

Benefits Handbook Date July 1, 2024

Administrative Information

Marsh McLennan



Administrative Information

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

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

Included in this document is information about the Benefits Handbook itself (such as the plans for which the Benefits Handbook serves as the Summary Plan Description and the official plan document), description of certain laws that apply to the benefit plans, and your rights under those laws. References in this section to Marsh & McLennan Companies mean Marsh McLennan.

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

In This Section	See Page
How the Benefits Handbook Is Used	1
Administrative Details about the Plans	1
The \$1,600 and \$3,200 Deductible Plans and Surest Copay Plan	2
The Basic Life Insurance Plan.....	9
The Basic Long Term Disability Plan	11
Teladoc Medical Experts Program	13
The Business Travel Accident Insurance Plan.....	15
Dental Plan.....	16
The Dependent Care Flexible Spending Account Plan (DCFSA)	18
The Employee Assistance Program (EAP)	20
The Group Benefits Plan	21
The Group Variable Universal Life Insurance (GVUL) Plan	23
Hawaii - HMSA's Health Plan Hawaii Plus HMO (HMO).....	24
Hawaii - HMSA's Preferred Provider Plan (PPP)	26
The Health Advocate Program	27
The Health Care Flexible Spending Account Plan (HCFSA).....	28
The Health Savings Account (HSA)	30
The Individual Disability Insurance Plan.....	31
The Legal Assistance Plan.....	33
The Limited Purpose Health Care Flexible Spending Account Plan (LPHCFSA)	35
Long Term Disability Bonus Income Plan	36
The Sword Thrive Digital Physical Therapy Program.....	38
The Sword Health Wellness Prevention Program	39
The Marsh & McLennan Companies Health & Welfare Benefits Program	40
The Marsh & McLennan Companies Retirement Plan	42
The MSK Direct Program	43
The Optional Long Term Disability Plan.....	44
The Voluntary AD&D Plan.....	46
The Retiree Reimbursement Account Plan (RRA)	48
The Marsh & McLennan Companies 401(k) Savings & Investment Plan.....	49
The MMA 401(k) Savings & Investment Plan.....	51
The Short Term Disability Benefits Payroll Policy	54
The Vision Care Plan	55
Other Administrative Details	57
ERISA and Your Rights under ERISA	58
Your Rights under ERISA.....	59
Prudent Actions by Plan Fiduciaries.....	60
Enforce Your Rights	60
Assistance with Your Questions.....	60
Summary Plan Descriptions	61
Annual Funding Notice and Summary Annual Reports	62
Plan Summaries	81
Official Plan Documents	82
Plan Amendments	83

Plan Termination	83
Limits on Plan Amendments.....	85
Claims, Reviews, and Appeals.....	86
Authority over Benefit Determinations and Appeals.....	86
Healthcare and Welfare Plans.....	87
Healthcare Plans	88
Dependent Care Flexible Spending Account Plan	94
Disability Plans	94
Life Insurance, Accident Insurance and Legal Assistance Plans	97
Retirement and Savings Plans	98
Right of Recovery/Subrogation	101
Conversion or Portability Rights	104
Non-Assignment of Benefits	105
About Plan Coverage	106
Healthcare Plans	106
Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account	108
Dependent Care Flexible Spending Account	109
Health Savings Account	110
Other Important Information about the Plans.....	111

How the Benefits Handbook Is Used

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

The Claims Administrator (or Account Administrator or Plan Administrator, as applicable) for each plan described in the Benefits Handbook uses the description of the applicable plan in the Benefits Handbook to make determinations on claims for benefits under the plan and processes the claims. (Should any plan provision described become invalid or unenforceable, it will not affect the validity or enforceability of any other plan provision.) When necessary, the Claims Administrators (or Account Administrators or Plan Administrator, as applicable) may also refer to their internal guidelines and other formal documents such as insurance policies, certificates of insurance, and benefits summaries in making claims/benefits determinations. Such other documents are available to you upon request without any cost. The Claims Administrator (or Account Administrator or Plan Administrator, as applicable), has full discretion and authority to make all such claims/benefits determinations.

Unless the Plan Administrator has delegated such authority to a Claims Administrator or Account Administrator, the Plan Administrator shall have complete authority to interpret and construe the provisions of the plans, make findings of fact, correct errors, and supply omissions. All decisions and interpretations of the Plan Administrator made pursuant to the plan shall be final, conclusive, and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious.

Conflicts in Terms

Unless otherwise noted, for a self-insured benefit, if there is a conflict between a specific provision under the Benefits Handbook and a benefit booklet/summary, the Benefits Handbook controls. For fully insured benefits, the terms of the certificate of insurance/evidence of coverage or insurance policy will control when describing specific benefits that are covered or insurance-related terms.

Headings, Navigation Menus, Tables of Contents, Etc.

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

Administrative Details about the Plans

The following is administrative information about the benefits described in the Benefits Handbook.

Some of the plans are fully insured and some are self-insured, as indicated below. Fully insured means that benefits are provided under an insurance contract with an insurance company. Claims for benefits are sent to the insurance company, which is responsible for paying plan benefits, rather than the Company. (However, the insurance company and the Plan Administrator share responsibility for administering the plan, as discussed

below.) Some of the plans are self-insured, as indicated below. This means that there is no insurance company that collects premiums and pays benefits. Instead, participating employees, the Company, or both make contributions to cover the cost of benefits. The Company's payment of benefits may be made by the Company out of its general assets or through a trust established for that purpose. If contributions are required by the participating employees, the Company will determine the amount, in its discretion and in a uniform and consistent manner.

Eligibility for the Plans

Eligible employees of the Company are covered by the employee benefits plans described in this document, as well as employees of any subsidiary or affiliate, as described in the applicable plan eligibility sections of the Benefits Handbook.

You may write to the Plan Administrator for a complete list of the employers that participate in each of the plans.

The \$1,600 and \$3,200 Deductible Plans and Surest Copay Plan

\$1,600 and \$3,200 Deductible Plans (1) self-insured and administered by Aetna or Anthem BlueCross BlueShield (Anthem BCBS) all States excluding Hawaii or (2) insured by Kaiser - CA, CO, GA, MD, VA, Washington and DC.

Surest Copay Plan: Administered by Surest – all States excluding Hawaii.

Medical Plans Available Under Each Third Party Administrator (Or Carrier with Respect to the Insured Programs)

Seven plan options form part of the Marsh & McLennan Companies Health & Welfare Benefits Program:

- The Marsh & McLennan Companies \$1,600 Deductible Medical Plan
- The Marsh & McLennan Companies \$3,200 Deductible Medical Plan
- The Surest Copay Plan

Plan Number

501

Plan Type

This is a group medical plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – Deductible Medical Plans and Surest Copay Plan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plans.

Group Contract Number

Aetna - The group contract number is 868802.

Anthem BCBS - The group contract number is 270146.

Kaiser Permanente: - The group insurance contract number is by region as follows:

- Southern CA: 232189
- Northern CA: 604494
- CO: 35660
- GA: 10165
- Oregon and Southwest Washington: 19847
- VA/MD/DC: 23042
- WA (Western Washington and Spokane area): 25988

Surest – The group contract number is 78800361

Source of Benefits Funding and Trustee

For Aetna, Anthem BCBS and Surest:

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

The Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrators who are responsible for administering and processing claims for these self-insured plans, except with respect to eligibility to participate in the plans.

For Kaiser:

The plans are fully insured through Kaiser who administers and processes claims and is solely responsible for paying medical benefits.

Contributions are made by the Company and participating employees. These contributions are held in the Marsh McLennan Employer Funded Welfare Benefit Trust by the trustee:

The Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149

Premiums are payable solely from the trust.

