Benefits Handbook Date March 1, 2013

Participating in Healthcare Benefits

Marsh & McLennan Companies

Participating in Healthcare Benefits

This section explains which employees are eligible to participate in the Marsh & McLennan Companies (Company) healthcare benefits. This section also explains which family members are eligible to participate in the healthcare plans.

Participation Information for Non-Employees

For the healthcare plans that provide benefits for those who are not current employees (such as post 65 retirees), the eligibility and participation information is generally contained in the section that describes the applicable benefit. However, information on pre 65 retiree medical coverage can be found in the section called *Participating in Pre-65 Retiree Medical Coverage*.

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

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

- For Marsh & McLennan Companies participants: a U.S. regular employee of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies (other than Marsh & McLennan Agency, LLC and any of its subsidiaries (MMA)).
- For MMA participants: a U.S. regular employee of Marsh & McLennan Agency – Corporate (MMA-Corporate), Insurance Alliance, a Marsh & McLennan Agency LLC company (Insurance Alliance), Marsh & McLennan Agency LLC – Northeast (MMA-Northeast) or Marsh & McLennan Agency LLC – Alaska (MMA-Alaska).

Contents

Eligible Employees

To be eligible for the Company healthcare benefits described in this Benefits Handbook you must meet the eligibility criteria listed below.

Eligibility

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

You can also cover your eligible family members.

Approved opposite gender or same gender domestic partners are eligible for coverage under this Plan.

Eligibility Requirements

Eligible Marsh & McLennan Companies Employees (other than MMA)

You are eligible if you are an employee classified on payroll as a U.S. regular employee of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies (other than MMA and any of its subsidiaries).

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

Eligible MMA Employees

You are eligible if you are an employee classified on payroll as a U.S. regular employee of MMA-Corporate, Insurance Alliance, MMA-Northeast or MMA-Alaska.

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

Your Eligibility Date

	No Waiting Period	30-Day Waiting Period
Marsh & McLennan Companies (other than Marsh, MMA)	There is no waiting period if you are actively at work. Your eligibility date is the first day you are actively at work on or after your date of hire.	
Marsh	There is no waiting period for vision benefits if you are actively at work. Your eligibility date is the first day you are actively at work on or after your date of hire.	There is a 30-day waiting period after your date of hire for medical and dental plan benefits. For example, if you began your active work status on your date of hire on August 1, your effective date is August 31.

	No Waiting Period	30-Day Waiting Period
MMA	There is no waiting period for vision benefits if you are actively at work. Your eligibility date is the first day you are actively at work on or after your date of hire.	There is a 30-day waiting period after your date of hire for medical and dental plan benefits. For example, if you began your active work status on your date of hire on August 1, your effective date is August 31.

Eligible Family Members

If you are an eligible employee, you may enroll eligible family members for coverage under certain Company healthcare benefit plans.

To enroll your family members for any Company healthcare benefit:

- you must meet the employee eligibility requirements for the plan,
- the family members you want to cover must meet the eligibility requirements for the plan, and
- the benefit plan must provide coverage for the eligible family member you wish to cover.

Is evidence of insurability required for coverage?

No, evidence of insurability is not required for coverage under the Company healthcare plans.

Spouses and Domestic Partners

Adding a spouse or same gender or opposite gender domestic partner to certain benefits coverage is permitted upon employment or during the Annual Enrollment period for coverage effective the following January 1st if you satisfy the plans' criteria, or immediately upon satisfying the plans' criteria if you previously did not qualify. To obtain spousal or domestic partner coverage, you will need to complete an Affidavit of Eligible Family Membership via PeopleLink (www.mmcpeoplelink.com), declaring that:

Spouse / Domestic Partner

- You have already received a marriage license from a U.S. state or local authority, or registered your domestic partnership with a U.S. state or local authority.

Spouse Only

- Although not registered with a U.S. state or local authority, your relationship constitutes a marriage under U.S. state or local law (e.g. common law marriage or a marriage outside the U.S. that is honored under U.S. state or local law).

Domestic Partner Only

- Although not registered with a U.S. state or local authority, your relationship constitutes an eligible domestic partnership. To establish that your relationship constitutes an eligible domestic partnership you and your domestic partner must:
- be at least 18 years old
- not be legally married, under federal law, to each other or anyone else or part of another domestic partnership during the previous 12 months
- currently be in an exclusive, committed relationship with each other that has existed for at least 12 months and is intended to be permanent
- currently reside together, and have resided together for at least the previous 12 months, and intend to do so permanently
- have agreed to share responsibility for each other's common welfare and basic financial obligations
- not be related by blood to a degree of closeness that would prohibit marriage under applicable state law.

Marsh & McLennan Companies reserves the right to require documentary proof of your domestic partnership or marriage at any time, for the purpose of determining benefits eligibility. If requested, you must provide documents verifying the registration of your domestic partnership with a state or local authority, your cohabitation and/or mutual commitment, or a marriage license that has been approved by a state or local government authority.

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

My spouse or domestic partner also works for the Company; can I still cover my spouse or domestic partner under my healthcare plans?

You can cover your spouse or domestic partner as a family member under your healthcare plans, or your spouse or domestic partner can elect separate employee coverage. You or your spouse or domestic partner can't be covered as both an employee and a family member under the same Company healthcare plans.

Complete your affidavit, via PeopleLink (www.mmcpeoplelink.com). Select the **Health** tab and under **Medical Plans**, click any plan. Then go to **Take Action** in the right navigation bar and select **Enroll, view, change benefits.**

Children

If you are enrolled for coverage, you can cover:

- your biological child
- the child of an approved domestic partner
- your stepchild
- a child for whom you or your spouse are the legally appointed guardian with full financial responsibility
- your legally adopted child or child placed with you for adoption.

Note: Any child that meets one of these eligibility requirements and who is incapable of self support by reason of a total physical or mental disability as determined by the Claims Administrator, may be covered beyond the end of the calendar year in which the child attains age 26.

Eligibility for Children

Dependent children are eligible for healthcare coverage until the end of the calendar year in which they attain age 26. This eligibility provision applies even if your child is married, has access to coverage through his or her employer, doesn't attend school full-time or live with you, and is not your tax dependent.

Notes:

- Under HMSA's Health Plan Hawaii Plus HMO and HMSA's Preferred Provider Plan dependent children are eligible for healthcare coverage until the **end of the month in which they attain age 26**.
- While married children are eligible for healthcare coverage under your plan until the end of the calendar year in which they attain age 26, this provision does not apply to your child's spouse and/or child(ren), unless you or your spouse is the child's legally appointed guardian with full financial responsibility.

The Company has the right to require documentation to verify the relationship (such as a copy of the court order appointing legal guardianship). Company healthcare plan coverage does not cover foster children or other children living with you, including your grandchildren, unless you are their legal guardian with full financial responsibility—that is, you or your spouse claims them as a dependent on your annual tax return.

When Children Become Ineligible

If your covered child no longer meets the eligibility requirements, you must remove your child from coverage by signing in to PeopleLink (www.mmcpeoplelink.com).

- No refund of contributions will be paid beyond the date eligibility ceases.
- If you fail to remove your child from coverage and any claims are paid for expenses incurred after the date eligibility ceases, you and your family must reimburse the Plan for these claims.

How long can I cover my child?

Generally, you can cover your child through the end of the calendar year in which the child attains age 26. You may be able to extend coverage for your child beyond the end of the calendar year in which the child attains age 26, if your child is disabled.

Your child's coverage will stop upon the earlier of:

- reaching the maximum age for coverage (the end of the calendar year in which the child attains age 26), or
- no longer meeting the Plan's eligibility requirements.

If your child continues to be disabled over the age limit for coverage, your child may still be eligible to continue coverage. Otherwise, if your child reaches the age limit for coverage (the end of the calendar year in which the child attains age 26) or no longer meets the eligibility requirements, you must remove your child from coverage. Sign in to PeopleLink (www.mmcpeoplelink.com), select the **Health** tab and under **Medical Plans**, click **applicable plan**. Then go to **Take Action** in the right navigation bar and select **Enroll, view, change benefits**. No refund of contributions will be paid beyond the date eligibility ceases. If you fail to remove your child from coverage and any claims are paid for expenses incurred after the date eligibility ceases, you and your family must reimburse the Plan for these claims. Failure to timely remove your child may also result in missing the child's opportunity for COBRA continuation coverage.

My spouse or domestic partner also works for the Company; can we both cover our child?

Your child can be covered under either your coverage or your spouse's or domestic partner's coverage, but not both. To be covered, your child has to meet the dependent child eligibility requirements.

I am divorced and do not have sole custody of my child; can I still cover my child under the healthcare plans?

You can still cover your child until the end of the calendar year in which the child attains age 26.

Can I continue covering my disabled child once my child reaches the age limit for coverage?

You can cover your disabled child over the limiting age. To be eligible for coverage, your child has to be incapable of self support by reason of a total mental or physical disability, as determined by the Claims Administrator.

In order to register a child as disabled, you must fill out the applicable medical plan provider form (contact your medical plan provider for the appropriate form) for continuing coverage beyond the limiting age and return the form to the Claims Administrator no later than 30 calendar days after the disabled child's coverage would otherwise end. The Claims Administrator will review the request for disabled status and will notify the

Company and the employee whether the child is determined as disabled. If approved, eligibility records will be adjusted to allow for coverage beyond the end of the calendar year in which your child attains age 26, as long as the child meets the remaining eligibility requirements.

Your child's disability has to begin before the date eligibility would otherwise end. In addition, to be covered beyond the limiting age, your child must already be covered or have current continuous coverage under one of the Company healthcare plans prior to reaching the limiting age.

If approved, eligibility records will be adjusted to allow for coverage beyond the limiting age as long as the child meets the remaining eligibility requirements.

Can I cover my grandchild?

You cannot cover your grandchild unless you are the legally appointed guardian or you have legally adopted the child, and the child resides with you.

My dependent child is having a baby; what will be covered?

If your daughter is covered under a Company medical plan, she is covered for maternity benefits, which include delivery of the baby. Unless the newborn meets the definition of an eligible child and is covered under the Company healthcare plan, medical care for the newborn, whether in or out of the hospital is not covered.

Can I cover my child who is not attending school, is temporarily out of school (as a student on leave or for medical reasons) or changes to a part-time status?

