Benefits Handbook Date May 1, 2018

Long Term Care Insurance Plan

Marsh & McLennan Companies

Long Term Care Insurance Plan

As of January 1, 2017, Genworth Life Insurance Company has discontinued their current Long Term Care product offering. Other long term care plan insurance coverage may be offered in the future at which point the details of these offerings will be communicated to you. Current policy holders will be allowed to continue their existing policy; however, no new enrollments in Marsh & McLennan Companies Long Term Care Insurance Plan will be accepted beyond December 31, 2016. All current policyholders will continue with their payroll deduction (or direct billing) with no change. It is important to note that all in-force certificates issued under this group policy will remain in-force subject to the terms and conditions of the respective certificates. If you have any questions, please contact Genworth Life Insurance Company at +1 800 416 3624.

SPD and Plan Document

This section provides a summary of the Long Term Care Insurance Plan (the "Plan") as of January 1, 2018. This section, together with the *Administrative Information* section forms the Summary Plan Description and plan document of the Plan.

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

A Note about ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) is a federal law that governs many employer-sponsored plans including this one. Your ERISA rights in connection with this Plan are detailed in the *Administrative Information* section.

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The Plan at a Glance

The Long Term Care Insurance Plan helps you pay for the care you or a family member could require as a result of an illness, an accident, or age. For more information, see “How the Plan Works” on page 10.

Plan Feature	Highlights
How the Plan Works	▪ This plan helps you pay for the care you or a family member could require as a result of an illness, an accident, or age. This care may be needed for a lengthy period of time, either in your home or in a facility that provides long-term care.
Eligibility	▪ You are eligible to participate in this program if you meet the eligibility requirements described below. ▪ See “Participating in the Plan” on page 3 for details.
Family Eligibility	▪ Your spouse/approved Domestic Partner and certain eligible family members, to the extent permissible by state insurance regulations, are also eligible to apply for coverage. ▪ See “Participating in the Plan” on page 3 for details.
Enrollment	▪ Eligible new hires have 90 days from date of eligibility to apply to enroll for coverage without submitting EVIDENCE OF INSURABILITY. You must be ACTIVELY-AT-WORK at the time you apply and on your effective date of coverage. Your eligible family members always need to provide Evidence of Insurability. ▪ New hires may apply to enroll for the Long Term Care Insurance Plan within the 90 day new hire window by completing an online or paper application form. Their spouses or approved Domestic Partners under the age of 66 may apply by completing a short-form online or paper application. The short-form application contains a short health questionnaire. Based on the spouse’s or Domestic Partner’s answers, medical records may be required and in some instances, a 20 to 30 minute telephone interview may also be required. Employees applying outside of the 90 day new hire window, as well as their spouses or approved Domestic Partners, aged 66 through 79 and eligible family members under the age of 80, need to fill out a paper enrollment form which may be downloaded at the www.mmcvoluntarybenefits.com and/or by requesting an Information Kit through Genworth. ▪ Once your application to enroll has been approved, you may view your deduction amount by going to Voluntary Benefits (www .mmcvoluntarybenefits.com). If you wish to change coverage, where eligible, you must contact the Plan Administrator.
Cost of Coverage	▪ The cost of coverage is based on the options selected and the age of the applicant. ▪ Each covered family member has his or her own cost based on the above factors.