Claims Administrator

For filing a medical claim:

For Aetna:

Aetna
P.O. Box 981106
El Paso, TX 79998-1106
Phone: +1 866 210 7858

For precertification:

Aetna
Phone: +1 866 210 7858

For filing a retail prescription drug claim:

CVS Caremark
One CVS Drive
Woonsocket, RI 02895
Phone: +1 844 449 0362
Website: www.caremark.com
Group #: 21CW

For filing a mail-order prescription drug claim:

CVS Caremark
P.O. Box 659541
San Antonio, TX 78265-9541
Phone: +1 844 449 0362
Website: www.caremark.com
Group #: 21CW

For appealing a medical claim:

Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, KY 40512

For appealing a prescription drug claim:

CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072-2084
Attn: Appeals Department MC 109
Claims Appeal Fax: +1 866 443 1172
Specialty Appeal Fax: +1 855 230 5548

For COBRA coverage:

My Benefits Service Center
Phone: +1 866 324 4087

For Anthem BCBS:

Anthem BCBS
Attn: Claims
P.O. Box 105187
Atlanta, GA 30348-5187
Phone: +1 855 570 1150

For precertification:

Anthem BCBS
Phone: +1 855 570 1150

For filing a retail prescription drug claim:

CVS Caremark
One CVS Drive
Woonsocket, RI 02895
Phone: +1 844 449 0362
Website: www.caremark.com
Group #: 21CW

For filing a mail-order prescription drug claim:

CVS Caremark
P.O. Box 659541
San Antonio, TX 78265-9541
Phone: +1 844 449 0362
Website: www.caremark.com
Group #: 21CW

For appealing a medical claim:

Anthem BCBS
Attn: Medical Appeals
P.O. Box 105568
Atlanta, GA 30348
Phone: +1 855 570 1150

For appealing a prescription drug claim:

CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072-2084
Attn: Appeals Department MC 109
Claims Appeal Fax: +1 866 443 1172
Specialty Appeal Fax: +1 855 230 5548

For COBRA coverage:

My Benefits Service Center
Phone: +1 866 324 4087

For Kaiser:

Kaiser Customer Service Phone Numbers:

Region	Toll Free	TTY
Georgia	+1 888 865 5813	711
Northern California	+1 800 464 4000	711
Southern California	+1 800 464 4000	711
Oregon and Southwest Washington	+1 800 813 2000	711
Colorado	+1 800 632 9700	711
Virginia/Maryland/Washington, DC	+1 800 777 7902	711
Washington (Western Washington and Spokane area)	+1 888 901 4636	711

Claims Processing

Region	Address	Phone:
Kaiser Permanente – Northern CA	Kaiser Foundation Health Plan, Inc. P.O. Box 12923 Oakland, CA 94612	+1 800 464 4000
Kaiser Permanente – Southern CA	Kaiser Foundation Health Plan, Inc. P.O. Box 7004 Downey, CA 90242-0361	+1 800 464 4000
Kaiser Permanente – CO	Kaiser Foundation Health Plan of Colorado P.O. Box 373150 Denver, CO 80237-9998	+1 800 632 9700
Kaiser Permanente – GA	Kaiser Permanente P.O. Box 370010 Denver, CO 80237-9998	+1 888 865 5813
Kaiser Permanente – MAS (Virginia/Maryland/Washington, D.C.)	Kaiser Permanente P.O. Box 371860 Denver, CO 80237-9998	+1 800 777 7902
Kaiser Permanente – Oregon and Southwest Washington	Kaiser Foundation Health Plan of the Northwest Kaiser Permanente Claims Administration P.O. Box 370050 Denver, CO 80237-9998	+1 800 813 2000
Kaiser Permanente – Washington (Western Washington and Spokane area)	Kaiser Foundation Health Plan of Washington Kaiser Permanente Claims Administration P.O. Box 30766 Salt Lake City, UT 84130-0766	+1 888 901 4636

Appeals:

Region	Address	Phone:
Kaiser Permanente – Northern and Southern CA	Kaiser Foundation Health Plan, Inc. Special Services Unit P.O. Box 23280 Oakland, CA 94623	+1 800 464 4000
Kaiser Permanente – CO	Appeals Program Kaiser Foundation Health Plan of Colorado P.O. Box 378066 Denver, CO 80237-8066	+1 303 344 7933 +1 888 370 9858 Fax: +1 866 466 4042
Kaiser Permanente – GA	Kaiser Permanente Appeals Department Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736	+1 404 364 4862 Fax: +1 404 364 4793
Kaiser Permanente – MAS (Virginia/Maryland/Washington, D.C.)	Member Services Appeals Unit Kaiser Permanente 2101 East Jefferson Street Rockville, MD 20852	+1 301 468 6000 Fax: +1 301 816 6192
Kaiser Permanente – Oregon and Southwest Washington	Kaiser Foundation Health Plan of the Northwest Member Relations Department 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099	+1 503 813 4480 Fax: +1 503 813 3985
Kaiser Permanente – Washington (Western Washington and Spokane area)	Kaiser Foundation Health Plan of Washington Member Appeals Department P.O. Box 30766 Salt Lake City, UT 84130-0766	+1 866 458 5479 Fax: +1 206 901 7340

For Surest:

For filing a medical claim:

Surest
P.O. Box 211758
Eagan, MN 55121
Phone: +1 866 683 6440

For precertification:

Surest
Phone: +1 877 237 0006

For filing a retail prescription drug claim:

CVS Caremark
One CVS Drive
Woonsocket, RI 02895
Phone: +1 844 449 0362
Website: www.caremark.com
Group #: 21CW

For filing a mail-order prescription drug claim:

CVS Caremark
P.O. Box 659541
San Antonio, TX 78265-9541
Phone: +1 844 449 0362
Website: www.caremark.com
Group #: 21CW

For appealing a medical claim:

Surest
Attn: Member Appeals Department
P.O. Box 211758
Eagan, MN 55121
Phone: +1 866 683 6440

For appealing a prescription drug claim:

CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072-2084
Attn: Appeals Department MC 109
Claims Appeal Fax: +1 866 443 1172
Specialty Appeal Fax: +1 855 230 5548

For COBRA coverage:

My Benefits Service Center
Phone: +1 866 324 4087

The Basic Life Insurance Plan

Plan Name

Marsh & McLennan Companies Basic Life Insurance Plan

The plan forms part of the Marsh & McLennan Companies Health & Welfare Benefits Program.

Plan Number

501

Plan Type

This is a life insurance plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – Basic Life Insurance
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

The group insurance contract number is 1098400.

Source of Benefits Funding and Trustee

The Basic Life Insurance Plan is fully insured through contracts with the Metropolitan Life Insurance Company (MetLife). MetLife, who administers and processes claims for this plan, except with respect to claims for eligibility to participate in the plan, is solely responsible for paying benefits. Contributions are intended to be made solely by the Company. These contributions are held in the Marsh & McLennan Companies Employer Funded Welfare Benefit Trust by the trustee:

The Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149

Premiums are payable solely from the trust.

Claims Administrator

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

For filing a claim:

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

For appealing a claim:

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

For converting your coverage:

Metropolitan Life Insurance Company
Phone: +1 877 431 1167

Website: www.metlife.com/metlife-advice

The Basic Long Term Disability Plan

Plan Name

Marsh & McLennan Companies Basic Long Term Disability Plan

The plan forms part of the Marsh & McLennan Companies Health & Welfare Benefits Program.

Plan Number

501

Plan Type

This is a long term disability insurance plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – Basic Long Term Disability
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

The group insurance policy number is GLT-342134.

Source of Benefits Funding and Trustee

The Basic Long Term Disability Plan is partially self-insured by the Company and partially insured by The Hartford Life and Accident Insurance Company. Contributions for the self-insured portion are intended to be made solely by the Company. These contributions are held in the Marsh McLennan Employer Funded Welfare Benefit Trust by the trustee:

The Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149

The Company pays the premiums for the insured portion of the plan directly to The Hartford Life and Accident Insurance Company.

Benefits for the self-insured portion of the plan are payable solely from the trust and benefits for the insured portion of the plan are payable solely by The Hartford Life and Accident Insurance Company.

The Company has engaged the services of The Hartford Life and Accident Insurance Company to be the Claims Administrator who is responsible for processing all claims for the plan, except with respect to claims for eligibility to participate.

Claims Administrator

The Hartford Life and Accident Insurance Company
P.O. Box 14306
Lexington, KY 40512-4306
Phone: +1 866 432 6727
Fax: +1 866 411 5613

For filing a claim:

If you have been disabled due to a non-work related medical condition for a period greater than seventeen weeks, a Long Term Disability Claim will automatically be initiated by the Claims Administrator. The Claims Administrator will send a Long Term Disability forms packet to you for completion to your home address. The forms should be returned to The Hartford Life and Accident Insurance Company as soon as possible. The receipt of these forms by the Claims Administrator constitutes your request for Long Term Disability benefits. A return envelope will be provided for your convenience. For work related disabilities, a claim form will automatically be sent to your home address by Marsh McLennan. If you have been disabled for more than four months, and you have not received the form, you can contact the Marsh McLennan Leave Management Team.

For appealing a claim:

The Hartford Life and Accident Insurance Company
Appeals Unit
P.O. Box 14087
Lexington, KY 40512-4087
Fax: +1 855 339 7249

Teladoc Medical Experts Program

Plan Name

The Teladoc Medical Experts Program

The Teladoc Medical Experts Program forms part of the Marsh & McLennan Companies Group Benefits Plan.

