of your death) must contact the Claims Administrator and pay the required contribution within 31 days of the date you lose coverage.

Employee Assistance Plan

If you or your eligible family members do not elect COBRA, your coverage will end. You cannot convert coverage to an individual policy.

Non-Assignment of Benefits

Generally, benefits under the Company's plans may not be sold, transferred, pledged or assigned before you receive them, except as permitted by law. For certain healthcare plans, however, you may assign your benefits to the person or organization that provided the services the benefit is being paid to cover. And in certain situations, court orders may require benefits to be provided for a certain individual or individuals, typically an employee's family member.

Qualified Medical Child Support Order (QMCSO)

A qualified medical child support order, also known as a QMCSO, is any judgment, decree or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible, and that the Plan Administrator determines is qualified under the

terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who don't reside with you. The plan won't provide coverage it doesn't otherwise offer—for example, children who are no longer eligible due to their age can't be added under a QMCSO.

The Company will comply with all valid QMCSOs. You and your dependents may receive, upon request to the Plan Administrator and without charge, a copy of the procedures applicable to QMCSOs.

Qualified Domestic Relations Order (QDRO)

A qualified domestic relations order, also known as a QDRO, is a state court order, decree or judgment that directs a Plan Administrator to pay all or a portion of your retirement and/or savings plan benefits to a former spouse or a dependent. The terms of the applicable plan control all questions of benefit entitlement and calculation. The plan can honor a QDRO (and make payments) only if the QDRO is properly compiled and meets the criteria for QDROs in the state in which it is filed. A QDRO can't modify the terms of the plan.

The Company will notify you if it receives a QDRO affecting your retirement/savings plan benefits. You and your former spouse or dependents may obtain a copy of the procedures governing the processing of a QDRO without charge by contacting:

QDRO Consultants Co.
Attention: Marsh & McLennan QDRO Compliance Team
110 South Huntington Street
Medina, Ohio 44256
1-800-527-8481

About Plan Coverage

Healthcare Plans

If You No Longer Satisfy the Plan's Eligibility Requirements

Your plan coverage ends on the date you no longer satisfy the plan's eligibility requirements. Coverage for eligible family members ends when yours does.

When your Company plan coverage ends, COBRA coverage may be available, as described in the Participation sections of the Benefits Handbook.

If You Die

If you die while you are an active employee with employee + one or family coverage, your covered family members can continue to be covered (with Company subsidy) for up to 12 months if they pay the contribution required for family members. When this period ends, your eligible family members may be eligible for coverage under COBRA. For information on COBRA, see the Participation sections of the Benefits Handbook.

If Your Family Member Loses Eligibility Status

If your family member no longer meets the eligibility requirements, his or her coverage under the plan ends.

It is your responsibility to cancel coverage when a family member is no longer eligible. No refund of contributions will be paid beyond the date eligibility ceases.

Family members who lose coverage under the Company plans may be eligible for coverage under COBRA provisions described in the Participation sections of the Benefits Handbook.

If You Become Disabled

During a period of approved disability, your plan coverage will continue for you and your covered family members. Your deductibles and out-of-pocket limits will continue at the same level as at the time your disability began. It is your responsibility to pay any contributions due for plan coverage on an after-tax basis.

If You Have an Authorized Unpaid Leave of Absence

If the Company grants you an authorized unpaid leave of absence, medical coverage for you and your family members continues for the duration of your authorized period of leave. It is your responsibility to pay any employee contributions due. (If your leave is covered by the Family and Medical Leave Act, you may prepay certain contributions on a before-tax basis by authorizing a lump-sum payroll deduction prior to the start of your leave.)

If the Company Ends the Benefit

While the Company intends to maintain the plans, the Company reserves the right to terminate or amend this plan, in whole or part, at any time and for any reason as it deems advisable, as to any and all employees covered. In fact, as a matter of prudent business planning, the Company periodically evaluates the plans.

Healthcare Flexible Spending Accounts

If You No Longer Satisfy the Plan's Eligibility Requirements

Your before-tax contributions to the HCFSA will end on the date you no longer satisfy the plan's eligibility requirements. You may receive reimbursements up to the total amount (less any reimbursement amounts you may have already received) for expenses incurred before the date you no longer satisfied the plan's eligibility requirements. In addition, you or a qualified beneficiary may elect to continue your coverage on an after-tax basis under COBRA as described the in Participation sections of the Benefits Handbook.