Plan Feature	Highlights
Levels of Coverage	▪ You can create a personalized plan by choosing from these levels or options of coverage. ▪ **Four Levels of the Facility Care Maximum:** – $3,000 monthly benefit option – $6,000 monthly benefit option – $9,000 monthly benefit option – $12,000 monthly benefit option ▪ **Two Optional Levels of Coverage:** – 3 years (36 months), 75% Home & Community Care – 5 years (60 months), 75% Home & Community Care – Informal Benefit Included: For maintenance or personal care services provided in the insured's home, by someone who does not normally reside there, a daily benefit up to 1% of the Facility Care Maximum, up to 30 days per calendar year – Nonforfeiture Benefit Included: The Nonforfeiture Benefit allows the insured to retain partial coverage if he or she decides to cancel his or her long term care coverage after it has been in force for more than three years. ▪ **Three** INFLATION **Protection Options** – Buy More Coverage Over Time (Future Purchase Option Benefit) – Automatic 3% Compound Benefit Increases for Life – Automatic 5% Compound Benefit Increases for Life
Contact Information	Long Term Care Insurance is underwritten by Genworth Life Insurance Company in all states except NY. For NY Residents it is underwritten by Genworth Life Insurance Company of New York (together, Genworth). For more information, contact: Genworth Life Insurance Company Phone: +1 800 416 3624 Website: www.mmcvoluntarybenefits.com Marsh & McLennan Companies does not administer this Plan. Genworth's decisions are final and binding.

Participating in the Plan

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

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 and opposite gender or same gender Domestic Partners under this Plan to the extent permissible by state insurance regulations.

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

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

- For Marsh & McLennan Companies participants: a US regular employee of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies (other than MMA or Mercer PeoplePro).
- For MMA participants: a US regular employee of MMA-Corporate, MMA-Alaska, MMA-Southwest, MMA-Northeast, Security Insurance Services and MMA-West.

Eligible Employees

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

Eligible Marsh & McLennan Companies Employees (other than MMA)

You are eligible if you are an employee classified on payroll as a US 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)).

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 US regular employee of Marsh & McLennan Agency LLC – Corporate (MMA-Corporate), Marsh & McLennan Agency LLC – Alaska (MMA-Alaska), Marsh & McLennan Agency LLC – Southwest (excluding MHBT Inc.) (MMA-Southwest), Marsh & McLennan Agency LLC – Northeast (excluding Corporate Consulting Services Limited) (MMA-Northeast), or Security Insurance Services and certain employees of Marsh & McLennan Agency LLC - West, the P&C client team who transferred to MMA from Marsh on January 1, 2015 (employees who are coded in PeopleSoft to Codes M66AD4 and M66AD5) (MMA-West).

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

Employee Eligibility

There is no waiting period if you are ACTIVELY-AT-WORK. Your eligibility date is the first day you are Actively-At-Work on or after your date of hire.

Eligible Spouses and Domestic Partners

Your legally married spouse is eligible to apply for coverage, to the extent permissible by state insurance regulations.

Your approved same gender or opposite gender Domestic Partner, to the extent permissible by state insurance regulations is also eligible to apply for coverage.

To obtain spousal or Domestic Partner coverage, you will need to agree to the Affidavit of Eligible Family Membership declaring that:

Spouse / Domestic Partner

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

Spouse Only

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

Domestic Partner Only

- Although not registered with a US 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.

For New York Residents Only: Once your Affidavit of Eligible Family Membership is completed and processed, you may cover the adult child(ren), between the ages of 18 and 79, of your spouse or domestic partner.

Go to Colleague Connect (**https://colleagueconnect.mmc.com**), click **Career & Rewards** and select **Mercer Marketplace Benefits Enrollment Website** under Tools.

Eligible Family Members

The following eligible family members, between the ages of 18 and 79, are eligible to apply for coverage, to the extent permissible by state insurance regulations:

- your parents
- your legally married spouse
- your approved Domestic Partner, to the extent permissible by state insurance regulations
- your parents-in-law
- your approved domestic partner's parents or stepparents
- your approved domestic partner's grandparents
- your stepparents
- your stepparents-in-law
- your grandparents
- your grandparents (in-law).

For New York Residents Only:

- your children between the ages of 18 and 79, to the extent permissible by state insurance regulations
- your spouse's or approved Domestic Partner's children between the ages of 18 and 79, to the extent permissible by state insurance regulations.

Enrollment

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

New employees have 90 days from their eligibility date to apply to enroll without submitting EVIDENCE OF INSURABILITY. In order to apply to enroll and for your coverage to take effect, you must be ACTIVELY-AT-WORK. You can apply to enroll outside of the 90 day new hire window, but you will be required to provide Evidence of Insurability.