As long as your child meets the eligibility requirements, coverage will continue through the end of the calendar year in which your child attains age 26, whether or not a full- or part-time student. This provision also applies if your child is married, has access to coverage through his or her employer, doesn't live with you and is not your tax dependent.

When your child reaches the age limit for coverage (the end of the calendar year in which your child attains age 26) or no longer meets the eligibility requirements, you must remove your child from coverage. Sign in to PeopleLink (www.mmcpeoplelink.com), select the **Health** tab and under **Medical Plans**, click **applicable plan**. Then go to **Take Action** in the right navigation bar and select **Enroll, view, change benefits**. No refund of contributions will be paid beyond the date eligibility ceases. If you fail to remove your child from coverage and any claims are paid for expenses incurred after the date eligibility ceases, you and your family must reimburse the Plan for these claims.

Can I cover my married child who is still dependent on me?

Yes, you can cover a married child up to the end of the calendar year in which your child attains age 26.

Note: While married children are eligible for healthcare coverage under your plan until the end of the calendar year in which they attain age 26, this provision does not apply to your child's spouse and/or child(ren), unless you or your spouse is the child's legally appointed guardian with full financial responsibility.

Once your child reaches the age limit for coverage (the end of the calendar year in which your child attains age 26), you must remove your child from coverage. Sign in to PeopleLink (www.mmcpeoplelink.com), select the **Health** tab and under **Medical Plans**, click **applicable plan**. Then go to **Take Action** in the right navigation bar and select **Enroll, view, change benefits**. No refund of contributions will be paid beyond the date eligibility ceases. If you fail to remove your child from coverage and any claims are paid for expenses incurred after the date eligibility ceases, you and your family must reimburse the Plan for these claims. Failure to timely remove your child may also result in missing the child's opportunity for COBRA continuation coverage.

Can I cover my child when a Qualified Medical Child Support Order (QMCSO) is in effect?

In order to add a child as required by a Qualified Medical Child Support Order, submit the QMCSO to the Global Benefits Department for validation. If the QMCSO is determined to be complete and valid, you will be notified and your child will be added to your coverage.

Retiree Plan Participation

Retiree Eligibility Requirements

You are eligible to participate if you:

- are a U.S. regular employee of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies, (other than MMA and any of its subsidiaries) who terminates employment at age 55 or older with at least five years of vesting service, or at age 65 or older, or
- are a current retiree under age 65.

Note: Although you may be eligible to participate in retiree medical coverage, the opportunity to defer your retiree medical coverage election only applies to employees that terminate employment on or after April 1, 2010. As an example, if you are under age 65 and terminated employment prior to April 1, 2010, the rules regarding the deferral of your retiree medical coverage election do not apply to you.

Does eligibility to participate in retiree medical coverage impact any benefits other than active employee medical coverage?

Yes, if you are eligible to participate in retiree medical coverage, your active employee medical, dental, vision care plan, and/or EAP coverage, whichever plans you are enrolled in, will be continued through the end of the month in which you terminate.

If I am not enrolled in active employee medical coverage at the time of my termination, am I eligible to participate in retiree medical coverage?

Yes, if you meet the retiree eligibility requirements you are eligible to participate in retiree medical coverage. You will be given an opportunity to immediately elect or defer retiree medical coverage following your termination of employment.

Since you were not enrolled in Company's active medical coverage, you will not have the option to elect COBRA medical coverage.

What happens to my active employee medical coverage upon termination of employment if I am not eligible to participate in retiree medical coverage?

If you (and your eligible family members) are enrolled in active employee medical coverage but you are not eligible to participate in retiree medical coverage, coverage for you and your eligible family members ends on your last day of employment.

COBRA medical coverage will automatically be offered to you. You will have 60 calendar days from the date of the COBRA notice to elect COBRA continuation. Your COBRA premium will be due 45 days from your election date. The COBRA medical coverage effective date will be the day following your last day of employment.

Should I elect to participate in retiree medical coverage immediately following my termination date?

This is an individual decision that you must make based on your personal facts and circumstances. Note though, if you defer your retiree medical coverage enrollment election beyond 60 calendar days of your termination, additional rules and documentation requirements apply.

Transfers/Status Changes/Rehires

Will I retain my eligibility for retiree medical coverage if I transfer from a participating to a non-participating company?

Yes, if you met the retiree eligibility requirements prior to your transfer to the non-participating company, you will retain the opportunity to immediately elect or defer retiree medical coverage participation when you subsequently terminate from employment.

Will I retain my eligibility for retiree medical coverage if my status changes from a regular to a temporary employee within a participating company?

Yes, if you met the retiree eligibility requirements prior to your change in status within a participating company, you will retain the opportunity to immediately elect or defer retiree medical coverage participation when you subsequently terminate from employment.

If I am rehired by a participating company after I terminate from a non-participating company, am I eligible for retiree medical coverage?

Yes, if you met the retirement eligibility requirements at a participating company, you are eligible for the opportunity to immediately elect or defer participation in retiree medical coverage upon subsequent termination from employment.

Am I eligible to participate in retiree medical coverage if I terminate after transferring from a participating company to a non-participating company?

Yes, if you met the retiree eligibility requirements prior to your transfer to the non-participating company, you will be eligible to elect to participate in retiree medical coverage. Eligibility provides you with an opportunity to **immediately elect or defer retiree medical coverage following termination**.

If I am rehired by a non-participating company after I terminate from a participating company, am I eligible for retiree medical coverage?

Yes, if you met the retirement eligibility requirements when you terminated from the participating company, you are eligible for the opportunity to immediately elect or defer participation in retiree medical coverage.

Enrollment

For all of the Company healthcare benefits except for the Vision Discount Program, you must formally enroll to participate. You can enroll for coverage by signing in to PeopleLink (www.mmcpeoplelink.com). You must enroll within 30 calendar days of the date you become eligible or during Annual Enrollment. You may be able to make changes to your elections during the plan year if you have a qualified family status change.

Automatic Enrollment

You do not need to enroll for the Vision Discount Program. If you are an eligible, active employee your participation begins automatically.

Enrolling/Terminating Retiree Medical Plan Coverage

What are the available Retiree Medical Plan options?

If eligible, you can elect retiree medical coverage. If you elect this coverage, retiree medical coverage is considered an alternative to continuing Company medical coverage through COBRA.

You can elect any of the medical plan options that are available to active employees in the state in which you reside regardless of whether you were enrolled in active employee medical coverage. However, if you or a family member who you wish to cover is deemed to be Medicare eligible (generally age 65 or over as of your retirement date), the Comprehensive Medical Plan is your only available medical plan option.

How do I enroll in retiree medical coverage?

In order to initiate your retiree medical coverage election, you must call the Employee Service Center at least 30 calendar days prior to your Retiree Medical Coverage Participation Date. Contact the Employee Service Center at +1 866 374 2662, any business day, from 8:00 a.m. to 8:00 p.m. Eastern time, to make your election. The requirement to contact the Employee Service Center at least 30 calendar days prior to your Retiree Medical Coverage Participation Date will be waived if you elect to participate in retiree medical coverage within 60 calendar days following your termination from the Company.

If you are eligible to participate in retiree medical coverage and you elect to participate, your Retiree Medical Coverage Participation Date will be reflected as the 1st of the month following your termination date, or if you defer your election and elect coverage at a later date, the 1st of any month, but no later than the1st of the month following your attainment of age 65 (retiree medical coverage participation dates always are on the 1st of a month).

If you defer your retiree medical coverage participation election date beyond 60 calendar days of your termination date, you can elect to participate at a later date (no later than the 1st of the month following your attainment of age 65) **provided you submit proof of continuous coverage**.

Your retiree medical coverage will take effect the 1st of the month following the earlier of loss of continuous coverage or the 1st of the month following attainment of age 65. If you do not contact the Employee Service Center at least 30 calendar days prior to your participation date, your coverage will begin the 1st of the next month following notification if within 63 days of loss of continuous coverage. If you notify the Employee Service Center beyond 63 days of your loss of continuous coverage or following your attainment of age 65, you will be denied retiree medical coverage.

When should I contact the Employee Service Center to elect my retiree medical coverage?

To elect retiree medical coverage, you must contact the Employee Service Center at +1 866 374 2662, any business day, from 8:00 a.m. to 8:00 p.m. Eastern time, at least 30 calendar days prior to your Retiree Medical Coverage Participation Date. The requirement to contact the Employee Service Center at least 30 calendar days prior to your Retiree Medical Coverage Participation Date will be waived if you elect to participate in retiree medical coverage within 60 calendar days of your termination from the Company.

For example:

- If you terminate on June 30th, you can contact the Employee Service Center on August 15th to elect Retiree Medical Coverage effective July 1st. This election is valid since it is within 60 calendar days of the loss of your active medical coverage.
- If you terminate on June 30th, you cannot contact the Employee Service Center on September 15th to elect Retiree Medical Coverage effective July 1st. This election is beyond the 60 calendar days.

Can I enroll my spouse in a Company retiree medical plan coverage option upon termination of COBRA coverage?

Yes, if you choose to elect COBRA for your spouse at retirement, once COBRA coverage is exhausted, you can enroll your spouse in any applicable Company retiree medical plan option within 30 calendar days of the event provided you met eligibility requirements upon termination of employment. Termination of COBRA is considered a HIPAA qualifying event.

Can I terminate my retiree medical coverage?

Yes, you can terminate your retiree medical coverage at any time by calling the Employee Service Center at +1 866 374 2662, any business day, from 8:00 a.m. to 8:00 p.m. Eastern time. Alternatively, you can send a letter requesting the discontinuance of your retiree medical coverage to:

Employee Service Center
P.O. Box 9740
Providence, RI 02940-9740

Whether you terminate coverage via the phone or in writing, you must submit a termination of coverage request 30 calendar days prior to your coverage end date (always the last day of a month).

Retiree medical coverage cannot be terminated on a retroactive basis, nor can paid premiums be refunded. Also remember, terminated retiree medical coverage cannot be reinstated. You have a one-time opportunity to elect retiree medical coverage.

Can I elect COBRA coverage if I terminate my Retiree Medical Plan coverage?

No. Your request to discontinue your Retiree Medical Plan coverage is not considered a qualifying event. COBRA coverage is not an available option following your termination of Retiree Medical Plan coverage.

Deferring Retiree Medical Plan Coverage

If I defer my retiree medical coverage election, will I remain eligible for the present medical plan design and coverage?

No, if you defer your retiree medical coverage election, you will be eligible for the benefit plans and options available at the time of your election to participate.