Plan Number

503

Plan Type

This is a health plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Marsh McLennan – Teladoc Medical Experts
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

N/A

Source of Benefits Funding

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

Claims Administrator

For filing a claim:

Teladoc Medical Experts
1250 Hancock Street
Quincy, MA 02169
Phone: +1 800 835 2362

For appealing a claim:

Teladoc Medical Experts
1250 Hancock Street
Quincy, MA 02169
Phone: +1 800 835 2362

For COBRA coverage:

My Benefits Service Center
Phone: +1 866 324 4087

The Business Travel Accident Insurance Plan

Plan Name

Marsh & McLennan Companies Business Travel Accident Insurance Plan

The plan forms part of the Marsh & McLennan Companies Group Benefits Plan.

Plan Number

503

Plan Type

This is an accident insurance plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – Business Travel Accident Insurance
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

The group contract number is MTA 9160537.

Source of Benefits Funding

The Business Travel Accident Insurance Plan is insured through a contract with the National Union Fire Insurance Company of Pittsburgh Pa (National Union), a division of AIG, and is solely responsible for paying benefits. National Union Fire Insurance Company of Pittsburgh Pa (National Union), a division of AIG, is the Claims Administrator that administers and processes claims for this plan, except with respect to claims for eligibility to participate.

The Company has engaged the services of the Claims Administrator who is responsible for processing claims, except with respect to eligibility to participate.

Claims Administrator

National Union Fire Insurance Company of Pittsburgh Pa (National Union), a division of AIG
P.O. Box 25897
Shawnee Mission, KS 66225
Phone: +1 800 551 0824 or +1 913 495 6520

For filing a claim:

National Union Fire Insurance Company of Pittsburgh Pa (National Union) a division of AIG
AIG A&H Claims Division
P.O. Box 25897
Shawnee Mission, KS 66225
Phone: +1 800 551 0824 or +1 913 495 6520

Fax: +1 866 893 8574

Email: MTAClaimsSubmissions@aig.com

For appealing a claim:

National Union Fire Insurance Company of Pittsburgh Pa (National Union) a division of AIG
AIG A&H Claims Division
P.O. Box 25897
Shawnee Mission, KS 66225
Phone: +1 800 551 0824 or +1 913 495 6520

Fax: +1 866 893 8574

Email: MTAClaimsSubmissions@aig.com

Dental Plan

Plan Name

Marsh & McLennan Companies Dental Plan

The plan forms part of the Marsh & McLennan Companies Health & Welfare Benefits Program.

Plan Number

501

Plan Type

This is a dental plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – Dental Plan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

The group contract number is 1098400.

Source of Benefits Funding and Trustee

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

The Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, MetLife, to process claims for this self-insured plan, except with respect to claims for eligibility to participate.

Claims Administrator

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

Contacts

For filing a claim:

MetLife Dental Claims
P.O. Box 981282
El Paso, TX 79998-1282
Phone: +1 800 942 0854

For appealing a claim:

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

For COBRA coverage:

My Benefits Service Center
Phone: +1 866 324 4087

For a copy of participating dentists:

www.MetLife.com/dental
Phone: +1 800 942 0854

The Dependent Care Flexible Spending Account Plan (DCFSA)

Plan Name

Marsh & McLennan Companies Dependent Care Flexible Spending Account

The DCFSA does not form part of the Marsh & McLennan Companies Health & Welfare Benefits Program and is not an ERISA-covered plan.

Plan Number

N/A

Plan Type

This is a dependent care flexible spending account plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – DCFSA
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

The group contract number is 36-2668272.

Source of Benefits Funding and Trustee

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

The Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan, except with respect to claims for eligibility to participate.

Claims Administrator

For sending a claim:

Spending Account Service Center
P.O. Box 350
Conshohocken, PA 19428
Phone: +1 866 324 4087
Fax: +1 888 788 1928

For appealing a claim:

Spending Account Service Center
P.O. Box 350
Conshohocken, PA 19428
King of Prussia, PA 19406
Phone: +1 866 324 4087
Fax: +1 888 788 1928

The Employee Assistance Program (EAP)

Plan Name

Marsh & McLennan Companies Employee Assistance Program

The EAP forms part of the Marsh & McLennan Companies Group Benefits Plan.

Plan Number

503

Plan Type

This is an employee assistance program.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Marsh McLennan – Employee Assistance Program
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

N/A

Source of Benefits Funding

The Employee Assistance Program is insured through a contract with Cigna Behavioral Health. Cigna Behavioral Health is the Claims Administrator that administers claims for this plan, except with respect to claims for eligibility to participate, and is solely responsible for paying benefits.

Contributions are intended to be made solely by the Company.

Claims Administrator

To obtain services:

Phone: +1 800 382 3432
24 hours a day, 7 days a week

When you call, provide the name of the Marsh McLennan operating company in which you are employed.

For filing a claim:

Cigna Behavioral Health
3636 Nobel Drive Suite 150
San Diego, CA 92122
Phone: +1 800 382 3432

For appealing a claim:

Cigna Behavioral Health
3636 Nobel Drive Suite 150
San Diego, CA 92122
Phone: +1 800 382 3432

For COBRA coverage:

My Benefits Service Center
Phone: +1 866 324 4087

The Group Benefits Plan

Plan Name

Marsh & McLennan Companies Group Benefits Plan

The plan provides health, legal, death and disability benefits to eligible employees through the following component welfare plans:

- Teladoc Medical Experts Program
- The Business Travel Accident Insurance Plan
- The Employee Assistance Program (EAP)

- The Individual Disability Insurance Plan
- The Legal Assistance Plan
- Long Term Disability Bonus Income Plan
- The Voluntary AD&D Plan
- The Vision Care Plan

Plan Number

503

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Marsh McLennan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

N/A

Source of Benefits Funding

The Group Benefits Plan provides benefits through various component welfare plans. For information on the source of funding for each plan, see the descriptions of the individual welfare plans in this Administrative Details about the Plans section.

The Group Variable Universal Life Insurance (GVUL) Plan

Plan Name

Marsh & McLennan Companies Group Variable Universal Life Insurance (GVUL) Plan

The plan forms part of the Marsh & McLennan Companies Health & Welfare Benefits Program.

Plan Number

501

Plan Type

This is a life insurance plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – Group Variable Universal Life Insurance Plan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 - 5000

The Plan Administrator is responsible only for determining claims with respect to eligibility to participate in the plan.

Group Contract Number

The group contract number is 0105231.

Source of Benefits Funding

The Group Variable Universal Life Insurance Plan is insured through contracts with MetLife. MetLife is the Claims Administrator, who administers claims for this plan, except with respect to claims for eligibility to participate, and is solely responsible for paying benefits:

Premiums are intended to be made solely by participating employees and are paid directly to MetLife.

Claims Administrator

For filing a claim:

Metropolitan Life Insurance Company
13045 Tesson Ferry Road
Mail Code A2-10
St Louis, MO 63128

For appealing a claim:

Metropolitan Life Insurance Company
13045 Tesson Ferry Road
Mail Code A2-10
St Louis, MO 63128

For converting your coverage: Contact Mercer Voluntary Benefits at +1 800 225 2265, Monday - Friday, 8 a.m. - 10 p.m., Eastern time and you will be transferred to a MetLife GVUL Customer Service Representative.

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

Plan Name

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

The plan forms part of the Marsh & McLennan Companies Health & Welfare Benefits Program.

Plan Number

501

Plan Type

This is a group medical plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – HMSA HMO
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

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

Source of Benefits Funding and Trustee

The plan is fully insured through HMSA. HMSA is the Claims Administrator that administers claims for this plan, except with respect to claims for eligibility to participate, and is solely responsible for providing medical benefits and claims determinations.

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

The Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149

Premiums are payable solely from the trust.

Claims Administrator

For appealing a medical or prescription drug claim:

HMSA - HPH
Attention: Appeals Coordinator
P.O. Box 1958
Honolulu, HI 96805-1958
Phone: +1 800 462 2085
Fax: +1 808 952 7546

For COBRA coverage:

My Benefits Service Center
Phone: +1 866 324 4087

Hawaii - HMSA's Preferred Provider Plan (PPP)

The plan forms part of the Marsh & McLennan Companies Health & Welfare Benefits Program.

Plan Name

Marsh & McLennan Companies HMSA's Preferred Provider Plan

Plan Number

501

Plan Type

This is a group medical plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – HMSA PPP
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

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

Source of Benefits Funding and Trustee

The plan is fully insured through HMSA. HMSA is the Claims Administrator that administers claims, except with respect to claims for eligibility to participate, and is solely responsible for providing medical benefits and claims determinations.

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

The Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149

Premiums are payable solely from the trust.