If You Leave and Are Rehired

If you leave salaried employment and are rehired as a salaried employee within 30 days in the same calendar year, your participation will be reinstated automatically with the same before-tax contributions in effect before you left.

If You Die

Your before-tax contributions will end on the day of your death. Your family can continue receiving reimbursement from the plan for expenses incurred until your date of death. Reimbursement may equal your total annual amount (less any reimbursement amounts you may have already received). Your qualified beneficiary may elect to continue your participation to year end, on an after-tax basis, through COBRA. See the Participation sections of the Benefits Handbook for more details.

If You Become Disabled

Your before-tax contributions will continue while you are receiving Short Term Disability benefits. If you then become eligible for Long Term Disability benefits, your before-tax contributions to your account will cease. You may receive reimbursement up to your total annual amount (less any reimbursement amount you may have already received) for eligible expenses incurred to the date you are placed on Long Term Disability. You or a qualified beneficiary may elect to continue your participation (less any reimbursements already made) to plan year end, on an after-tax basis, under COBRA. See the Participation sections of the Benefits Handbook for more details.

If You Have an Authorized Unpaid Leave of Absence

Your before-tax contributions to the plan will cease on the day you begin leave (unless you prepay contributions under Family and Medical Leave Act provision, as described below). Your contributions must be made on an after-tax basis during the leave to receive reimbursement for expenses incurred during the leave.

If you return to active employment within the same plan year, your participation will be reinstated automatically with the same before-tax contribution in effect before you left.

If You Take an Authorized Leave of Absence That is Covered under the Family and Medical Leave Act

If you are on a leave of absence during annual enrollment and you elect to participate in the account for the following plan year and do not return from leave by the following January 1, you may pay the new plan year contributions on an after-tax basis under COBRA. If you do this, you may claim reimbursement for expenses incurred during the leave.). See the Participation sections of the Benefits Handbook for more details.

If the Company Ends the Benefit

While the Company intends to maintain the plans, the Company reserves the right to terminate or amend this plan, in whole or part, at any time and for any reason as it deems advisable, as to any and all employees covered. In fact, as a matter of prudent business planning, the Company periodically evaluates the plans.

Dependent Care Flexible Spending Account

If You No Longer Satisfy the Plan's Eligibility Requirements

Your before-tax contributions to the DCFSA will end on the date you no longer satisfy the plan's eligibility requirements. You may receive reimbursements up to the remaining contributions for expenses incurred before the date you no longer satisfied the plan's eligibility requirements.

If You Leave and Are Rehired

If you leave salaried employment and are rehired as a salaried employee within 30 days in the same calendar year, your participation will be reinstated automatically with the same before-tax contributions in effect before you left.

If You Die

Your before-tax contributions will end on the day of your death. Your family can continue receiving reimbursement from the plan for expenses incurred until your date of death. Your expenses may be reimbursed up to the contributions remaining in your account.

If You Discontinue Contributions While in Active Service

If you discontinue contributions to the plan but remain employed by the Company, only expenses incurred before contributions ceased are eligible for reimbursement, up to the contributions remaining in your account.

If You Become Disabled

Your before-tax contributions will continue while you are receiving Short Term Disability benefits. If you then become eligible for Long Term Disability benefits, your before-tax contributions to your account will cease. You may receive reimbursement up to the remaining balance for eligible expenses incurred to the date you are placed on Long Term Disability. (Remember, however, that expenses are only reimbursable if they enable you or your spouse to work, look for work, or go to school full-time.

If You Have an Authorized Unpaid Leave of Absence

Your before-tax contributions to the plan will cease on the day you begin leave.

If you return to active employment within the same plan year, your participation will be reinstated automatically with the same before-tax contribution in effect before you left.

If the Company Ends the Benefit

While the Company intends to maintain the plans, the Company reserves the right to terminate or amend this plan, in whole or part, at any time and for any reason as it deems advisable, as to any and all employees covered. In fact, as a matter of prudent business planning, the Company periodically evaluates the plans.