Your eligible family members always need to provide Evidence of Insurability.

All eligible persons must be at least 18 years of age, maintain a permanent United States residence and have a valid Social Security number or tax identification number issued by the United States government.

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

New hires applying to enroll in Long Term Care Insurance within the 90 day new hire window can apply to enroll by completing an online or paper application form. Their spouses or approved Domestic Partners under the age of 66 may apply to enroll by completing a short-form online or paper application. The short-form application contains a short health questionnaire. Based on the spouse's or Domestic Partner's answers, medical records may be required and in some instances, a 20 to 30 minute telephone interview may also be required. Employees, spouses and approved Domestic Partners applying outside of the 90 day new hire window and eligible family members other than your spouse or approved Domestic Partner applying at any time, are required to fill out a paper application which is available through Genworth. Your eligible family members always need to provide Evidence of Insurability.

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

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

Evidence of Insurability is required for eligible family members.

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

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

Do I need an ID card?

You will not be sent an ID card. Each insured person will be sent a Certificate of Insurance. You can contact Genworth if you need a replacement Certificate of Insurance.

Evidence of Insurability

EVIDENCE OF INSURABILITY needs to be provided by:

- employees who do not enroll within 90 days of eligibility, and
- your eligible family members.

Cost of Coverage

Premium rates, benefits and any restrictions that apply are included in the Information Kit or at the website, www.mmcvoluntarybenefits.com. The insured pays the cost of the Long Term Care Insurance. The cost of coverage depends on the options selected and the age of the applicant. Each covered family member has his or her own cost based on the below factors listed below.

Levels of Coverage

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

Two Levels of Coverage:

- 3 years (36 months), 75% Facility Care Maximum (FCM) Home & Community Care, Informal Care Included
- 5 years (60 months), 75% FCM Home & Community Care, Informal Care Included

Four Levels of the Facility Care Maximum (FCM):

- $3,000 monthly benefit option
- $4,500 monthly benefit option
- $9,000 monthly benefit option
- $12,000 monthly benefit option

Three INFLATION **Protection Options:**

- Buy More Coverage Over-Time – Future Purchase Option Benefits
- Automatic 3% Compound Benefit Increases for Life
- Automatic 5% Compound Benefit Increases for Life

Nonforfeiture Benefit Included

This benefit allows the insured to retain partial coverage if he or she decides to cancel his or her long term care coverage after it has been in force for more than three years.

Can I pay for coverage through payroll deductions?

You can pay for coverage through the following:

- you can pay for your coverage(s) for you and your spouse or approved Domestic Partner through payroll deductions.
- your eligible family members can be billed for their coverage quarterly, semi-annually or annually.

When does my cost of coverage change?

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

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

Will my cost for coverage increase as I get older?

Generally, your cost for coverage remains unchanged. However, if you elect the Buy More Coverage Over Time – Future Purchase Option, inflation protection feature, your cost for this increased coverage will be based on your age as of the effective date of the increase in coverage and reflects the additional cost associated with providing coverage to persons in your age category.

Are my premiums waived while I'm receiving benefits?

Yes, your premiums are waived for you while you are receiving benefits for facility care, home and community care, hospice care, or the bed reservation benefit. Your premiums will start again the first day of the month on or following the date you are no longer certified as CHRONICALLY ILL.

You should contact Genworth regarding qualifying benefits.

Taxes

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

You make Plan payments with after-tax dollars.

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

- a portion of your premium paid may be tax deductible. If your eligible premium, in conjunction with other medical expenses, exceeds 7.5% of your adjusted gross income and does not exceed dollar limits as specified by the IRS, it will be tax deductible if you itemize your taxes. (There are caps on the amount that can be deducted, based on your age.)

- benefits you receive will generally not be considered taxable income, provided that they are within IRS limits or that amounts in excess of the IRS limits are used for medical care.