If I defer retiree medical coverage beyond 60 calendar days of my termination date, will I retain the employer subsidy enhanced severance benefit under the severance plan?

No, if you are eligible for Enhanced Severance Benefits under the Company Severance Pay Plan and choose to defer your retiree medical coverage beyond 60 calendar days of your termination date, you will forfeit the Company contribution towards the premium cost of retiree medical coverage.

Can the Company change the medical post-termination eligibility rules?

Yes, Marsh & McLennan Companies reserves the right to make changes to plan design including eligibility rules, continuous coverage, etc.

How do I defer my retiree medical coverage participation election?

No action is required to defer your retiree medical coverage participation election. Once you decide to initiate your retiree medical coverage participation election, contact the Employee Service Center at +1 866 374 2662, any business day, from 8:00 a.m. to 8:00 p.m. Eastern time, to make your election and then submit proof of continuous coverage within the required time period.

If I defer my retiree medical coverage participation election beyond 60 calendar days of my termination date, how do I show proof of continuous coverage?

To enroll in retiree medical coverage after 60 calendar days following your termination date, the Retiree Medical Plan requires that you provide a HIPAA Notice of Creditable Coverage certificate(s) for each eligible family member you wish to enroll to prove “continuous coverage” from your date of termination with the Company to your Retiree Medical Coverage Participation Date.

When you contact the Employee Service Center to make your retiree medical participation election, you must also send in your proof of continuous coverage to the address listed below:

Employee Service Center – H&B
P.O. Box 9740
Providence, RI 02940-9740

What are examples of continuous medical coverage that provide HIPAA creditable coverage certificates?

You should check with the coverage provider to make sure they will provide a HIPAA certificate upon request. Be sure to keep your HIPAA certificates in a safe place. Under current HIPAA rules, the following types of coverage qualify as creditable coverage:

- Group health plan coverage (whether as an active or former employee, a spouse, a dependent, or as a COBRA beneficiary)
- Individual or group health insurance policy
- Medicare or Medicaid
- Military health insurance program
- The Federal Employees Health Benefits Program
- Health program of the Indian Health Service or a tribal organization
- State health benefits risk pool
- Peace Corps
- Public health plan (including U.S. and foreign government plans whether insured or self-insured
- State Children's Health Insurance Plan (SCHIP).

The following coverage is not considered creditable coverage:

- Coverage under any plan that is excluded from the definition of a group health plan such as dental or vision plans.
- Plans providing specified disease or limited accident benefit coverage.

What is considered "continuous coverage" if I elect to defer my retiree medical coverage election?

If your proof of "continuous coverage" does not show a coverage gap (single period of 63 or more days without coverage), you will be deemed to have "continuous coverage". If you have a period of 63 or more days for which you do not have a HIPAA certificate, your request for retiree medical coverage participation will be denied. Note, time spent in

a group health plan waiting period or in an application review period for an individual policy will not count as part of the coverage gap.

For example, if you terminate employment on May 1, 2010 and wish to enroll in retiree medical coverage with a Retiree Medical Participation Date of October 1, 2011, and you provide HIPAA certificates:

Covering the Period of:	"Continuous Coverage" Status
▪ May 1, 2010 – January 1, 2011 ▪ February 15, 2011 - September 30, 2011	You are deemed to have "continuous coverage" because the period from January 1, 2011 to February 15, 2011 for which you do not have a HIPAA certificate is less than 63 days.
▪ May 1, 2010 – January 1, 2011 ▪ July 1, 2011 - September 30, 2011	You will not be deemed to have "continuous coverage" because the period from January 1, 2011 to July 1, 2011 for which you do not have a HIPAA certificate is more than 63 days.
▪ June 1, 2010 – January 1, 2011 ▪ February 15, 2011 - September 30, 2011	You are deemed to have "continuous coverage" because the period from May 1, 2010 to June 1, 2010 and January 1, 2011 to February 15, 2011 for which you do not have HIPAA certificates are each less than 63 days.

What happens if I do not provide proof of continuous coverage by my elected Retiree Medical Coverage Participation Date?

If proof of continuous coverage is not received by your elected Retiree Medical Coverage Participation Date, your coverage will not go into effect. If proof of continuous coverage is received within 63 days of your requested Retiree Medical Coverage Participation Date and it is deemed to be in good order, your retiree medical coverage will go into effect retroactively.

If proof of continuous coverage is not received in good order within the 63 day grace period, you will be denied retiree medical coverage.

If I defer retiree medical coverage, will I automatically receive a COBRA package?

Yes, upon termination, Trion will automatically mail a package, including a COBRA election form and an explanation of your COBRA rights to your home address on file. If you wish to elect COBRA coverage, complete your election form and return it to Trion within your 60-day COBRA election period.

Costs

The cost of your coverage under each of the healthcare plans is listed in the sections that describe each plan.

If you and your spouse are under age 65 and eligible for Retiree Medical Plan coverage, see “Paying for Coverage” in the *Participating in Pre-65 Retiree Medical Coverage* section. If you or your spouse is 65 or over and eligible for Retiree Medical Plan coverage, see “Participating in the Plan - Cost of Coverage” in the *Comprehensive Medical Plan* section.

Will my costs change?

Your costs for coverage may change. Generally, these changes occur each January 1.

The Company reserves the right to change the amount you are required to contribute at any time.

Taxes

Do I pay for my healthcare coverage with before-tax or after-tax dollars?

You pay for your coverage (other than coverage for a domestic partner and his/her approved dependent child(ren)) with before-tax dollars.

What effect does paying for coverage on a before-tax basis have on my other benefits?

None. Your annual base salary will be used to calculate all salary related benefits.

What effect does paying for coverage on a before-tax basis have on my paycheck?

Paying for coverage on a before-tax basis means that the amount you pay toward your healthcare coverage comes out of your pay before taxes are withheld, so you are paying taxes on a lower amount of salary. Your take-home pay is higher than it would be if you paid for your coverage on an after-tax basis.

What effect does paying for my coverage on a before-tax basis have on my Social Security benefit?

Your Social Security benefits may be slightly reduced because you pay for coverage on a before- tax basis. This is because your Social Security is based on your taxable pay, and your taxable pay is reduced by the amount you pay for healthcare coverage.

Are contributions for an approved domestic partner and child(ren) of an approved domestic partner made on a before-tax basis?

Your contribution to cover a domestic partner and the dependent child(ren) of a domestic partner is the same as the cost to cover other eligible family members. However, because of IRS requirements, these contributions will be made on an after-tax basis—even for coverage that would in most cases be paid on a before-tax basis. Additionally, the difference between the cost of coverage and your contributions could be imputed as taxable income to you.

An exception applies if your domestic partner and the child(ren) of a domestic partner are your tax dependents. If your partner (or his or her child(ren)) qualifies as a dependent under IRS Section 152and IRS Publication 501, your contributions for domestic partner coverage will be on a before-tax basis, and imputed income would not apply.

What is imputed income and why am I taxed on it for domestic partner coverage?

Under current tax laws, the Company's cost for providing healthcare coverage to domestic partners results in "imputed income" to you; you must pay tax on this income. The full cost of domestic partner coverage (both the employee and employer contributions to coverage) is subject to federal, Social Security (FICA) and if applicable, state and local income taxes.

Your amount of imputed income equals the full cost to cover your partner (and/or partner's child(ren)) less your after-tax contribution to cover that person. Your dollar amount of imputed income is calculated every payroll cycle and is reflected on your semi-monthly electronic pay check. It is also reported on your year-end W-2 Form as a component of taxable income from the Company.

Tables in each of the sections describing an affected healthcare plan show the imputed income amounts.

If your domestic partner (or his or her child(ren)) qualifies as a dependent under Internal Revenue Code Section 152 and IRS Publication 501 (that is, are your tax dependents), imputed income does not apply.

Does the Company offer federal tax equalization for a same-sex domestic partner or spouse?

Marsh & McLennan Companies offers active U.S. employees in same-sex marriages/domestic partnerships federal tax equalization to offset the additional taxes paid on medical, dental and vision coverage for their same-sex domestic partners or same-sex spouses and if applicable, the partner's or spouse's eligible children.

Who is eligible for federal tax equalization?

You are eligible for federal tax equalization if you are an active U.S. employee:

- in a same-sex marriage, in a state where same-sex marriage is legally recognized,
- in a same-sex domestic partnership, or civil union in a state where same-sex marriage is not currently recognized.

Employees who have the legal option to marry in the state in which they reside are not eligible if they choose not to marry.

How is federal tax equalization to be paid?

Eligible employees will receive the applicable federal tax equalization in each of their paychecks.

Will the salaries be changed to reflect the federal tax equalization?

No. As with other gross-up issues, salaries will not change.

How do I elect federal tax equalization?

If you qualify for federal tax equalization for your same-sex domestic partner or spouse, your federal taxes will be automatically adjusted. If you are eligible, you will receive a federal tax equalization adjustment to offset the additional taxes paid on medical, dental and vision coverage for your same-sex domestic partner or same-sex spouse and if applicable, your partner's or spouse's eligible children.

If my approved domestic partner qualifies as a tax dependent, how can I begin making contributions on a before-tax basis and have imputed income stopped?

You must complete the Declaration of Domestic Partner's Tax Status form and return it as the form instructs. You can obtain a form by accessing PeopleLink, clicking on Forms under the left navigational bar, clicking on Domestic Partners and then clicking on "Marsh & McLennan Companies Declaration of Domestic Partner Tax Status". You will be notified by Mercer if additional information is required or if you qualify. You can download the Marsh & McLennan Companies Declaration of Domestic Partner Tax Status Form by going online to PeopleLink (www.mmcpeoplelink.com). Select the **Health** tab and under **Medical Plans**, click any medical plan. Then go to **Forms and Documents** in the right navigation bar and select **Domestic Partner Forms**.

When Coverage Starts

Existing Employees

If you are an existing employee and you experience a qualified family status change (such as marriage), your family member's coverage will become effective on the date of the event, if you enroll the family member within 30 calendar days of the qualified family status change (60 calendar days of the qualified family status change for medical plan changes).

Marsh & McLennan Companies New Hire (other than Marsh and MMA)

Your coverage will be effective on the first day you are actively at work on or after your date of hire, as long as you complete enrollment within 30 days of your eligibility date.