Claims Administrator

For filing a medical or prescription drug claim:

HMSA
Claims Department
PO Box 860
Honolulu, HI 96808-0860

HMSA
Out of State Claims
P.O. Box 2970
Honolulu, HI 96802-2970

For appealing a medical or prescription drug claim:

HMSA - HPH
Attention: Appeals Coordinator
P.O. Box 1958
Honolulu, HI 96805-1958
Phone: +1 800 462 2085
Fax: +1 808 952 7546

For COBRA coverage:

My Benefits Service Center
Phone: +1 866 324 4087

The Health Advocate Program

Plan Name

The Health Advocate Program

The Company has engaged the services of the Health Advocate Program to assist employees and their families navigate the health care system. It is not a plan subject to ERISA.

Plan Number

N/A

Plan Type

This is an advocacy program.

Plan Year

N/A

Plan Sponsor

N/A

Plan Administrator

N/A

Claims Administrator

To request assistance:

Health Advocate
3043 Walton Road, Suite 150
Plymouth Meeting, PA 19462
Phone: +1 866 799 2488

The Health Care Flexible Spending Account Plan (HCFSA)***Plan Name***

Marsh & McLennan Companies Health Care Flexible Spending Account Plan

The plan forms part of the Marsh & McLennan Companies Health & Welfare Benefits Program.

Plan Number

501

Plan Type

This is a health care flexible spending account plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – HCFSA
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

The group contract number is 36-2668272.

Source of Benefits Funding

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

The Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan, except with respect to claims for eligibility to participate.

Claims Administrator

For sending a claim:

Spending Account Service Center
P.O. Box 350
Conshohocken, PA 19428
Phone: +1 866 324 4087
Fax: +1 888 788 1928

For appealing a claim:

Spending Account Service Center
P.O. Box 350
Conshohocken, PA 19428
Phone +1 866 324 4087
Fax: +1 888 788 1928

For COBRA coverage:

My Benefits Service Center
Phone: +1 866 324 4087

The Health Savings Account (HSA)

Plan Name

The Health Savings Account

The HSA is not a plan subject to ERISA.

Plan Number

N/A

Plan Type

N/A

Plan Year

N/A

Plan Sponsor

N/A

Plan Administrator

N/A

Group Contract Number

The group contract number is 36-2668272.

Source of Benefits Funding

Participating employees and the Company can make contributions to an HSA. These contributions are passed through the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust and immediately deposited in each participating employee's HSA. The trustees for the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefits Trust is:

The Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the participating employee's HSA.

Claims Administrator

The Spending Account Service Center processes HSA reimbursements.

For sending a completed claim:

Spending Account Service Center
P.O. Box 350
Conshohocken, PA 19428
Phone: +1 866 324 4087
Fax: +1 888 788 1928

For appealing a claim:

Spending Account Service Center
P.O. Box 350
Conshohocken, PA 19428
Phone: +1 866 324 4087
Fax: +1 888 788 1928

The Individual Disability Insurance Plan

Plan Name

Marsh & McLennan Companies Individual Disability Insurance Plan

The plan forms part of the Marsh & McLennan Companies Group Benefits Plan.

Plan Number

503

Plan Type

This is a long term disability plan.

Plan Year

The plan year is September 1 - August 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – Individual Disability Insurance Plan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

N/A

Source of Benefits Funding

The Individual Disability Insurance Plan is insured by individual insurance policies through Unum Group (Unum), who is the Claims Administrator that administers claims for this plan, except with respect to claims for eligibility to participate, and is solely responsible for paying disability benefits.

Premiums are made by the participating employees and paid directly to Unum. All benefits are paid by Unum.

Claims Administrator

Unum Group
The Benefits Center
P.O. Box 100262
Columbia, SC 29202-3262
Phone: +1 888 226 7959 (Monday – Friday, 8:00 am to 8:00 pm ET)
Fax: +1 866 562 4794
www.unum.com/claims

For filing a claim:

Unum Group
The Benefits Center
P.O. Box 100262
Columbia, SC 29202-3262
Phone: +1 888 226 7959 (Monday – Friday, 8:00 am to 8:00 pm ET)
Fax: +1 866 562 4794
Email: benefitsintake@unum.com

For appealing a claim:

Unum Group
The Appeals Unit
PO Box 15112
Worcester, MA 01615-0112
Fax: +1 866 562 4794

The Legal Assistance Plan***Plan Name***

Marsh & McLennan Companies Legal Assistance Plan

The plan forms part of the Marsh & McLennan Companies Group Benefits Plan.

Plan Number

503

Plan Type

This is a legal assistance plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – Legal Assistance Plan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

The group contract number is 130.

Source of Benefits Funding

The Legal Assistance Plan is provided through a contract with MetLife Legal Plans. MetLife Legal Plans is the Claims Administrator that administers claims, except with respect to claims for eligibility to participate, for this plan and is solely responsible for providing benefits.

Contributions are made solely by participating employees. These contributions are paid directly to MetLife Legal Plans.

Claims Administrator

For filing a claim:

MetLife Legal Plans
1111 Superior Avenue
Cleveland, OH 44114-2507

For appealing a claim:

MetLife Legal Plans
1111 Superior Avenue
Cleveland, OH 44114-2507

For converting your coverage:

MetLife Legal Plans
Phone: +1 800 535 4137
Website: legalplans.com

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

Plan Name

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

The plan forms part of the Marsh & McLennan Companies Health & Welfare Benefits Program.

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – Limited Purpose HCFSAs
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

The group contract number is 36-2668272.

Source of Benefits Funding and Trustee

The Limited Purpose HCFSAs are self-insured by the Company through contributions intended to be made solely by participating employees. These contributions are held in

the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust by the trustee:

The Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan, except with respect to claims for eligibility to participate.

Claims Administrator

For sending a claim:

Spending Account Service Center
P.O. Box 350
Conshohocken, PA 19428
Phone: +1 866 324 4087
Fax: +1 888 788 1928

For appealing a claim:

Spending Account Service Center
P.O. Box 350
Conshohocken, PA 19428
Phone: +1 866 324 4087
Fax: +1 888 788 1928

For COBRA coverage:

My Benefits Service Center
Phone: +1 866 324 4087

Long Term Disability Bonus Income Plan

Plan Name

Marsh & McLennan Companies Long Term Disability Bonus Income Plan

The plan forms part of the Marsh & McLennan Companies Group Benefits Plan.

Plan Number

503

Plan Type

This is a long term disability plan.

Plan Year

The plan year is January 1 – December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

Plan Administrator

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

Plan Administrator – Long Term Disability Bonus Income Plan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

The group insurance policy number is GLT-204034.

Source of Benefits Funding and Trustee

The Long Term Disability Bonus Income Plan is insured through The Hartford Life and Accident Insurance Company, who is the Claims Administrator that administers claims for this plan, except with respect to claims for eligibility to participate, and is solely responsible for paying disability benefits.

Premiums are made by the participating employees and paid directly to The Hartford Life and Accident Insurance Company. All benefits are paid by The Hartford Life and Accident Insurance Company.

Claims Administrator

The Hartford Life and Accident Insurance Company
P.O. Box 14306
Lexington, KY 40512-4306
Phone: +1 866 432 6727
Fax: +1 866 411 5613

For filing a claim:

If you elected Long Term Disability Bonus Income coverage and have been disabled due to a non-work related medical condition for a period greater than seventeen weeks, a Long Term Disability Claim will automatically be initiated by the Claims Administrator. The Claims Administrator will send a Long Term Disability forms packet to you for completion to your home address. The forms should be returned to The Hartford Life and Accident Insurance Company as soon as possible. The receipt of these forms by the Claims Administrator constitutes your request for Long Term Disability benefits. A return envelope will be provided for your convenience. For work related disabilities, a claim form will automatically be sent to your home address by Marsh McLennan.

If you have been disabled for more than four months, and you have not received the form, you can contact the Marsh McLennan Leave Management Team.

For appealing a claim:

The Hartford Life and Accident Insurance Company
Appeals Unit
P. O. Box 14087
Lexington, KY 40512-4087
Fax: +1 855 339 7249

The Sword Thrive Digital Physical Therapy Program

Plan Name

The Sword Thrive Digital Physical Therapy Program

Plan Number

N/A

Plan Type

The Sword Thrive Digital Physical Therapy Program is a digital program designed to treat chronic and acute pain or post-surgical care including, but not limited to hip, knee, back, neck and shoulder pain, without medication or surgery. The Program is provided as part of the Aetna, Anthem and Surest medical plan options.

Plan Year

N/A

Plan Sponsor

N/A

Plan Administrator

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

Plan Administrator – Deductible Medical Plans and Surest Copay Plan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plans.