Health Savings Account

If You No Longer Satisfy the Plan's Eligibility Requirements

Your before-tax contributions to the HSA will end on the date you no longer satisfy the plan's eligibility requirements. You may receive reimbursements up to the total amount (less any reimbursement amounts you may have already received) for expenses incurred. In addition, amounts contributed to an HSA belong to you and are completely portable. Although you cannot roll the HSA funds over into an IRA, you can roll the HSA funds into another HSA account/

If You Leave and Are Rehired

If you leave salaried employment and are rehired as a salaried employee within 30 days in the same calendar year, your participation will be reinstated automatically with the same before-tax contributions in effect before you left.

If You Die

Your before-tax contributions will end on the day of your death. Your qualified beneficiary will receive your account. The tax treatment depends on who you have designated as your beneficiary. For example, if you designate your spouse as your beneficiary, your spouse becomes the owner of the HSA and the transfer is not subject to taxation. If your designated beneficiary is anyone else, your account ceases to be an HSA and your beneficiary will receive the fair market value of the HSA assets on the date of your death as taxable income. Unless your beneficiary is your estate, the taxable amount is reduced by any payments from your HSA made for your qualified medical expenses, if made within one year after death. You should consider talking to a professional tax advisor before you designate a beneficiary.

If You Discontinue Contributions While in Active Service

If you discontinue contributions to the plan but remain employed by the Company, qualified expenses are eligible for reimbursement, up to the contributions remaining in your account. Any unused balance in your account at the end of the calendar year will be carried forward to the next calendar year, even if you do not participate in the plane the next year.

If You Become Disabled

Your before-tax contributions will continue while you are receiving Short Term Disability benefits. If you then become eligible for Long Term Disability benefits, your before-tax contributions to your account will cease. You may receive reimbursement up to your total annual amount (less any reimbursement amount you may have already received) for eligible expenses incurred to the date you are placed on Long Term Disability. You or a qualified beneficiary may elect to continue your participation (less any reimbursements already made) to plan year end, on an after-tax basis, under COBRA. See the Participation sections of the Benefits Handbook for more details.

If You Have an Authorized Unpaid Leave of Absence

Your before-tax contributions to the plan will cease on the day you begin leave (unless you prepay contributions under Family and Medical Leave Act provision, as described below). Your contributions must be made on an after-tax basis during the leave to receive reimbursement for expenses incurred during the leave.

If you return to active employment within the same plan year, your participation will be reinstated automatically with the same before-tax contribution in effect before you left.

If You Take an Authorized Leave of Absence That is Covered under the Family and Medical Leave Act

If you are on a leave of absence during annual enrollment and you elect to participate in the account for the following plan year and do not return from leave by the following January 1, you may pay the new plan year contributions on an after-tax basis under COBRA. If you do this, you may claim reimbursement for expenses incurred during the leave.). See the Participation sections of the Benefits Handbook for more details.

If the Company Ends the Benefit

While the Company intends to maintain the plans, the Company reserves the right to terminate or amend this plan, in whole or part, at any time and for any reason as it deems advisable, as to any and all employees covered. In fact, as a matter of prudent business planning, the Company periodically evaluates the plans.

Other Important Information about the Plans

Not a Contract of Employment

These plans and the Benefits Handbook, whether on a single basis or in combination, are not a contract of employment and do not give any individual a right of employment or continued employment with Marsh & McLennan Companies, Inc.

If a Mistake Occurs

Every effort is made to pay your benefits from the plans accurately, but mistakes may occur occasionally. The Plan Administrator or Claims Administrator will make corrections that it deems appropriate, such as requiring a participant to repay an overpayment to the applicable plan, making an additional payment to an underpaid participant, adjusting future benefit payments, or other actions as necessary to correct errors or omissions. You or your family member will be notified if a plan determines that a mistake was made.

Right of Recovery

If for some reason a benefit is paid that is larger than the amount allowed by a particular plan, the plan has a right to recover the excess amount from the person or agency that received it. The Plan Administrator or Claims Administrator must produce any instruments or papers necessary to insure the right of recovery, unless prohibited by law, and present them to the person receiving benefits.

Conversion Rights

If a plan is required to provide COBRA coverage, a COBRA event occurs and you or your eligible family members do not elect COBRA, your plan coverage will end. You cannot convert the plan’s coverage to an individual policy.