Marsh New Hire

Your coverage will be effective on the 31st calendar day from your date of hire for medical and dental plan benefits (the date your active work status began), as long as you complete enrollment within 30 days of your eligibility date.

Your coverage for vision benefits will be effective on the first day you are actively at work on or after your date of hire, as long as you complete enrollment within 30 days of your eligibility date.

MMA New Hire

Your coverage will be effective on the 31st calendar day from your date of hire for medical and dental plan benefits (the date your active work status began), as long as you complete enrollment within 30 days of your eligibility date.

What happens if I am not at work on the day my coverage is supposed to start?

If you are a new hire and you are not actively at work on the day your coverage is supposed to begin, your coverage will be effective on your first day of employment when you are actively at work, as long as you complete enrollment within 30 calendar days of your eligibility date.

If you are an existing employee and you are not actively at work on the day your coverage is supposed to begin, your coverage will be effective on the day it is supposed to begin. If you are hospitalized on the day your coverage is supposed to begin and you had prior coverage, your prior plan would pay for the confinement and ancillary charges until discharge.

What happens if I am in the hospital when my coverage is supposed to start?

If you are hospitalized on the day your coverage is supposed to begin, your coverage will start on the first day you are actively at work.

If you had prior coverage, your prior plan would pay for the confinement and ancillary charges until discharge.

What happens if my family member is in the hospital when coverage is supposed to start?

If your family member is confined to a health care facility or home under a physician's care on the date coverage would otherwise become effective, your family member's medical coverage will begin the day after the hospitalization ends.

Your coverage for vision benefits will be effective on the first day you are actively at work on or after your date of hire, as long as you complete enrollment within 30 days of your eligibility date.

When does my child's coverage start?

A newborn natural child is eligible for coverage at birth. An adopted child is eligible for coverage on the day the child is placed for adoption or the date the adoption is finalized. A stepchild is eligible for coverage upon your marriage to his or her parent.

You must enroll your child within 30 calendar days of the event that made the child eligible for coverage (within 60 calendar days of the event for medical coverage). If you do not enroll the child within that period, you must wait until the next Annual Enrollment period to enroll your child.

When will my retiree medical coverage be effective?

If you decide to elect to participate, your Retiree Medical Coverage Participation Date will be reflected as the 1st of the month following your termination date, or if you defer your election and elect coverage at a later date, the1st of any month, but no later than the 1st of the month following your attainment of age 65 (retiree medical coverage participation dates always are on the 1st of a month).

If You Have Other Coverage

If you or an eligible family member has coverage under the Company healthcare benefits plans and coverage under another healthcare plan (such as a plan sponsored by your spouse's employer), the Company's benefits are "coordinated" with those provided by the other plan.

In addition to having your benefits coordinated with other group health plans, benefits from the Company healthcare plans are coordinated with "no fault" automobile insurance and any payments recoverable under any workers' compensation law, occupational disease law or similar legislation.

What is coordination of benefits?

Coordination of benefits is what happens when a person is covered under more than one group plan.

You or a covered family member may be entitled to benefits under another group health plan (such as a plan sponsored by your spouse's employer) that pays part or all of your health treatment costs. If this is the case, benefits from the Company healthcare plan will be "coordinated" with the benefits from the other plan. In addition to having your benefits coordinated with other group health plans, benefits from the Company healthcare plan are coordinated with "no fault" automobile insurance and any payments recoverable under any worker's compensation law, occupational disease law or similar legislation.

When the Company healthcare plan is primary, it pays benefits first without consideration of the other plan. After you receive payment from the Company healthcare plan, you may then submit a claim to your secondary plan and possibly receive additional reimbursement. Reimbursement from your secondary plan depends on that plan's coverage levels and coordination of benefits rules. Reimbursements by both plans cannot exceed the full amount of covered expenses.

How does coordination of benefits work when my spouse and I are covered under two plans?

When you or your spouse is covered under two plans, there are certain rules that determine which plan pays its benefits first. The plan that covers you or your spouse as the employee pays its benefits before the plan that covers you or your spouse as a family member.

If it is determined that the other plan will pay first, the benefits payable under your Company healthcare plan will be reduced by the amount or value of the services paid by the other plan.

You should submit your claims to the primary plan first. When you receive a payment from the primary plan, you should submit a claim form and a copy of the Explanation of Benefits to the secondary payer, for any additional benefit.

How does coordination of benefits work when children are covered under two plans, and the parents are not divorced or separated?

The benefit plan of the parent whose birthday falls earlier in the calendar year pays first. If both parents have the same birthday, the plan that has covered the child(ren) longer pays first. If the other plan does not have the parent birthday rule, the other plan's coordination of benefits rule applies.

You should submit your claims to the primary plan first. When you receive a payment from the primary plan, you should submit a claim form and a copy of the Explanation of Benefits to the secondary payer, for any additional benefit.

How does coordination of benefits work when children of divorced parents?

The plan that pays first is decided in this order:

- If a court decree has established financial responsibility for the child's health care expenses, and the plan of that parent has actual knowledge of those terms, the plan of the parent with this responsibility pays first.
- Next, the plan of the parent with custody of the child pays.
- Then, the plan of the spouse of the parent with custody of the child pays (if applicable).
- Then, the plan of the natural parent not having custody of the child pays.
- Then, the plan of the spouse of the parent not having custody of your child pays.

In the case of joint custody where there is no financial responsibility for a child's health care has been established by the court order, the plan of the parent whose birthday falls earlier in the year will pay first.

You should submit your claims to the primary plan first. When you receive a payment from the primary plan, you should submit a claim form and a copy of the Explanation of Benefits to the secondary payer, for any additional benefit.

How does coordination of coverage work when one person is covered as the employee under two plans?

If you are covered as the employee under two separate medical plans, the medical plan that has covered you for the longest time will be the primary plan and will pay its benefits first.

You should submit your claims to the primary plan first. When you receive a payment from the primary plan, you should submit a claim form and a copy of the Explanation of Benefits to the secondary payer, for any additional benefit.

If I become disabled and I am eligible for coverage through Medicare, can I remain in my current Company medical plan?

If you become disabled and qualify for Medicare while on long term disability, you must sign up for Medicare Parts A and B. If you are enrolled in a Company medical plan; other than the Kaiser HMO Plan, Medicare will be the primary plan and your Company medical plan coverage will be the secondary plan. The Company plan will pay as if it is secondary even if you fail to sign up for Medicare.

You should submit your claims to the primary plan first. When you receive a payment from the primary plan, you should submit a claim form and a copy of the Explanation of Benefits to the secondary payer, for any additional benefit.

If I am disabled and eligible for coverage through Medicare, how are my family member's benefits impacted?

If you are disabled and qualify for Medicare, your family member(s) will continue their primary plan coverage under the Company medical plan.

If I am disabled and eligible for coverage through Medicare, how are my family member's benefits impacted if they are deemed to be Medicare-eligible?

If you are disabled and qualify for Medicare and your family member is deemed to be Medicare-eligible (e.g., disabled, attains age 65) your family member(s) must sign up for Medicare Parts A and B.

If a covered family member becomes disabled and eligible for coverage through Medicare, but I'm still an active employee, can he/she remain covered by my Company medical plan?

While you are in active employment, your Company medical plan is your primary plan, even if your family member is eligible for Medicare. If your family member is enrolled in Medicare, Medicare becomes the secondary plan for that family member.

Dental Coverage

In general, Medicare doesn't provide dental coverage.

But if there is an expense that both the Dental Plan and Medicare cover, the Dental Plan will pay benefits before Medicare.

If I become injured or ill as a result of an accident caused by a third party, what happens to any payment I may receive ("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 will include, but is not limited to, damages for pain and suffering and lost income.

The Plan is entitled to recover these amounts from you, as the employee, 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.

Changing Levels of Coverage

You can change your level of coverage:

- during Annual Enrollment for coverage effective January 1
- within 30 calendar days of certain qualified family status changes (60 calendar days of the qualified family status change for medical plan changes)
- within 30 calendar days of losing other coverage

See the *Life Events* section in the Handbook to determine whether your qualified family status change allows you to enroll, increase, decrease or discontinue coverage.

Changes Must Be Consistent

Any changes you make in your Company benefits following a qualifying change in status or losing other coverage must be consistent with that change in status.

When Coverage Ends

Company healthcare coverage ends on the first of the following to occur:

- the date you discontinue coverage
- the last date you've paid contributions (if you do not make the required contributions)
- the date you no longer meet the eligibility requirements
- the date you terminate your employment
- the date of your death
- the date the Plan is terminated.

What happens to my active employee medical coverage upon termination of employment if I am eligible to participate in retiree medical coverage?

If you (and your eligible family members) are enrolled in active employee medical coverage, active employee medical coverage for you and your eligible family members ends on the last day of the month in which you terminate employment. If you are eligible to participate in retiree medical coverage, you will be given an **opportunity to enroll immediately following your termination of employment or defer** your Company retiree medical coverage enrollment to some time in the future. If you defer, no immediate action is required at termination unless you which to elect COBRA.

Can I continue coverage through COBRA?

Yes, you can continue coverage under the Company-sponsored plans (except the Vision Discount Program) if you experience a COBRA qualifying event and register your event within the legally allowable time frame.

If you terminate and are eligible to retire, Trion will automatically mail a package, including a COBRA election form and an explanation of your COBRA rights to your home address on file. If you wish to elect COBRA coverage, you must complete your election form and return it to Trion within your 60-day COBRA election period.

Can my domestic partner (or the child(ren) of my domestic partner) continue coverage through COBRA?

Although not legally required to do so, Marsh & McLennan Companies extends COBRA continuation coverage to domestic partners of Marsh & McLennan Companies

employees and/or their dependent children who are eligible for coverage under the Company-sponsored plans. (A few medical plans may not extend COBRA to domestic partners or their children; refer to the specific medical plan sections to learn about COBRA medical availability.)

This coverage may be changed or terminated by the Company at any time.

Continuing Coverage

Can I convert my Company healthcare coverage to an individual policy when my coverage ends?

No, you can not convert your Company healthcare coverage to individual policies when your coverage ends.

About COBRA Coverage

COBRA continuation allows you and/or your covered family members to temporarily extend current company sponsored coverage at group rates plus an administrative fee in certain circumstances when coverage could otherwise end.