When Coverage Starts

Coverage becomes effective the first of the month or the first pay period following acceptance into the Plan. Coverage will take effect only if the employee is ACTIVELY-AT-WORK for the prior 30 calendar day period. If this requirement is not met, the effective date of coverage will be deferred until the first of the month or the first day of the payroll billing period on which the employee is Actively-At-Work and has been Actively-At-Work for the prior 30 calendar day period.

What happens if I'm not Actively-At-Work on the effective date?

If you are an eligible employee who applied without providing EVIDENCE OF INSURABILITY and you are not Actively-At-Work on the day your coverage is supposed to go into effect, your coverage will begin the first of the month or the first day of the payroll billing period following your return to work.

When can I change my coverage?

Long Term Care coverage selections can be changed at any time:

- To increase the coverage level to a higher option at any time a request must be sent with satisfactory proof of good health. Upon approval, premiums for the additional coverage will be based on the age of the insured on the date the change is effective.

- To decrease the coverage level, proof of good health is not required. The premium for the reduced coverage will be based on the original issue age.

When Coverage Ends

What happens if I leave the Company?

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

What happens when I die?

Coverage ends at the death of the insured. If the surviving spouse also has coverage, that coverage will remain in place, as long as he or she continues to pay the premiums. If premiums were paid through payroll deductions for the spouse's coverage, upon the employee's death, those deductions will end and a bill will be sent to the surviving spouse.

How the Plan Works

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

In the event of a conflict among the terms in this Summary Plan Description and the Certificate of Coverage, the Certificate of Coverage will govern. You will receive a Certificate of Coverage from Genworth once your application is processed and approved.

What is long-term care?

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

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

If I am on an authorized unpaid leave of absence or am disabled, does the Plan still provide a benefit?

You will be able to continue paying for your coverage, at your current premium, on a direct bill basis with Genworth. You should contact Genworth to see if you qualify to collect Long Term Care Benefits.

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

To be eligible for benefits, Genworth must receive:

- An eligibility certification, signed by a Licensed Health Care Practitioner during the preceding 12 month period, that the insured is a CHRONICALLY ILL individual; and
- Ongoing proof that demonstrates the Covered Care received is needed due to the insured continually being a Chronically Ill individual.

Before benefits are payable, the Elimination Period must be satisfied. The Elimination Period is a period of 90 calendar days during which the insured remains a Chronically Ill individual before benefits are payable. The Elimination Period begins on the first day that the insured is both a Chronically Ill individual and incurs a Covered Expense. However, the insured is not required to continue to incur covered expenses to satisfy the Elimination Period. The insured must remain a Chronically Ill individual for each consecutive day after the first day of the Elimination Period in order to satisfy the Elimination Period. The Elimination Period needs to be met only once during the insured's lifetime.

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

You or your covered eligible family member must be certified as chronically ill.

Can I choose where to receive my care?

Yes, you can choose where to receive care.

Care Coordination Services

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

Yes. Care Coordination Services will provide you with a team of Covered Care Coordinators who will review your specific situation and develop Plans of Care to meet your needs. You or your family should contact Genworth when you choose to use the services of a Covered Care Coordinator. Covered Care Coordinators will work with you to identify the specific services and care providers you require.

Care Coordination Services are furnished by a team of Covered Care Coordinators provided by Genworth at no cost to the insured. Genworth will pay for these services when the insured receives them while the insured's coverage is in effect. The payments will be at Genworth's expense; and will not count against any payment maximum.

Care Coordination

What is the role of Covered Care Coordinators?

Professional care coordinators review the insured's specific situation and develop an appropriate Plan of Care to meet those needs. The cost of this service is not deducted from the Policy Lifetime Maximum.

Do I have to use Care Coordination Services?

No. Care Coordination Services are voluntary.

When do I need to contact Genworth regarding Care Coordination Services?

You or your family should contact Genworth when you choose to use the services of a Covered Care Coordinator. Genworth will then make arrangements for a Covered Care Coordinator to contact you and begin providing you with this assistance.