Claims Administrator

To request assistance:

Sword Health
13937 Sprague Lane, Suite 100
Draper, UT 84020

join.swordhealth.com/mm/

The Sword Health Wellness Prevention Program

Plan Name

The Sword Health Wellness Prevention Program

Plan Number

N/A

Plan Type

The Sword Health Wellness Prevention Program provides educational and instructional information on the prevention of back, joint and muscle pain. It provides educational videos that teach specific mobility and strength exercises to help prevent pain. This Program is not part of the Company's medical plans and is not subject to ERISA.

Plan Year

N/A

Plan Sponsor

N/A

Plan Administrator

N/A

Claims Administrator

To request assistance:

Sword Health
13937 Sprague Lane, Suite 100
Draper, UT 84020

join.swordhealth.com/mm/

The Marsh & McLennan Companies Health & Welfare Benefits Program

Plan Name

Marsh & McLennan Companies Health & Welfare Benefits Program

The plan provides health, dependent care, life insurance and disability benefits to eligible employees through the below component welfare plans. Each of the welfare plans that form the Marsh & McLennan Companies Health & Welfare Benefits Program is not an individual “plan” but is component benefit under a single plan.

- The \$1,600 and \$3,200 Deductible Plans
- The Surest Copay Plan
- The Basic Life Insurance Plan
- The Basic Long Term Disability Plan
- Dental Plan
- The Group Variable Universal Life Insurance (GVUL) Plan
- Hawaii – HMSA’s Health Plan Hawaii Plus (HMO)
- Hawaii – HMSA’s Preferred Provider Plan (PPP)
- The Health Care Flexible Spending Account Plan (HCFSA)
- The Limited Purpose Health Care Flexible Spending Account Plan (LPHCFSA)
- Optional Long Term Disability Plan

Plan Number

501

Plan Type

This is a welfare plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

Unless otherwise stated in the individual welfare plan, the Plan Administrator is Marsh & McLennan Companies, Inc. Benefits Administration Committee and can be reached at:

Marsh McLennan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of each of the individual welfare plans that form the Marsh & McLennan Companies Health & Welfare Benefits Program except to the extent authority has been granted to the Claims Administrator for adjudication of claims under such welfare plans.

Group Contract Number

N/A

Source of Benefits Funding

The Marsh & McLennan Companies Health & Welfare Benefits Program provides benefits through various welfare plans. For information on the source of funding, see the individual welfare plans. Notwithstanding anything to the contrary, (i) all of the benefits payable under the Marsh & McLennan Companies Health & Welfare Benefits Program may be paid from contributions made by (a) Marsh & McLennan Companies, Inc., (b) the participating employee or (c) the participating employee paying a fixed fee amount with Marsh & McLennan Companies, Inc. paying the balance and that any of the benefits under the plan may be partly or completely funded through a trust or an insurance policy, (ii) as a condition of eligibility for benefits under any benefit available under the plan, a participant may be required to contribute to the plan in amounts determined by Marsh & McLennan Companies, Inc. in its sole discretion, and (iii) any assets of the plan, including participant contributions, may be used to pay for any benefit costs and administrative expenses of the plan and other legally permissible expenses.

The Marsh & McLennan Companies Retirement Plan

Plan Name

Marsh & McLennan Companies Retirement Plan

Plan Number

001

Plan Type

The Retirement Plan is a funded, tax-qualified defined benefit pension plan under which benefits are determined under a formula and Company contributions are actuarially determined.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036-2774

Information regarding eligibility to participate in the Marsh & McLennan Companies Retirement Plan can be found in the *Marsh & McLennan Companies Retirement Plan* section of the Benefits Handbook.

Plan Administrator

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

Plan Administrator – Marsh & McLennan Companies Retirement Plan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of the Plan. Day-to-day plan administration and recordkeeping is provided through a contract with an outside administrative services provider.

Source of Benefits Funding and Trustee

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

Marsh & McLennan Companies Master Retirement Savings Trust
The Northern Trust Company of Chicago, Illinois
50 South La Salle Street
Chicago, Illinois 60690

An Investment Committee of 3 or more persons is appointed by the Global Benefits Oversight Committee to manage and supervise Plan Investments.

Claims Administrator

For filing a claim:

Plan Administrator
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

For appealing a claim:

Plan Administrator – Marsh & McLennan Companies Retirement Plan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The MSK Direct Program

Plan Name

The MSK Direct Program

The Company has engaged the services of the MSK Direct Program to help you with general questions about cancer treatment and provide support navigating the cancer treatment process. It is not a plan subject to ERISA.

Plan Number

N/A

Plan Type

This is a cancer treatment coordination program.

Plan Year

N/A

Plan Sponsor

N/A

Plan Administrator

MSK Direct

Hours: Any business day, from 8:00 a.m. to 6:00 p.m. Eastern time

Phone: +1 844 MMC 2MSK (+1 844 662 2675)

The Optional Long Term Disability Plan***Plan Name***

Marsh McLennan Companies Optional Long Term Disability Plan

The plan forms part of the Marsh & McLennan Companies Health & Welfare Benefits Program.

Plan Number

501

Plan Type

This is a long term disability plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – Optional Long Term Disability
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

The group insurance policy number is GLT-342135.

Source of Benefits Funding and Trustee

The Optional Long Term Disability Plan is partially self-insured by the Company and partially insured by The Hartford Life and Accident Insurance Company. Contributions are intended to be made by participating employees. These contributions are held in the Marsh & McLennan Companies Employee-Funded Welfare Benefit Trust by the trustee:

The Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149

The Company pays the premiums for the insured portion of the plan directly to The Hartford Life and Accident Insurance Company.

Benefits for the self-insured portion of the plan are payable solely from the trust and benefits for the insured portion of the plan are payable solely by The Hartford Life and Accident Insurance Company.

The Company has engaged the services of The Hartford Life and Accident Insurance Company to be the Claims Administrator, who is responsible for processing all claims for the plan, except with respect to claims for eligibility to participate.

Claims Administrator

The Hartford Life and Accident Insurance Company
P.O. Box 14306
Lexington, KY 45012-4306
Phone: +1 866 432 6727
Fax: +1 866 411 5613

For filing a claim:

If you have elected Optional Long Term Disability coverage and have been disabled due to a non-work related medical condition for a period greater than seventeen weeks, a Long Term Disability Claim will automatically be initiated by the Claims Administrator. The Claims Administrator will send a Long Term Disability forms packet to you for completion to your home address. The forms should be returned to The Hartford Life and Accident Insurance Company as soon as possible. The receipt of these forms by the Claims Administrator constitutes your request for Long Term Disability benefits. A return envelope will be provided for your convenience. For work related disabilities, a claim form will automatically be sent to your home address by Marsh McLennan. If you have been disabled for more than four months, and you have not received the form, you can contact the Marsh McLennan Leave Management Team.

For appealing a claim:

The Hartford Life and Accident Insurance Company
Appeals Unit
P. O. Box 14087
Lexington, KY 40512-4087
Fax: +1 855 339 7249

The Voluntary AD&D Plan

Plan Name

Marsh & McLennan Companies Voluntary AD&D Plan

The plan forms part of the Marsh & McLennan Companies Group Benefits Plan.

Plan Number

503

Plan Type

This is an accidental death and dismemberment plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – Voluntary AD&D
Marsh McLennan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

The group insurance contract number for active employees is PAI 0009131403-B.

The group insurance contract number for retired employees is PAI 0009132260-B.

Source of Benefits Funding

The Voluntary AD&D Plan is fully insured through contracts with National Union Fire Insurance Company of Pittsburgh Pa (National Union), an AIG Company. National Union Fire Insurance Company of Pittsburgh Pa (National Union), an AIG Company is the Claims Administrator, who administers claims for this plan, except with respect to claims for eligibility to participate, and National Union Fire Insurance Company of Pittsburgh Pa (National Union), an AIG Company is solely responsible for paying benefits.

Contributions are made solely by participating employees and retirees.