If you or one of your covered family members is losing Company-sponsored coverage because of a qualifying event, you can elect to continue coverage in these Company-sponsored plans:

- medical
- dental
- vision
- Health Care Flexible Spending Account
- Limited Purpose Health Care Flexible Spending Account
- Employee Assistance Program (EAP)
- Best Doctors
- Health Advocate
- Alere

To continue coverage, you and/or your covered family members must be enrolled in these plans on the date of the qualifying event.

The length of time you can continue coverage depends on the type of qualifying event.

You must enroll within a specified time period to continue coverage.

Coverage continuation for domestic partners varies depending on the medical plan in which you're enrolled.

Will my annual deductible or out-of-pocket maximum under my medical or dental plan count towards the deductibles and out-of-pocket maximums under COBRA?

Amounts you have paid toward your deductible or out-of-pocket limit under your medical and dental plan as an active employee (or covered family member) will be credited toward your COBRA deductible or out-of-pocket limit in the same calendar year. For example, if your annual deductible for a medical plan is $300, and you paid $160 toward this deductible before your qualifying event, your COBRA deductible for the rest of the calendar year will be $140. Starting with the next calendar year, your COBRA deductible will again be $300.

COBRA Eligibility and Enrollment

You are eligible for COBRA continuation if you are enrolled in Company-sponsored coverage and lose coverage due to a qualifying event. **Note: An event is a qualifying event only if it causes a covered family member (beneficiary) to lose coverage.**

Qualifying for Coverage/Qualifying Events

You and your covered family members can continue medical, dental, vision, Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account, Employee Assistance Program (EAP), Alere, Best Doctors and/or Health Advocate coverage for up to 18 months (Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account coverage continues through the end of the calendar year of the qualifying event) if:

- your employment terminates, unless you were terminated because of gross misconduct
- you experience a reduction in hours.

Although not required by law, Marsh & McLennan Companies currently allows you to continue medical, dental, vision, Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account, Employee Assistance Program (EAP), Alere, Best Doctors and/or Health Advocate coverage for up to 18 months (Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account coverage continues through the end of the calendar year of the qualifying event) if your status is changed to hourly from salaried.

Your covered family members can continue coverage for up to 36 months if:

- you become divorced or legally separated

- you die while you are covered under an eligible plan
- your family member no longer qualifies as an eligible family member
- you are a retiree who participates in a Company medical plan and the Company files for bankruptcy.

The coverage period for eligible family members may be longer if you enroll in Medicare while covered by COBRA. If you experience an employment termination or a reduction of hours following Medicare enrollment, your spouse and dependent child(ren) who are your covered family members may elect COBRA coverage for up to 36 months from the date of Medicare enrollment or 18 months from the employee's termination or reduction in hours, whichever is longer.

Periods of Coverage:

Qualifying Events	Covered Family Members	Coverage
▪ Termination of employment ▪ Reduction of hours	▪ Employee ▪ Spouse ▪ Dependent child	18 months*
▪ Employee enrolled in Medicare ▪ Divorce or legal separation from employee ▪ Death of covered employee	▪ Spouse ▪ Dependent child	36 months
▪ Loss of "dependent child" status	▪ Dependent child	36 months

* In the case of individuals who are determined by the Social Security Administration to be disabled when they leave the Company or within the 60 calendar day COBRA election period, special rules may apply to extend coverage by an additional 11 months for the disabled individual and other individuals who are qualified beneficiaries with respect to the same qualifying event.

Participants in the Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account may be eligible for COBRA coverage. This COBRA coverage may continue only until the end of the calendar year in which the qualifying event occurs and may not be continued into the next calendar year.

You can continue your Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account for the balance of the calendar year if you go on an unpaid leave of absence or terminate employment.

You can continue coverage under the Employee Assistance Program, Alere, Best Doctors and/or Health Advocate through COBRA if you experience a COBRA qualifying event and register your event within the legally allowable time frame.

Qualifying Event—Termination of employment

COBRA Due to Termination

How long is COBRA coverage available if I lose my job?

COBRA coverage is available for up to 18 months if your employment ends for any reason, unless you lost your job because of gross misconduct. COBRA coverage can be extended if there is a second qualifying event during the COBRA continuation period.

Disabled at Termination

If I'm totally disabled when I leave the Company, is there any difference in my COBRA coverage?

Yes. If you are disabled according to the Social Security Administration when you leave the Company or become disabled according to the Social Security Administration within the 60 calendar day COBRA election period, you and your covered family members can extend your COBRA coverage for an additional 11 months, for a total of 29 months from termination.

Note that your premiums are increased to 150% of the full group rate for those additional 11 months from the beginning of the 19th month through the end of the 29th month.

If a second qualifying event occurs within the first 18 months of the COBRA coverage, you pay the full group rate on an after-tax basis plus an additional two percent for administrative expenses from the beginning of the 19th month through the end of the 36th month. If a second qualifying event occurs within the 19th through 29th month of COBRA coverage extended for disability, your premiums will be increased by an additional 50 percent through the end of the 36th month.

Family or Medical Leave of Absence under FMLA

What happens if I take a family or medical leave of absence under FMLA?

Taking a family or medical leave of absence under the Family and Medical Leave Act (FMLA) usually will not constitute a qualifying event. A qualifying event occurs, however, if 1) you do not return to employment with the Company after the end of the FMLA leave and 2) without COBRA coverage, you or your covered family member would lose coverage before the end of the maximum coverage period.

Absence Due to Military Service

How will my absence from employment because of military service affect my coverage?

Your absence from employment because of military service is not a qualifying event under COBRA; however, you may elect to continue existing coverage for up to 18 months under the Uniformed Services Employment and Reemployment Rights Act (USERRA). For an absence of more than 30 days, you are not required to pay more than 102% of the full group rate. However, if our leave of absence is less than 31 days, you may not lose your coverage and will not have to pay more than the active employee contribution.

Company Involved in a Merger or Asset Sale

What happens to my coverage if the Company is involved in a merger or asset sale?

Special rules, policies and practices may apply if coverage is lost if the Company is involved in a merger or asset sale. You may be entitled to COBRA coverage from a buyer or the Company, depending on the transaction. A stock sale, however, is not a qualifying event for employees who continue their jobs after the sale, or for their family members.

COBRA Notification

When will I be notified about COBRA eligibility after my coverage ends because my employment terminates?

The Company has 30 days to notify its COBRA Administrator of your termination of employment. You and your covered family members will be sent written notification of your COBRA eligibility within 14 days of the date the Company's COBRA Administrator has been notified of your termination of employment.

If you were terminated because of gross misconduct, neither you nor your covered family members will be eligible for COBRA.

Qualifying Event—Reduction in hours

Reduction in Hours

Can I continue my coverage under COBRA if I lose health coverage as a result of a reduction in hours?

Yes, you can continue coverage for you and your covered family members under COBRA for up to 18 months if your hours are reduced, and you are no longer eligible for coverage under a Company-sponsored plan. COBRA coverage can be extended if there is a second qualifying event.

Determination of COBRA Eligibility Due to a Reduction in Hours

When will I be eligible for COBRA coverage because of a reduction in hours?

You will be eligible for COBRA coverage if you experience a loss of coverage under your plan because of a reduction of hours; such as an absence from work due to disability, a temporary layoff or any other reason other than FMLA leave and your employment is not terminated.

Change from Regular to Temporary Status

Can I continue my coverage under COBRA if I lose health coverage as a result of a change in my employment status from regular to temporary?

Although not required by law, Marsh & McLennan Companies currently allows you to continue coverage for you and your covered family members under COBRA for up to 18 months if your employment status is changed and you are no longer eligible for coverage under a Company-sponsored plan. Your continuation coverage can be extended if there is a second qualifying event.

Non-resident Alien

Can I continue my coverage under COBRA if I am a non-resident alien employee of the Company?

No, you are not eligible for COBRA coverage if you are a non-resident alien employee of the Company who received no earned income from Marsh & McLennan Companies that constituted income from sources within the United States. Your spouse and dependent children will not be eligible for COBRA coverage through your status as a Marsh & McLennan Companies employee either.

COBRA Notification

When will I be notified about COBRA eligibility after my coverage ends because of a reduction in hours or a change from regular to temporary status?

The Company has 30 days to notify its COBRA Administrator of your reduction in hours or change from regular to temporary status. You and your covered family members will be sent written notification of your COBRA eligibility within 14 days of the date the Company's COBRA Administrator has been notified of your reduction in hours or change in employment status.

Qualifying Event—Medicare Entitlement

COBRA Eligibility for Family Members Due to Medicare Entitlement

What happens if I terminate employment and elect COBRA for myself and my family. Then, during the 18-month COBRA period, I become covered by Medicare?

Your COBRA coverage will end when you enroll in Medicare. Your family members will be able to continue their coverage for 36 months from the date of the original qualifying event (which was your termination of employment).

COBRA Eligibility for Active Employees Enrolling in Medicare

If I am an active employee who enrolls in Medicare, will I be entitled to COBRA continuation coverage?

No, an active employee's enrollment in Medicare is not a qualifying event that gives rise to COBRA eligibility. However, COBRA coverage is available for you and your covered family members if you subsequently experience a qualifying event (such as, termination of employment or reduction in hours).

The maximum coverage period for eligible family members ends on the later of:

- 36 months from Medicare entitlement, or
- 18 months (29 months if there is a disability extension) from the qualifying event.

Qualifying Event—Family Member No Longer Qualifies as an Eligible Family Member

Dependent Child Reaching Maximum Age

If my dependent child reaches the maximum age allowed under my plan, can my child continue coverage under COBRA?

Yes, your child can continue coverage under COBRA for up to 36 months, if your child reaches the maximum age under your plan.

If you are an active employee, a notification reminding you to report the COBRA qualifying event will automatically be sent to the Company's COBRA Administrator at the end of the calendar year in which your dependent child turns 26.

Family Members Lose Coverage at Annual Enrollment

If I drop my family member coverage during Annual Enrollment, are my family members eligible for COBRA coverage?

No. If you drop your family member coverage during Annual Enrollment, your family members are not eligible for COBRA coverage, because Annual Enrollment is not a qualifying event. You also cannot remove a family member from your coverage in anticipation of a qualifying event, such as a divorce.

Your family members are eligible for COBRA coverage if they are covered by the plan when you lose your coverage, or if they lose coverage because they are no longer eligible family members and you register the qualifying event.

Family Member Joining Military

If my dependent family member enters the military, is he or she eligible for COBRA coverage?

No. Your family member isn't eligible for COBRA after entering the military because your family member has not experienced a qualifying event.