About Your Benefits

What services are covered by this Plan?

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

- adult day care—75% of the monthly benefit selected
- Alzheimer's facility—100% of the monthly benefit selected

- assisted living facility—100% of the monthly benefit selected
- at-home hospice care—75% of the monthly benefit selected
- home care—75% of the monthly benefit selected
- in-patient hospice—100% of the monthly benefit selected
- nursing home services—100% of the monthly benefit selected
- respite care—up to the Facility Care Maximum in a calendar year
- bed reservation—up to the Facility Care Maximum for up to 60 days per calendar year
- home assistance expenses—up to 2X the Facility Care Maximum per lifetime
- informal care—up to 1% of the Facility Care Maximum up to 30 days per calendar year
- care coordination services at no cost.

There is a lifetime maximum benefit of:

- three years: 36 times your Monthly Benefit Amount
- five years: 60 times your Monthly Benefit Amount

For example, the lifetime maximum benefit for a $6,000 monthly benefit option for five years would be $360,000 ($6,000 X 60).

Some services have specific limits or restrictions.

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

Does the Plan cover organic and inorganic brain diseases?

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

Are benefits provided outside the United States?

International coverage is available for care and support services including room and board provided by a nursing facility located outside of the United States, limited to 75% of the Facility Care Maximum, for up to 48 months.

Is there an automatic inflation protection feature?

The types of INFLATION protection available under the Group Program are:

- Future Purchase Options: This benefit will apply if neither of the automatic options are selected. Every three years the insured is offered the opportunity to increase his or her benefit amounts by 5% compounded annually. The offer is guaranteed as long as the option has not been declined two consecutive times. The premium for the additional coverage is based on the insured's attained age as of the effective date of the increase. The offer is not made if the insured is in claim, is benefit eligible, is receiving benefits, or is satisfying the Elimination Period.
- Automatic 3% Compound Benefit Increases for Life: Under this optional rider, the benefit amounts increase automatically each year by 3% compounded annually while the insurance is in effect and premiums are paid. There is an additional premium for this rider.
- Automatic 5% Compound Benefit Increases for Life: Under this optional rider, the benefit amounts increase automatically each year by 5% compounded annually while the insurance is in effect and premiums are paid. There is an additional premium for this rider.

Do I have a Nonforfeiture option?

The Nonforfeiture benefit is included. It allows the insured to retain partial coverage if he or she decides to cancel his or her long term care coverage after it has been in force for more than three years.

What is Home and Community Care?

Home and Community Care benefits are payable for expenses incurred for home and community care which includes adult day care, and nurse or therapist services, home health or personal care services and incidental homemaker and chore care provided in the insured's home, up to the Home and Community Care Maximum, based on the option selected.

What is the Home Assistance Benefit?

The Home Assistance Benefit covers home assistance expenses that are stated and furnished in accordance with the insured's Plan of Care which are intended to enable the insured to remain in his or her home, including home modifications, emergency medical response systems and caregiver training, up to the lifetime maximum of two times the Facility Care Maximum.

What Is Not Covered

Are there any Exclusions under this Plan?

State variations may apply to coverage options, exclusions and limitations.

Read the Outline of Coverage in the Information Kit carefully. It will reflect any applicable state variations.

For Employees who Reside in States Other than New York

Exclusions: Benefits are not paid for any expenses incurred for any room and board, care, treatment, services, equipment, or other items:

- For which no charge is normally made in the absence of insurance;
- Provided outside the United States of America, its territories and possessions; except as described in the International Coverage Benefit;
- Provided by the insured's immediate family member, unless a benefit specifically states that a member of your immediate family can provide Covered Care. Genworth will not consider care to have been provided by a member of your immediate family when:
  - The insured's immediate family member is a regular employee of the organization that is providing the services; and
  - Such organization receives payment for the services; and
  - The insured's immediate family member receives no compensation other than the normal compensation for employees in her or his job category;
- Provided by or in a Veteran's Administration or Federal government facility, unless a valid charge is made to you or your estate;
- Resulting from war or an act of war, whether declared or not, provided that:
  - The impairment results from illness or injury that occurs while the insured person is serving in the military, naval or air forces of any country, combination of countries or international organization; and results from the special hazards incident to service in the military, naval or air forces of any country, combination of countries or international organization, if the impairment results form illness or injury that occurs while the insured person is serving in such forces and is outside the home area; or
  - The impairment results from war or an act of war while the insured person is serving in any civilian non-combatant unit supporting or accompanying any military, naval or air forces of any country, combination of countries or international organization; and results from the special hazards incident to service in any civilian non-combatant unit supporting or accompanying such forces, provided the illness or injury occurs while the insured person is serving in such unit and is outside the home area; or
  - The impairment results from illness or injury suffered as a result of war or an act of war while the insured person is not in the military, naval or air forces of any country, combination of countries or international organization or in any civilian non-combatant unit supporting or accompanying such forces, if the illness or injury occurs outside the home area.

- Resulting from attempted suicide or an intentionally self-inflicted injury;
- Resulting from participation in a felony, riot, or insurrection;
- Resulting from the insured person's alcoholism or addiction to drugs or narcotics (except for an addiction to a prescription medication when administered in accordance with the advice of a physician);
- For which the insured person receives, or is eligible to receive workers' compensation benefits, occupational disease act benefits, or similar benefits.
- Benefits will be paid only for Covered Care expenses that are in excess of the amount paid or payable under:
- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- Any other federal, state or other governmental health care program or law except Medicaid.

For Employees who Reside in New York

Exclusions: Benefits are not paid for any expenses incurred for any room and board, care, treatment, services, equipment, or other items:

- For which no charge is normally made in the absence of insurance;
- Provided outside the United States of America, its territories and possessions; except as described in the International Coverage Benefit;
- Provided by the insured's immediate family, unless a benefit specifically states that a member of the immediate family can provide Covered Care. Genworth will not consider care to have been provided by a member of the immediate family when:
  - The insured's immediate family member is a regular employee of the organization that is providing the services; and
  - Such organization receives payment for the services; and
  - The insured's immediate family member receives no compensation other than the normal compensation for employees in her or his job category;
- Provided by or in a Veteran's Administration or Federal government facility, unless a valid charge is made to the insured's estate;
- Resulting from war or any act of war, whether declared or not;
- Resulting from attempted suicide or an intentionally self-inflicted injury;
- Resulting from participation in a felony, riot, or insurrection;

- Resulting from the insured's alcoholism or addiction to drugs or narcotics (except for an addiction to a prescription medication when administered in accordance with the advice of a physician);
- For which the insured person receives, or is eligible to receive, workers' compensation benefits, occupational disease act benefits, or similar benefits.
- Benefits are payable for Alzheimer's disease, subject to the same exclusions, limitations and provisions otherwise applicable to other Covered Care.

Non-Duplication of benefits: Benefits will be paid only for Covered Care expenses that are in excess of the amount paid or payable under;

- Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount); and
- Any other federal, state or other governmental health care program or law except Medicaid.

Alternate plan of service provision

What if the service I want is not covered?

Alternate care expenses not otherwise covered by the Plan, may be covered when the insured, his or her physician if appropriate and Genworth agree in writing to the alternate care services. Prior approval is required. Genworth must determine that the care or services are qualified Long Term Care services that are cost-effective and appropriate; are consistent with general standards of care; provide an equal or greater quality of care than other services covered by the Plan; and are clearly specified in the insured's Plan of Care and in a separate written mutual agreement between the insurer and the insured.

Filing a Claim

How do I file a claim?

Payment of claims under the Plan will be made by the Claims Administrator, Genworth. Claims for benefits under the Plan are to be submitted to the Claims Administrator as provided in the Claim Payments section of the Certificate of Insurance.

Contact the Claims Administrator with any questions regarding a claim or need for claim forms.

Notify the Claims Administrator within 30 days of the date the covered loss starts or as soon as reasonably possible thereafter.