Claims Administrator

National Union Fire Insurance Company of Pittsburgh Pa (National Union), an AIG Company
P.O. Box 25987
Shawnee Mission, KS 66225
Phone: +1 800 551 0824 or +1 913 495 6520

For filing a claim:

National Union Fire Insurance Company of Pittsburgh Pa (National Union), an AIG Company
AIG A&H Claims Division
P.O. Box 25987
Shawnee Mission, KS 66225
Phone: +1 800 551 0824 or +1 913 495 6520
Fax: +1 866 893 9574
Email: ahclaims@aig.com

For appealing a claim:

National Union Fire Insurance Company of Pittsburgh Pa (National Union),
an AIG Company
AIG A&H Claims Division
P.O. Box 25987
Shawnee Mission, KS 66225
Phone: +1 800 551 0824 or +1 913 495 6520
Fax: +1 866 893 9574
Email: ahclaims@aig.com

For converting your coverage:

National Union Fire Insurance Company of Pittsburgh Pa (National Union),
an AIG Company
c/o Reuben Warner Associates
1655 Richmond Avenue
Staten Island, New York 10312
Phone: +1 800 421 3005

Fax: +1 718 477 7366

The Retiree Reimbursement Account Plan (RRA)

Plan Name

Marsh & McLennan Companies Retiree Reimbursement Account (RRA)

Plan Number

505

Plan Type

This is a group health plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

The Plan Administrator can be reached at:

Plan Administrator – RRA
Marsh McLennan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Source of Benefits Funding and Trustee

The RRA is self-insured by the Company through contributions made by the Company. These contributions are held in the Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust by the trustee:

The Bank of New York Mellon
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan, except with respect to claims for eligibility to participate.

Claims Administrator

For filing a claim:

Mercer Marketplace
P.O. Box 9748
Providence, RI 02940-9748, USA
Phone: +1 800 553 4958
Website: www.retiree.mercermarketplace.com

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

Plan Name

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

Plan Number

003

Plan Type

This is a defined contribution plan under which accounts are maintained for each participant. The plan qualifies as a 401(k) savings plan. The plan is intended to qualify as a participant-directed "section 404(c) plan" pursuant to ERISA. The plan offers participants and beneficiaries the opportunity to exercise control over the assets contributed and accumulated on their behalf by allowing them to choose the manner in which these assets will be invested from a broad range of investment alternatives. This means that participants or their beneficiaries may not hold the plan's fiduciaries liable for any losses sustained in their plan account that are the result of their exercise of control over how the account balance invested.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

Information regarding eligibility to participate in the Marsh & McLennan Companies 401(k) Savings & Investment Plan can be found in the *Marsh & McLennan Companies 401(k) Savings & Investment Plan* section of the Benefits Handbook.

Plan Administrator

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

Plan Administrator – Marsh & McLennan Companies 401(k) Savings & Investment Plan
Marsh McLennan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of the plan. Day-to-day plan administration and recordkeeping is provided through a contract with an outside administrative services provider.

Source of Benefits Funding and Trustee

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

Marsh & McLennan Companies Master Retirement Savings Trust
The Northern Trust Company
801 South Canal Street
Chicago, Illinois 60607

The investment options currently available for investment are listed in the Marsh & McLennan Companies 401(k) Savings & Investment Plan section in this Benefits Handbook. Current prospectuses and certain other financial information about these funds are available on request from the Plan Administrator and on the plan's website at <https://mmcglobal.sharepoint.com/sites/Home>. Specifically, the following information may be requested from the Plan Administrator regarding the plan's investment options:

- Copies of prospectuses or, alternatively short form or summary prospectuses, or other similar documents;
- Copies of financial reports, shareholder reports, statements of additional information or other similar materials to the extent provided to the Plan Administrator;
- A statement of the value of a share or unit of each investment option; and
- A list of assets that comprise the portfolio of any investment option that constitute "plan assets" under 29 CFR 2510.3-101 and the value of each asset.
- Paper copies of the materials required by ERISA to be maintained on the plan's website regarding investment alternatives.

The plan provides that certain expenses of investment and administration, including fees for third-party service providers, may be paid out of plan assets. Refunds of Section 12b-1 and other similar fees received in connection with the plan's investment options may be applied towards these expenses. The Plan Administrator has discretion to determine how to reasonably allocate these expenses among accounts.

Claims Administrator

For filing a claim:

Marsh & McLennan Companies 401(k) Savings & Investment Plan Claims
Marsh McLennan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036

For appealing a claim:

Plan Administrator – Marsh & McLennan Companies 401(k) Savings & Investment Plan
Marsh McLennan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036

The MMA 401(k) Savings & Investment Plan

Plan Name

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

Plan Number

006

Plan Type

This is a defined contribution plan under which accounts are maintained for each participant. The plan qualifies as a 401(k) savings plan. The plan is intended to qualify as a participant-directed "section 404(c) plan" pursuant to ERISA. The plan offers participants and beneficiaries the opportunity to exercise control over the assets contributed and accumulated on their behalf by allowing them to choose the manner in which these assets will be invested from a broad range of investment alternatives. This means that participants or beneficiaries may not hold the plan's fiduciaries liable for any losses sustained in their plan account that are the result of their exercise of control over how the account balance was invested.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036-2774

Information regarding eligibility to participate in the Marsh & McLennan Agency 401(k) Savings & Investment Plan can be found in the *Marsh McLennan Agency 401(k) Savings & Investment Plan* section of the Benefits Handbook.

Plan Administrator

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

Plan-Administrator – MMA 401(k) Savings & Investment Plan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator has full discretion and authority to control and manage the operation and administration of the plan. Day to day plan administration and recordkeeping is provided through a contract with an outside plan administrative services provider.

Source of Benefits Funding and Trustee

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

Marsh & McLennan Companies Master Retirement Savings Trust
The Northern Trust Company
801 South Canal Street
Chicago, Illinois 60607

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

<https://mmcglobal.sharepoint.com/sites/Home>. Specifically, the following information may be requested from the Plan Administrator regarding the plan's investment options:

- Copies of prospectuses or, alternatively short form or summary prospectuses, or other similar documents;
- Copies of financial reports, shareholder reports, statements of additional information or other similar materials to the extent provided to the Plan Administrator;
- A statement of the value of a share or unit of each investment option; and
- A list of assets that comprise the portfolio of any investment option that constitute "plan assets" under 29 CFR 2510.3-101 and the value of each asset.

The plan provides that certain expenses of investment and administration, including fees for third-party service providers, may be paid out of plan assets. Refunds of Section 12b-1 and other similar fees received in connection with the plan's investment options may be applied towards these expenses. The Plan Administrator has discretion to determine how to reasonably allocate these expenses among accounts.

Claims Administrator

For filing a claim:

MMA 401(k) Savings & Investment Plan Claims
Marsh McLennan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036

For appealing a claim:

Plan Administrator – MMA 401(k) Savings & Investment Plan
Marsh McLennan
c/o Global Benefits Department – 31st Floor

1166 Avenue of the Americas
New York, NY 10036

The Short Term Disability Benefits Payroll Policy

Plan Name

Marsh & McLennan Companies Short Term Disability Benefits Payroll Policy

The plan is not an ERISA-covered plan.

Plan Type

N/A

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

The Plan Administrator can be reached at:

Plan Administrator – Short Term Disability Benefits Payroll Policy
Marsh McLennan
c/o Global Benefits Department – 31st Floor
1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

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

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

Claims Administrator

For filing a claim:

Marsh McLennan Leave Management Team
400 W Market Street Suite 400
Louisville, KY 40202
Phone: +1 866 374 2662 Option 4

For filing an appeal:

The Hartford Life and Accident Insurance Company
Appeals Unit
P.O. Box 14087
Lexington, KY 40512-4087

Fax: +1 855 339 7249

The Vision Care Plan

Plan Name

Marsh & McLennan Companies Vision Care Plan

The plan forms part of the Marsh & McLennan Companies Group Benefits Plan.

Plan Number

503

Plan Type

This is a vision plan.

Plan Year

The plan year is January 1 – December 31.

Plan Sponsor

The Plan Sponsor is:

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

Plan Administrator

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

Plan Administrator – Vision Care Plan
Marsh McLennan
c/o Global Benefits Department – 31st Floor

1166 Avenue of the Americas
New York, NY 10036
Telephone: +1 212 345 5000

The Plan Administrator is responsible only for determining eligibility to participate in the plan.

Group Contract Number

The group contract number is 40153086.

Source of Benefits Funding

The plan is insured through VSP, which is the Claims Administrator who administers claims and is solely responsible for providing vision benefits and determinations, except with respect to claims for eligibility to participate.

Premiums are paid by participating employees.

Claims Administrator

VSP
3333 Quality Drive
Rancho Cordova, CA 95670

For filing an out-of-network claim:

VSP
P.O. Box 495918
Cincinnati, OH 45249

For appealing a claim:

VSP
3333 Quality Drive
Rancho Cordova, CA 95670
Phone: +1 800 877 7195

For COBRA coverage:

My Benefits Service Center
Phone: +1 866 324 4087

Other Administrative Details

Employer Identification Number (EIN)

36-2668272

Agent for Legal Process

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

Marsh McLennan
1166 Avenue of the Americas
New York, NY 10036

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

Limitations on Actions

The claims review and appeal procedures for the plans provide that no legal action for benefits may be brought by any participant or beneficiary unless the plan's claim review procedure has been exhausted (that is, all appeals of adverse decisions have been made).