Length of COBRA Continuation Coverage for Family Members

How long does COBRA coverage last for my family members if they do not qualify for coverage under my plan any longer?

Your family members can continue COBRA coverage for up to 36 months after they are no longer considered eligible for coverage due to a qualifying event, such as your divorce or legal separation or a dependent child reaching maximum age under the Plan.

Notification to Employer of Family Member Loss of Eligibility

When do I have to provide notification that my family member isn't eligible for coverage any more?

You or a family member must notify the Company of a divorce, legal separation or a child losing dependent status under the applicable plan within 60 calendar days of the qualifying event.

There are two ways to notify the Company and be eligible for COBRA coverage:

- within 30 calendar days of the event: by signing into PeopleLink (www .mmcpeoplelink.com), or
- after 30 calendar days, but within 60 calendar days of the later of the qualifying event or loss of coverage: Contact the Employee Service Center in writing at: Employee Service Center, P.O. Box 9740, Providence, RI, 02940-9740. You will not be refunded any of your contributions if you notify the Company after 30 calendar days.

Note: If the Company is not notified within 60 calendar days of the event, your family member who loses coverage will not be offered the option to elect COBRA coverage.

Family Member COBRA Notification

When will my family members be notified about COBRA eligibility?

The Company has 30 days to notify its COBRA Administrator of your qualifying event. You or your covered family member will be notified of the right to COBRA coverage within 14 days of the date the Company's COBRA Administrator has been notified of the qualifying event. A COBRA notification and enrollment form are mailed to you or your covered family members' last known address.

You must complete the COBRA enrollment form and return it as the form instructs.

You have 60 calendar days from the later of (1) the date you receive notice of your right to COBRA coverage, or (2) the date coverage would otherwise end to elect COBRA.

Qualifying Event—Divorce, Legal Separation, Termination of an Approved Domestic Partnership

Continuing Family Coverage Through COBRA After a Divorce or Legal Separation

If I get divorced or legally separated, can my family get coverage under COBRA?

Yes, your spouse can continue coverage under COBRA when you are divorced or legally separated. If your children are no longer eligible dependents under the plan as a result of your divorce or legal separation, they can also continue coverage under COBRA if you register the event.

After a divorce or legal separation, COBRA coverage is available to your covered family members for up to 36 months.

Special Note on Domestic Partners

Do all plans cover domestic partners under COBRA?

Although not legally required to do so, Marsh & McLennan Companies extends COBRA continuation coverage to domestic partners of Marsh & McLennan Companies employees and/or their dependent children who have been approved for coverage under the Company Benefits Program. (A few medical plans may not extend COBRA to domestic partners or their children; refer to the specific medical plan section to learn about COBRA availability.)

Notification to Employer of Divorce, Legal Separation, or Termination of an Approved Domestic Partner

When do I have to provide notification that I am getting a divorce, legal separation or terminating my domestic partnership?

You or a family member must notify the Company of a divorce, legal separation or a child losing dependent status under the applicable plan within 60 calendar days of the qualifying event.

There are two ways to notify the Company and be eligible for COBRA coverage:

- within 30 calendar days of the event: by signing into PeopleLink (www .mmcpeoplelink.com), or
- after 30 calendar days, but within 60 calendar days of the later of the qualifying event or loss of coverage: Contact the Employee Service Center in writing at: Employee Service Center, P.O. Box 9740, Providence, RI, 02940-9740. You will not be refunded any of your contributions if you notify the Company after 30 calendar days.

Note: If the Company is not notified within 60 calendar days of the event, your family member who loses coverage will not be offered the option to elect COBRA coverage.

Qualifying Event—Death

Continuing COBRA Coverage for Family Members

If I die, can my family members continue their coverage under COBRA?

Yes, COBRA coverage is available to your covered family members for up to 36 months after your death.

Although not legally required to do so, Marsh & McLennan Companies allows any covered family members to continue medical and dental coverage at Company subsidized rates for one year after your death. The COBRA period will begin after that one-year period.

COBRA Notification

When will my family members be notified about COBRA eligibility after their coverage ends because of my death?

The Company has 30 days to notify its COBRA Administrator of death. Your covered family members will be notified of the right to COBRA coverage within 14 days of the date of the Company's COBRA Administrator has been notified that the one year Company subsidized period ends. Your covered family members will be sent a bill each month for the first year of coverage before the COBRA period begins. Your covered family members will be notified of their right to COBRA.

COBRA and Flexible Spending Accounts

What is the benefit of continuing contributions to my Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account under COBRA?

If you have an outstanding balance in your Health Care Flexible Spending Account or your Limited Purpose Health Care Flexible Spending Account when you experience a qualifying event, you can elect COBRA and continue to receive reimbursements from your Health Care Flexible Spending Account or Limited Purpose Health Care Flexible Spending Account until the end of the calendar year. You can continue to receive reimbursements after your active employee coverage ends.

For example, if you elected to contribute $1,000 to a Health Care Flexible Spending Account for the calendar year and incurred expenses of $600 when your employment ended, you must elect COBRA continuation coverage in order for the additional $400 you spend to be reimbursed.

Note: Contributions must be made on an after-tax basis, plus an additional two percent for administrative expenses will be charged.

Employee Enrollment in COBRA Coverage

You must complete the COBRA enrollment form and return it as the form instructs.

You have 60 calendar days to elect COBRA from the later of (1) the date you receive notice of your right to COBRA coverage, or (2) the date coverage would otherwise end.

Notification of Qualifying Event

When do I have to provide notification of a qualifying event?

You or a family member must notify the Company of a divorce, legal separation or a child losing dependent status under the applicable plan within 60 calendar days of the qualifying event.

There are two ways to notify the Company and be eligible for COBRA coverage:

- within 30 calendar days of the event: by signing into PeopleLink (www .mmcpeoplelink.com), or
- after 30 calendar days, but within 60 calendar days of the later of the qualifying event or loss of coverage: Contact the Employee Service Center in writing at: Employee Service Center, P.O. Box 9740, Providence, RI, 02940-9740. You will not be refunded any of your contributions if you notify the Company after 30 calendar days.

Note: If the Company is not notified within 60 calendar days of the event, your family member who loses coverage will not be offered the option to elect COBRA coverage.

If you fail to register the event and any claims are paid for expenses incurred after the date coverage would normally be lost because of divorce, legal separation or a child losing dependent status, you and your family must reimburse the plan for these claims.

The Company has 30 days to notify its COBRA Administrator of the qualifying event. You or your covered family member will be notified of the right to COBRA coverage within 14 days of the date the Company's COBRA Administrator has been notified of the qualifying event. A COBRA notification and enrollment form are mailed to your or your covered family members' last known address.

COBRA Effective Date

When will my COBRA coverage begin?

Once you choose COBRA, your COBRA coverage will be effective retroactive to the date you lost coverage.

You have to send your first payment for COBRA coverage within 45 days after you elected COBRA for your coverage to become effective. Your first payment has to include all of your back payments, beginning with the date you lost coverage because of a qualifying event, up to and including the month you send in your first payment.

Missed Enrollment Period

I didn't sign up for COBRA within the time limit; can I sign up now?

No, you can't sign up for COBRA once the 60 calendar day COBRA enrollment period ends.

If I do not continue all of the plans offered under COBRA, can I sign up for other plans later?

You can still add other coverage if you are within the 60 calendar day COBRA enrollment period. Once the 60 calendar day COBRA enrollment period ends, you can add or change plans during the Annual Enrollment period as long as you continue to be a COBRA participant.

Care Before Electing COBRA

What happens if one of my family members or I need medical or dental care after the qualifying event occurs but before I elect COBRA?

You will not have coverage until you or your covered family member elects COBRA and makes the required payments. Once the election and payments are made, your coverage will become effective, and any bills you received during this transition period will be processed under the rules for your plan as if you had coverage.

You may need to contact your plan to have your bills processed.

Disabled Employee COBRA Eligibility

If I am totally disabled when I qualify for COBRA coverage, what is the COBRA coverage period?

If you are disabled according to the Social Security Administration when you qualify for COBRA coverage or become disabled according to the Social Security Administration within the 60 calendar day COBRA election period, you and your covered family members can extend your COBRA coverage for an additional 11 months, for a total of 29 months from your qualifying event.

Note that your premiums are increased to 150% of the full group rate for those additional 11 months from the beginning of the 19th month through the end of the 29th month.

If a second qualifying event occurs within the first 18 months of the COBRA coverage, you pay the full group rate on an after-tax basis plus an additional two percent for administrative expenses from the beginning of the 19th month through the end of the 36th month. If a second qualifying event occurs within the 19th through 29th month of COBRA coverage extended for disability, your premiums will be increased by an additional 50 percent through the end of the 36th month.

Less Expensive Plan

Can I elect a less expensive plan now that I am eligible for COBRA coverage?

No, you cannot change plans outside of an Annual Enrollment period. However, when an Annual Enrollment period is made available to similarly-situated active employees, you and each covered family member can elect separately the plans under which COBRA is continued.

Revoking Waiver of COBRA Coverage

Can I revoke my waiver of COBRA coverage before the end of the COBRA election period?

If you waive COBRA coverage during the 60 calendar day election period, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA coverage, although coverage need not be provided

retroactively (that is, you may not be granted coverage from the date of your loss of coverage until the date you revoke your waiver).

Re-enrolling in COBRA

Can I re-enroll in COBRA if I dropped COBRA coverage?

You can re-enroll if you are still within the 60 calendar day COBRA enrollment period. Once the 60 calendar day COBRA enrollment period ends, you can't enroll or re-enroll for COBRA coverage.

Plan Coverage During COBRA

Will my coverage under my plan be the same while I am on COBRA coverage?

Yes, your coverage through COBRA will be the same as provided under the plan to other similarly situated employees and subject to the same plan policies and limitations.

ID Cards

Can I continue to use my ID card with COBRA?

For most plans, the identification card you used as an active employee is still appropriate for use with your COBRA coverage.

You should confirm the status of your card with your health plan.

How can I get ID cards for my covered family members?

Contact your medical or dental plan, as applicable, for any health care plan ID cards you need.

Enrolling a Family Member under COBRA

Do I have to enroll all my family members?

No, you do not have to enroll all of your family members. Each eligible family member has the right to enroll for COBRA coverage. You can enroll as a family, but you do not have to.

Can I enroll my domestic partner under COBRA coverage?