Upon receipt of a notice of claim, the claim forms needed to file proof of loss will be sent. If the claim forms are not received within 15 days, proof of loss can be filed without them with a letter describing the nature and extent of the loss and the covered expense for which claim is made. If the claim is for a continuing loss, written proof of loss must be given to the Claims Administrator within 90 days after the end of each monthly period for

which benefits may be payable. For any other loss, written proof must be given within 90 days after the date of such loss. Unless the insured is not legally capable, the required proof must always be given to the Claims Administrator no later than 1 year from the time specified.

The Claims Administrator must receive updates to the insured's Plan of Care on an ongoing basis.

Once the Elimination Period is satisfied, benefit payments will be made on a monthly basis after receipt of claim as long as the insured remains eligible to receive benefits. When a claim is paid, a notice showing the total amount of benefits that have been paid to date will be sent to the insured.

How do I appeal a benefit determination or denied claim?

If a claim under the Plan is denied in whole or in part, the insured will receive written notice. This notice will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim and an explanation of the claims review procedure. If Genworth fails to respond within 90 days, the claim is treated as denied.

Within 60 days after denial, the insured may submit a written request for reconsideration of the claim. Documents or records in support of the appeal should accompany any such request. The insured may review pertinent documents and submit issues and comments in writing. Genworth will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended by an additional 60 days under certain circumstances.) In the written response, Genworth will explain the reason for the decision, with specific reference to the provisions of the Plan on which the decision is based.

Glossary

ACTIVELY-AT-WORK

You are "Actively-At-Work" if you are an employee classified on payroll as a US regular employee who is performing the usual duties of his/her job at the usual place of work as required by Marsh & McLennan Companies. You are considered Actively-At-Work while on Company approved vacations, holidays and regularly scheduled days off, or during temporary business closures. You are not considered to be Actively-At-Work if you are unable to perform your usual duties due to a sickness, accident or injury; or if you are on a leave of absence, a sabbatical or retired from the Company.

AFTER TAX DEDUCTIONS (EMPLOYEE CONTRIBUTIONS)

Deductions taken from your pay after Social Security (FICA and Medicare) and federal unemployment insurance (FUTA) taxes and other applicable federal, state and local taxes are withheld.

APPROVED SPOUSE AND DOMESTIC PARTNER

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

Spouse / Domestic Partner

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

Spouse Only

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

Domestic Partner Only

- Although not registered with a US state or local authority, your relationship constitutes an eligible domestic partnership. To establish that your relationship constitutes an eligible domestic partnership you and your domestic partner must:
  - be at least 18 years old
  - not be legally married, under federal law, to each other or anyone else or part of another domestic partnership during the previous 12 months
  - currently be in an exclusive, committed relationship with each other that has existed for at least 12 months and is intended to be permanent
  - not be Medicare eligible
  - currently reside together, and have resided together for at least the previous 12 months, and intend to do so permanently
  - 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.

In order to cover the child(ren) of a spouse or domestic partner, you will be required to agree to the Affidavit of Eligible Family Membership. Go to Colleague Connect (**https://colleagueconnect.mmc.com**), click **Career & Rewards** and select **Mercer Marketplace Benefits Enrollment Website** under Tools.

BEFORE TAX DEDUCTIONS (EMPLOYEE CONTRIBUTIONS)

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

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

CARE ADVISOR

A health care professional from a Care Management Organization.

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

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

CHRONICALLY ILL

A Chronically Ill individual is a person who has been certified by a licensed Health Care Practitioner as:

- Being unable to perform, without substantial assistance (either standby assistance or hands-on assistance) from another individual, at least two Activities of Daily Living for a period of at least 90 days due to a loss of functional capacity. In addition, this loss of functional capacity must, at first, be expected to exist for a period of at least 90 days; or
- Requiring substantial supervision to protect the person from threats to health and safety due to Severe Cognitive Impairment.

EVIDENCE OF INSURABILITY

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

INFLATION

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