Any such action (whether at law, in equity or otherwise) must be commenced within one year. This one-year period shall be computed from the earlier of (a) the date a final determination denying such benefit, in whole or in part, is issued under the Plan's claim review procedure and b) the date such individual's cause of action first accrued.

California State Law

Except where pre-empted by ERISA or other US laws, the validity of the Kaiser medical plans and any of their provisions will be determined under the laws of the State of California without giving effect to principles of conflict of laws.

Delaware Law

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

Hawaii State Law

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

New York State Law

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

ERISA and Your Rights under ERISA

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

Health & Welfare Plans

- The \$1,600 and \$3,200 Deductible Plans
- The Surest Copay Plan
- The Basic Life Insurance Plan
- The Basic Long Term Disability Plan
- The Teladoc Medical Experts Program
- The Business Travel Accident Insurance Plan
- The Dental Plan
- The Employee Assistance Plan (EAP)
- The Group Variable Universal Life Insurance (GVUL) Plan
- Hawaii – HMSA's Health Plan Hawaii Plus (HMO)
- Hawaii – HMSA's Preferred Provider Plan (PPP)
- The Health Care Flexible Spending Account Plan (HCFSA)
- The Individual Disability Insurance Plan
- The Legal Assistance Plan
- The Limited Purpose Health Care Flexible Spending Account Plan (LPHCFSA)
- The Long Term Disability Bonus Income Plan
- The Optional Long Term Disability Plan
- The Voluntary AD&D Plan
- The Retiree Reimbursement Account Plan (RRA)
- The Vision Care Plan

Tax-qualified Retirement and Savings Plans

- The Marsh & McLennan Companies Retirement Plan
- The Marsh & McLennan Companies 401(k) Savings & Investment Plan
- The MMA 401(k) Savings & Investment Plan

Your Rights under ERISA

As a participant in a plan that is subject to ERISA, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

- Receive information about the plan and your benefits.
- Examine, at the Plan Administrator's office and other specified locations, including work sites, without charge, all plan documents governing the plan. These documents may include insurance contracts, if applicable, and the latest annual report (Form 5500 Series) filed by the plan with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefit Security Administration.
- Obtain, after sending a written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts, if applicable, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. You may be asked to pay a reasonable charge for the copies of documents which are not part of the prospectus.
- Receive a written summary of the plan's annual financial report. The Plan Administrator is required by law to provide each participant with a copy of this summary annual report. See "Annual Funding Notice and Summary Annual Reports" on page 62.
- For applicable plans, obtain a statement telling you whether you have a right to receive a retirement plan benefit at normal retirement age (age 65) and, if so, what your benefits would be at normal retirement age if you stop working under the plan now. If you do not have a right to a retirement benefit, the statement will tell you how many more years you have to work to get a right to a benefit. The Plan Administrator will provide this statement once every three years in the case of the Marsh & McLennan Companies Retirement Plan (or upon your written request but not more often than every 12 months), and once every quarter for the Marsh & McLennan Companies 401(k) Savings & Investment Plan, or the MMA 401(k) Savings & Investment Plan. The plan must provide the statement free of charge and are provided either electronically or via mail depending on an individual participant's election.
- For applicable plans, continue health care coverage for yourself, spouse, or covered family members if there is a loss of coverage under the plan as a result of a qualifying event. You or your covered family members will have to timely elect and pay for such coverage. Review the SPD and the documents governing the plan on the rules governing your continuation coverage rights under the Consolidated Omnibus Budget Reconciliation Act (COBRA).

- For applicable plans, the reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are several steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Administrator and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator’s control.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack of decision about the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about any of these plans, contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed

in your telephone directory. You may also contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, US Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Summary Plan Descriptions

Plans subject to ERISA, described under “ERISA and Your Rights under ERISA” on page 58, are required to provide Summary Plan Descriptions (SPDs) for those plans. This Benefits Handbook serves as the Summary Plan Description for the following plans:

Health & Welfare Plans

- The \$1,600 and \$3,200 Deductible Plans
- The Surest Copay Plan
- The Basic Life Insurance Plan
- The Basic Long Term Disability Plan
- The Teladoc Medical Experts Program
- The Business Travel Accident Insurance Plan
- The Dental Plan
- The Employee Assistance Plan (EAP)
- The Group Variable Universal Life Insurance (GVUL) Plan
- Hawaii – HMSA’s Health Plan Hawaii Plus (HMO)
- Hawaii – HMSA’s Preferred Provider Plan (PPP)
- The Health Care Flexible Spending Account Plan (HCFSA)
- The Individual Disability Insurance Plan
- The Legal Assistance Plan
- The Limited Purpose Health Care Flexible Spending Account Plan (LPHCFSA)
- The Long Term Disability Bonus Income Plan
- The Optional Long Term Disability Plan
- The Voluntary AD&D Plan
- The Retiree Reimbursement Account Plan (RRA)
- The Vision Care Plan

Tax-qualified Retirement and Savings Plans

- The Marsh & McLennan Companies Retirement Plan

About SPDs

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

- The Marsh & McLennan Companies 401(k) Savings & Investment Plan
- The MMA 401(k) Savings & Investment Plan

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

Annual Funding Notice and Summary Annual Reports

The Plan Administrator is required by federal law to provide participants with a copy of the annual funding notice or summary annual report for certain plans. The annual funding notice specifies the plan's "funded status" and describes the plan's funding/investment policy. The summary annual report (SAR) is a written summary of the plan's annual financial report. SARs are provided for the plans listed in the tables. The Marsh & McLennan Companies Retirement Plan SAR has been replaced with a Marsh & McLennan Companies Retirement Plan Annual Funding Notice.

The following tables list the available annual funding notice(s) and SARs and include links to a PDF file of the most recent annual funding notice and SAR.

2021 SARs

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies 401(k) Savings and Investment Plan		2021	<ul style="list-style-type: none"> ▪ Marsh & McLennan Companies 401(k) Savings and Investment Plan
Marsh McLennan Agency 401(k) Savings and Investment Plan		2021	<ul style="list-style-type: none"> ▪ Marsh McLennan Agency 401(k) Savings and Investment Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Health & Welfare Benefits Program		2021	<ul style="list-style-type: none"> ▪ \$400, \$900, \$1,500 and \$2,850 Deductible Plans ▪ MetLife Dental Plan ▪ Express Scripts Prescription Drug Plan ▪ Basic Long-Term Disability Plan ▪ Basic Life Insurance Plan ▪ Health Care Flexible Spending Account ▪ Limited Purpose Health Care Flexible Spending Account ▪ Fully Insured HMO and PPO (Kaiser and HMSA Plans) ▪ Optional Long-Term Disability Plan ▪ Group Variable Universal Life Insurance Plan
Marsh & McLennan Companies, Inc. Group Benefits Plans		2021	<ul style="list-style-type: none"> ▪ Hyatt Legal Plan ▪ National Union Fire Insurance Company, a Chartis Company (Voluntary Accidental Death and Dismemberment Plan) ▪ Vision Service Plan (VSP) ▪ National Union Fire Insurance Company of Pittsburgh PA a division of American International Group (AIG) (Business Travel Accident Plan) ▪ Connecticut General Life Insurance Company (Employee Assistance Program) ▪ Long Term Disability Bonus Income Plan

2020 SARs

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies 401(k) Savings and Investment Plan		2020	<ul style="list-style-type: none"> ▪ Marsh & McLennan Companies 401(k) Savings and Investment Plan
Marsh McLennan Agency 401(k) Savings and Investment Plan		2020	<ul style="list-style-type: none"> ▪ Marsh McLennan Agency 401(k) Savings and Investment Plan
Marsh & McLennan Companies, Inc. Health & Welfare Benefits Program		2020	<ul style="list-style-type: none"> ▪ \$400, \$900, \$1,500 and \$2,850 Deductible Plans ▪ MetLife Dental Plan ▪ Express Scripts Prescription Drug Plan ▪ Basic Long-Term Disability Plan ▪ Basic Life Insurance Plan ▪ Health Care Flexible Spending Account ▪ Limited Purpose Health Care Flexible Spending Account ▪ Fully Insured HMO and PPO (Kaiser and HMSA Plans) ▪ Optional Long-Term Disability Plan ▪ Group Variable Universal Life Insurance Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Group Benefits Plans		2020	<ul style="list-style-type: none"> ▪ Hyatt Legal Plan ▪ National Union Fire Insurance Company, a Chartis Company (Voluntary Accidental Death and Dismemberment Plan) ▪ Vision Service Plan (VSP) ▪ National Union Fire Insurance Company of Pittsburgh PA a division of American International Group (AIG) (Business Travel Accident Plan) ▪ Connecticut General Life Insurance Company (Employee Assistance Program) ▪ Long Term Disability Bonus Income Plan