Although not legally required to do so, Marsh & McLennan Companies extends COBRA coverage to domestic partners of Marsh & McLennan Companies employees and/or their dependent children who have been approved for coverage under the Company Benefits Program. (A few medical plans may not extend COBRA to domestic partners or their children; refer to the specific medical plan section to learn about COBRA availability.)

This coverage may be changed or terminated by the Company at any time.

What is the COBRA coverage period if my family member is totally disabled when qualifying for COBRA coverage?

If your family member is disabled according to the Social Security Administration when they qualify for COBRA coverage or become disabled according to the Social Security Administration within the 60 calendar day COBRA election period, you and your covered family members can extend your COBRA coverage for an additional 11 months, for a total of 29 months from the qualifying event.

Note that your premiums are increased to 150% of the full group rate for those additional 11 months from the beginning of the 19th month through the end of the 29th month.

If a second qualifying event occurs within the first 18 months of the COBRA coverage, you pay the full group rate on an after-tax basis plus an additional two percent for administrative expenses from the beginning of the 19th month through the end of the 36th month. If a second qualifying event occurs within the 19th through 29th month of COBRA coverage extended for disability, your premiums will be increased by an additional 50 percent through the end of the 36th month.

Changes While on COBRA

Can I make changes in my COBRA coverage during Annual Enrollment?

Yes, you can make changes to your COBRA coverage during Annual Enrollment. You can make the same changes to coverage you would if you were an active employee. For example, you can elect a different medical or dental plan if available in your resident location. When making changes, make sure to complete the enrollment form and return it as the form instructs.

Once I enroll in COBRA can I change plans if I relocate?

You can change plans if you move out of your medical service area after you choose your COBRA coverage. You have to notify the Company's COBRA Administrator within 30 calendar days of the date of your relocation.

How do I change my address if I move?

Once you are on COBRA, contact the Company's COBRA Administrator to register an address change. You may also want to notify your Human Resources representative as well so the Company's records will remain accurate.

Paying for COBRA Coverage

The cost to you to continue coverage is the full group rate on an after-tax basis, plus an additional two percent for administrative expenses.

If your coverage is extended from 18 to 29 months for disability, the cost to continue coverage is the full group rate, plus an additional 50% because of higher medical costs as a result of disability.

You pay monthly for your COBRA coverage.

How is the cost of my COBRA coverage determined if I am or my covered family member is totally disabled?

If you are disabled according to the Social Security Administration before you become eligible for COBRA or within the 60 calendar day COBRA election period, you are entitled to continue your COBRA coverage for a total of 29 months. Your COBRA cost is determined this way:

- For the first 18 months of coverage, your COBRA cost would be 100% of the group rate, plus an additional 2% to cover the Company's administrative expenses
- For the 11 months of extended coverage because of your disability, your COBRA cost would be 150% of the Company group rate (assuming the disabled family member is included in that coverage under the plan).

When do costs change?

Your COBRA costs may change:

- when the cost of the plan for all similarly-situated employees changes
- after you complete the first 18 months of COBRA coverage, if you are entitled to continue COBRA coverage because you are considered disabled by the Social Security Administration
- if you add or drop a family member and the coverage level changes.

You will be sent a notification of any change in the cost of your COBRA coverage.

Where do I send my COBRA payments?

Send your COBRA payments to the Company's COBRA Administrator. You should make your COBRA checks payable to COBRAServ.

When do I have to pay for coverage?

You have to send your first payment for COBRA coverage within 45 days of your COBRA election. Your first payment has to include all of your back payments, beginning with the date you lost coverage because of a qualifying event, up to and including the month you send in your first payment. For example, if your coverage ended on June 30 and you return your election form on August 15, you have until September 30 to send in the back payment due for July, August and September, as well as October's payment. In this example, your payment would be for four months of COBRA coverage.

After you make your first payment, you have to make payments for the upcoming month's coverage by the date shown on your COBRA invoice.

What happens if I am already enrolled in COBRA and miss my payment deadline?

If you miss your payment deadline, you have a grace period of 30 days. If you do not make your payment by the end of the grace period, your COBRA coverage will automatically end and will not be reinstated.

Can I have my family members' COBRA premiums deducted from my paycheck?

No, you can't have COBRA premiums for family members deducted from your paycheck. You have to submit premium payments directly to the Company's COBRA Administrator by check.

If I am offered COBRA coverage because my status on the Marsh & McLennan Companies payroll has been reclassified as hourly from salaried, can my COBRA premiums be deducted from my paycheck?

No, you can't have your COBRA premiums deducted from your paycheck. You have to submit premium payments directly to the Company's COBRA Administrator by check.

Will I be sent a monthly bill in the mail?

Yes, you will be sent a monthly COBRA bill at your last known address. However, if you do not receive the bill, you must still make payments by your due date in order for your coverage to continue. Neither the Company nor its COBRA Administrator are required to send bills for COBRA coverage.

Extending Benefits Due to Disability

If a family member or I become totally disabled while on COBRA coverage, can we extend benefits?

If you (or a family member) are disabled as determined by the Social Security Administration on the date COBRA coverage begins or within the first 60 days of COBRA coverage, your COBRA coverage can be extended for an additional 11 months, for a total of 29 months, or up to 36 months if there is a second qualifying event during the 29 month period.

Note that your premiums are increased by an additional 50 percent for the additional 11 months from the beginning of the 19th month through the end of the 29th month. If the second qualifying event occurs within the first 18 months of COBRA coverage, you pay the full group rate on an after-tax basis plus an additional two percent for administrative expenses from the beginning of the 19th month through the end of the 36th month. If a second qualifying event occurs within the 19th through 29th month of COBRA coverage extended for disability, your premiums will be increased by an additional 50 percent through the end of the 36th month.

If you or a family member becomes totally disabled after the first 60 days of COBRA coverage, you or that family member are not eligible for an 11-month COBRA disability extension.

When do I need to inform the Company of my disability?

You must inform the Company's COBRA Administrator of the Social Security Administration's determination of disability within the first 60 days after the Social Security Administration's determination and before the end of the 18-month COBRA coverage period.

Impact of Medicare Eligibility

I am actively employed and turning age 65; what will happen to my current medical plan coverage?

As long as you are actively employed, both you and your spouse will remain in the current Company healthcare plan, which will pay benefits first. Once you or covered family member is deemed to be eligible for Medicare, Medicare will pay secondary, and the Company plan will continue to pay primary.

How are my domestic partner's claims paid if I am actively employed and my domestic partner becomes Medicare eligible due to age?

If your domestic partner is under age 65 and becomes Medicare eligible, Medicare pays primary.

How are my domestic partner's claims paid if I am actively employed and my domestic partner becomes Medicare eligible due to disability?

If your domestic partner is under age 65 and becomes Medicare eligible, Medicare pays secondary.

I am currently on COBRA and turning age 65; what will happen to my COBRA coverage?

If you are on COBRA coverage and enroll in Medicare Part A or B when you turn 65, your COBRA coverage will end. You can continue your COBRA coverage beyond age 65 and delay enrolling in Medicare. Your COBRA coverage will end when you actually enroll in Medicare, and your family members can continue COBRA coverage for themselves for 36 months from the date of the original qualifying event when you enroll in Medicare.

Note: Delaying enrollment in Medicare may result in late enrollment penalties. For each 12-month period that you could have enrolled in Medicare Part B but did not, late enrollment penalties may be assessed.

What if I am enrolled in Medicare and later become eligible for and elect COBRA coverage?

If the effective date of your enrollment in either Medicare Part A or B is on or before the date that your COBRA continuation coverage is elected, then you can be enrolled in both Medicare and COBRA continuation coverage simultaneously.

If I terminate employment, elect COBRA and then enroll in Medicare, can my family members still continue their COBRA coverage?

Yes. If you enroll in Medicare after you elect COBRA, your family members can continue their COBRA coverage for up to 36 months beginning on the date of the original qualifying event (your termination of employment).

When COBRA Coverage Ends

COBRA coverage can end for you or a covered family member (as applicable) on the first of the following to occur:

- the last day of your allowable COBRA continuation period
- you fail to make a payment within 30 days of the due date (you are permitted 45 days to make your initial COBRA payment)
- you become covered under another group health plan after making the COBRA election that does not have any pre-existing condition exclusion or limitation that applies to you
- the day you first become covered by Medicare after making the COBRA election
- the Company stops offering all group health plans
- for extended disability coverage, the first of the month that begins at least 30 days after the date you are no longer considered disabled for Social Security purposes
- you engage in misconduct, such as submitting fraudulent claims.

Coverage Extensions

You can have a coverage extension in the following cases:

- A second qualifying event, such as divorce or a child's loss of dependent status may occur while coverage is being continued for the 18-month COBRA coverage period. If this happens, the spouse and the children already receiving continuation coverage may be eligible for additional months of coverage, up to a maximum of 36 months from the date of the original qualifying event.

- Disability extension: if the Social Security Administration issues a determination that you or another qualified family member is "disabled" at the time of or within 60 calendar days of the COBRA qualifying event due to your termination of coverage or reduction in hours, you may qualify for up to an additional 11 months of COBRA coverage, or up to a total of 29 months of COBRA coverage.

Continuing Coverage after COBRA Ends

Can I continue my coverage once my COBRA ends?

If you or a covered family member's COBRA coverage ends as a result of the expiration of the maximum coverage period, the group health plan must, during the 180-day period ending on the COBRA coverage expiration date, provide you or your covered family member the option of enrolling in a conversion health plan (i.e., and individual policy) if this option is otherwise available to similarly-situated non-COBRA beneficiaries under the group health plan. Your costs won't be based on the Company's group rates, and the Company won't have any involvement with your coverage.

Through the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the federal government improved the portability and continuity of health insurance coverage for you and your family members. To learn more about HIPAA, see "How HIPAA Affects COBRA Coverage" on page 43 and "HIPAA Certificates and COBRA" on page 43.

Note: You may also have certain legal rights to convert to an individual policy after your group coverage ends. However, no conversion option is offered under the Comprehensive Medical Plan, BlueCross Blue Shield Plan, or Dental Assistance Plan. If you have HMO coverage, you should contact your plan's Claims Administrator to find out if a conversion policy is offered when COBRA coverage ends.

Health Plan No Longer Offered

What if the Company stops offering the group health plan under which I elected COBRA coverage?

You will be permitted to elect another Company-sponsored group health plan provided to similarly-situated active employees for the duration of your COBRA coverage.

Covered by More Than One Plan

If I am covered by the Company's plan and another plan and lose coverage under the Company's plan, can I elect COBRA coverage?

Yes, you can elect coverage under COBRA if you lose coverage under the Company's plan due to a qualifying event.

Continuing COBRA with New Employer

Can I continue COBRA coverage even though my new employer offers coverage?

You cannot continue COBRA coverage if, after you have elected COBRA, your new employer offers coverage, unless the plan has a pre-existing condition, exclusion or

limitation that affects you. (In that case, the Company has the right to terminate your COBRA coverage once your new employer's plan's conditions to coverage are satisfied.)

How HIPAA Affects COBRA Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law enacted to provide improved portability and continuity of health insurance coverage for you and your covered family members. HIPAA restricts the ability of health plans to exclude coverage for pre-existing conditions and requires plans to provide Certificate of Creditable Coverage for special enrollment rights as described below.

HIPAA also restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to you, the plan may terminate your COBRA coverage.

HIPAA Certificates and COBRA

Do I receive a HIPAA certificate when I lose COBRA coverage?

HIPAA requires that if you and your covered family members lose group health coverage a certification of your coverage under the medical plan must be provided. You may need this certification in the event you later become covered by a new plan under a different employer, or under an individual policy.

You and/or your covered family members will be sent a Certificate of Creditable Coverage when your medical plan coverage terminates, again when COBRA coverage terminates (if you elected COBRA), and again upon your request (if the request is made within 24 months following termination of coverage).

You should keep a copy of the Certificate of Creditable Coverage you receive, as you may need to prove you had prior coverage when you join a new health plan. For example, if you obtain new employment and your new employer's plan has a pre-existing condition limitation (which delays coverage for conditions treated before you were eligible for the new plan), the employer may be required to reduce the duration of the limitation by one day for each day you had prior coverage (subject to certain requirements). If you are purchasing individual coverage, you may need to present the coverage certification to your insurer at that time as well.

Can I receive credit for previous COBRA coverage?

Yes. The period of time that you receive COBRA coverage counts as previous continuous health coverage under HIPAA as long as you didn't have a break in coverage of 63 days or longer.

Filing a Claim under COBRA

How do I submit a claim?

As with active coverage, you must complete and submit a claim form for benefits from the following plans:

- Medical Plans
- Dental Plan
- Health Care Flexible Spending Account
- Limited Purpose Health Care Flexible Spending Account

Complete the claim form and return it to the Claims Administrator as the form instructs.

Where do I get a claim form?

You can obtain a claim forms by signing in to PeopleLink and selecting Forms and Documents. You can also obtain claim form from the Claims Administrators. For information on the claims process of another plan, refer to the specific plan.

How do I appeal a benefit determination or denied claim?

There are special rules, procedures and deadlines that apply to appeals of benefit determinations and denied claims, and you have special legal rights under ERISA. Refer to the specific plan for a description of the appeal process.

COBRA Contact

For more information, contact the Company's COBRA administrator.

For election forms and premium payments:

Trion Group, Inc.
P.O. Box 2672
Omaha, NE 68108-2672

For all other correspondence:

Trion Group, Inc.
2300 Renaissance Blvd.
King of Prussia, PA 19406

Phone: +1 866 324 4087 Monday through Friday, 8:30 a.m. to 5:30 p.m., Eastern time.

Website: http://www.cobra-link.com/

The Company has hired Trion to administer this plan. To the maximum extent permitted by law, Trion's decisions are final and binding.

HIPAA

This section explains your rights under HIPAA, which stands for the Health Insurance Portability and Accountability Act of 1996, and is designed to protect health insurance coverage for you and your covered family members if your Company medical coverage ends.

HIPAA includes protections for coverage under group health plans that:

- Limit exclusions for pre-existing conditions
- Prohibit discrimination against employees and family members based on their health status
- Allow a special opportunity to enroll in a new plan to individuals in certain circumstances.

Eligibility

You are eligible for a HIPAA certificate if you and/or your family members are covered under an eligible plan on the date you or your family members lose coverage.

How HIPAA Works

HIPAA provides you with documentation of prior medical coverage that can be used to help get credit under new medical coverage for up to the past 18 months prior to losing coverage and without a preexisting condition exclusion.

HIPAA protects you if you have a pre-existing medical condition and prohibits discrimination in getting medical coverage because of your health status, physical or mental medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability.

HIPAA limits the exclusions for pre-existing conditions as long as you do not have a break in coverage (generally a break of 63 days or more. This 63-day break period may be extended under state law if your coverage is through an insured HMO. Check with your State Insurance Commissioner's Office to see whether a longer break period applies to you).

HIPAA gives you credit for medical coverage you had before enrolling in the Company medical plan or a new employer's plan (called creditable coverage under HIPAA), and provides a process for providing certificates to document that coverage.

HIPAA requires a new, special enrollment period for group health plans if you declined coverage before because of other health insurance or COBRA coverage.

Plans Covered

The following plans are eligible plans under HIPAA:

- Medical

Limited-scope dental or vision plans and benefits for long-term care, nursing home care, home health care, community-based care and other similar limited benefits are not covered under HIPAA.

Certificates

You will be sent a HIPAA certificate automatically after you and/or your covered family members' medical coverage ends. You can also request a HIPPA certificate within 24 months after your medical coverage ends.

Contact

For more information, contact the Employee Service Center at +1 866 374 2662.

Enrollment

Special Enrollment

If I don't enroll when I am first eligible, can I elect group medical coverage later on?

Yes. A special enrollment opportunity occurs if an individual with other health insurance loses that coverage or if a person becomes a new eligible family member through marriage, birth, adoption, or placement for adoption. However, you must first notify the plan of your request for special enrollment within 30 calendar days after losing your other coverage or within 30 calendar days of having (or becoming) a new eligible family member. You register the event by signing in to PeopleLink (www.mmcpeoplelink.com). You will be required to submit proof of loss of coverage following the event. Failure to do so will result in suspension of coverage.

You may also enroll during Annual Enrollment.

Nondiscrimination Requirement

Can my coverage be denied based on my health status?

No. Your coverage can't be denied, and you can't be excluded, under your medical plan just because you have a particular physical or mental illness, medical condition, or genetic information.

Change in Health Status

Can I lose coverage or be charged more for coverage if my health status changes?

Under HIPAA, your medical plan may not establish rules for eligibility (including continued eligibility) of any individual to enroll under the terms of the plan based on health status related factors. These factors include:

- health status
- medical condition (physical or mental)
- claims experience

- receipt of health care
- medical history
- genetic information
- Evidence of Insurability
- disability

You will not be required to pay a premium or contribution that is greater than that for a similarly situated individual based on a health status related factor.

Pre-existing Conditions and Coverage Information

Keeping Same Benefit

Does HIPAA guarantee that I will receive the same benefits I had under the old plan?

No. When you change from one plan to another, you will receive the benefits provided under the new plan.

Keeping My Doctor

Does HIPAA let me keep my doctor who is currently treating me for my pre-existing condition?

You may be able to keep the same doctor; however, it depends on the benefits and the provider network offered under your new plan. HIPAA does not require that your same doctor continue to treat you.

Pre-existing Condition Exclusions

Does a pre-existing condition exclusion apply to me?

The Company medical plan does not have a pre-existing condition exclusion, so you don't have to give the Company a certificate showing the coverage you had before.

Definition of a Pre-existing Condition

What is a pre-existing condition?

A pre-existing condition is a medical condition present before your enrollment date.

Under HIPAA, the only pre-existing conditions that may be excluded under a pre-existing condition exclusion are those for which medical advice, diagnosis, care or treatment was recommended or received within the 6-month period before your enrollment date. (Your enrollment date is your first day of coverage, or if there is a waiting period to get into the plan, the first day of the waiting period.)

If you had a medical condition in the past, but have not received any medical advice, diagnosis, care or treatment within the 6 months prior to your enrollment date in the plan, your old condition is not a pre-existing condition to which an exclusion can be applied.

Moreover, under HIPAA, pre-existing condition exclusions cannot be applied to pregnancy, regardless of whether the woman had previous health coverage.

In addition, a pre-existing condition exclusion cannot be applied to a newborn, an adopted child under age 18, or a child under age 18 placed for adoption as long as the child became covered under health coverage within 30 calendar days of the birth, adoption or placement for adoption and provided that the child does not incur a subsequent 63-day break in coverage.

Finally, genetic information may not be treated as a pre-existing condition in the absence of a diagnosis.

Plans Covered under HIPAA

What plans are covered under HIPAA?

HIPAA covers:

- Medical.

Limited-scope dental or vision plans and benefits for long-term care, nursing home care, home health care, community-based care and other similar limited benefits are not covered under HIPAA.

Other Certificate Information

HIPAA Certificate

What is a HIPAA certificate?

A HIPAA certificate documents the medical coverage you had before you lost coverage. When you and your eligible family members enroll in a medical plan that has a pre-existing condition exclusion, you can provide the certificate to have the waiting period waived or reduced.

Information Contained on a Certificate

What type of information is on the certificate?

The certificate includes:

- the date of the certificate
- the plan name
- the coverage level
- the participant's or family member's name
- covered family members
- family member coverage (if it applies)
- the plan administrator's name, address, and telephone number

- date of loss of coverage
- either a statement that the individual has at least 18 months of creditable coverage, or the date any waiting period began and the date creditable coverage began
- the date creditable coverage ended (unless the certificate indicates creditable coverage is continuing as of the date of the certificate).

Requesting a Replacement Certificate

How do I get a replacement copy of my HIPAA certificate?

If you need a replacement copy, contact your medical plan provider at any time within 24 months of your coverage ending.

Timing of a HIPAA Certificate

Certificates are sent automatically if you lose or drop group medical coverage for any reason or you otherwise become covered under a COBRA continuation provision and at the time you cease to be covered under a COBRA continuation provision. You can also ask for a certificate within 24 months after your coverage ends.

Timing of a HIPAA Certificate under COBRA

Who sends a certificate if I lose coverage while I'm on COBRA?

If coverage is lost or dropped while on COBRA, your healthcare plan sends a HIPAA certificate for that period of coverage.

Receiving a HIPAA Certificate

Who receives a certificate?

Certificates are automatically sent to employees and/or their family members who lose Company medical coverage.

Charge for a HIPAA Certificate

Will I be charged for a HIPAA certificate?

No. HIPAA certificates are provided without charge to participants and their eligible family members.