2019 SARs

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies 401(k) Savings and Investment Plan		2019	<ul style="list-style-type: none"> ▪ Marsh & McLennan Companies 401(k) Savings and Investment Plan
Marsh McLennan Agency 401(k) Savings and Investment Plan		2019	<ul style="list-style-type: none"> ▪ Marsh McLennan Agency 401(k) Savings and Investment Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Health & Welfare Benefits Program		2019	<ul style="list-style-type: none"> ▪ \$400, \$900, \$1,500 and \$2,850 Deductible Plans ▪ MetLife Dental Plan ▪ Express Scripts Prescription Drug Plan ▪ Basic Long-Term Disability Plan ▪ Basic Life Insurance Plan ▪ Health Care Flexible Spending Account ▪ Limited Purpose Health Care Flexible Spending Account ▪ Fully Insured HMO and PPO (Kaiser and HMSA Plans) ▪ Optional Long-Term Disability Plan ▪ Group Variable Universal Life Insurance Plan
Marsh & McLennan Companies, Inc. Group Benefits Plans		2019	<ul style="list-style-type: none"> ▪ Hyatt Legal Plan ▪ National Union Fire Insurance Company, a Chartis Company (Voluntary Accidental Death and Dismemberment Plan) ▪ Vision Service Plan (VSP) ▪ National Union Fire Insurance Company of Pittsburgh PA a division of American International Group (AIG) (Business Travel Accident Plan) ▪ Connecticut General Life Insurance Company (Employee Assistance Program) ▪ Long Term Disability Bonus Income Plan

2018 SARs

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies 401(k) Savings and Investment Plan		2018	<ul style="list-style-type: none"> ▪ Marsh & McLennan Companies 401(k) Savings and Investment Plan
Marsh McLennan Agency 401(k) Savings and Investment Plan		2018	<ul style="list-style-type: none"> ▪ Marsh & McLennan Agency 401(k) Savings and Investment Plan
Marsh & McLennan Companies, Inc. Health & Welfare Benefits Program		2018	<ul style="list-style-type: none"> ▪ \$400, \$900, \$1,500 and \$2,850 Deductible Plans ▪ MetLife Dental Plan ▪ Express Scripts Prescription Drug Plan ▪ Basic Long-Term Disability Plan ▪ Basic Life Insurance Plan ▪ Health Care Flexible Spending Account ▪ Limited Purpose Health Care Flexible Spending Account ▪ Fully Insured HMO and PPO (Kaiser and HMSA Plans) ▪ Optional Long-Term Disability Plan ▪ Group Variable Universal Life Insurance Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Group Benefits Plans		2018	<ul style="list-style-type: none"> <li data-bbox="1073 279 1317 304">▪ Hyatt Legal Plan <li data-bbox="1073 315 1393 499">▪ National Union Fire Insurance Company, a Chartis Company (Voluntary Accidental Death and Dismemberment Plan) <li data-bbox="1073 510 1430 535">▪ Vision Service Plan (VSP) <li data-bbox="1073 546 1422 730">▪ National Union Fire Insurance Company of Pittsburgh PA a division of American International Group (AIG) (Business Travel Accident Plan) <li data-bbox="1073 741 1414 867">▪ Connecticut General Life Insurance Company (Employee Assistance Program) <li data-bbox="1073 877 1365 932">▪ Long Term Disability Bonus Income Plan

2017 SARs

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies 401(k) Savings and Investment Plan		2017	<ul style="list-style-type: none"> ▪ Marsh & McLennan Companies 401(k) Savings and Investment Plan
Marsh McLennan Agency 401(k) Savings and Investment Plan		2017	<ul style="list-style-type: none"> ▪ Marsh & McLennan Agency 401(k) Savings and Investment Plan
Marsh & McLennan Companies, Inc. Health & Welfare Benefits Program		2017	<ul style="list-style-type: none"> ▪ \$350, \$800, \$1,500 and \$2,850 Deductible Plans ▪ MetLife Dental Plan ▪ Express Scripts Prescription Drug Plan ▪ Basic Long-Term Disability Plan ▪ Basic Life Insurance Plan ▪ Health Care Flexible Spending Account ▪ Limited Purpose Health Care Flexible Spending Account ▪ Fully Insured HMO and PPO (Kaiser and HMSA Plans) ▪ Optional Long-Term Disability Plan ▪ Group Variable Universal Life Insurance Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Group Benefits Plans		2017	<ul style="list-style-type: none"> ▪ Hyatt Legal Plan ▪ National Union Fire Insurance Company, a Chartis Company (Voluntary Accidental Death and Dismemberment Plan) ▪ Vision Service Plan (VSP) ▪ National Union Fire Insurance Company of Pittsburgh PA a division of American International Group (AIG) (Business Travel Accident Plan) ▪ Connecticut General Life Insurance Company (Employee Assistance Program) ▪ Long Term Disability Bonus Income Plan

2016 SARs

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies 401(k) Savings and Investment Plan		2016	<ul style="list-style-type: none"> ▪ Marsh & McLennan Companies 401(k) Savings and Investment Plan
Marsh McLennan Agency 401(k) Savings and Investment Plan		2016	<ul style="list-style-type: none"> ▪ Marsh & McLennan Agency 401(k) Savings and Investment Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Health & Welfare Benefits Program		2016	<ul style="list-style-type: none"> ▪ \$350, \$800, \$1,500 and \$2,850 Deductible Plans ▪ MetLife Dental Plan ▪ Express Scripts Prescription Drug Plan ▪ Basic Long-Term Disability Plan ▪ Basic Life Insurance Plan ▪ Health Care Flexible Spending Account ▪ Limited Purpose Health Care Flexible Spending Account ▪ Fully Insured HMO and PPO (Kaiser and HMSA Plans) ▪ Optional Long-Term Disability Plan ▪ Group Variable Universal Life Insurance Plan
Marsh McLennan Companies, Inc. Group Benefits Plans		2016	<ul style="list-style-type: none"> ▪ Hyatt Legal Plan ▪ National Union Fire Insurance Company, a Chartis Company (Voluntary Accidental Death and Dismemberment Plan) ▪ Vision Service Plan (VSP) ▪ National Union Fire Insurance Company of Pittsburgh PA a division of American International Group (AIG) (Business Travel Accident Plan) ▪ Connecticut General Life Insurance Company (Employee Assistance Program) ▪ Long Term Disability Bonus Income Plan
The Comprehensive Medical Plan		2016	<ul style="list-style-type: none"> ▪ UnitedHealthcare Comprehensive Medical Plan ("Post-65 Retiree Medical Plan")
MMC Retiree Reimbursement Account Plan		2016	<ul style="list-style-type: none"> ▪ MMC Retiree Reimbursement Account Plan

2015 SARs

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh McLennan Companies 401(k) Savings and Investment Plan		2015	<ul style="list-style-type: none"> ▪ Marsh & McLennan Companies 401(k) Savings and Investment Plan
Marsh McLennan Agency 401(k) Savings and Investment Plan		2015	<ul style="list-style-type: none"> ▪ Marsh & McLennan Agency 401(k) Savings and Investment Plan
Marsh & McLennan Companies, Inc. Health & Welfare Benefits Program		2015	<ul style="list-style-type: none"> ▪ \$350, \$800, \$1,500 and \$2,850 Deductible Plans ▪ MetLife Dental Plan ▪ Express Scripts Prescription Drug Plan ▪ Basic Long-Term Disability Plan ▪ Basic Life Insurance Plan ▪ Health Care Flexible Spending Account ▪ Limited Purpose Health Care Flexible Spending Account ▪ Fully Insured HMO and PPO (Kaiser and HMSA Plans) ▪ Optional Long-Term Disability Plan ▪ Group Variable Universal Life Insurance Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Group Benefits Plans		2015	<ul style="list-style-type: none"> ▪ Hyatt Legal Plan ▪ National Union Fire Insurance Company, a Chartis Company (Voluntary Accidental Death and Dismemberment Plan) ▪ Vision Service Plan (VSP) ▪ National Union Fire Insurance Company of Pittsburgh PA a division of American International Group (AIG) (Business Travel Accident Plan) ▪ Connecticut General Life Insurance Company (Employee Assistance Program) ▪ Long Term Disability Bonus Income Plan
The Comprehensive Medical Plan		2015	<ul style="list-style-type: none"> ▪ UnitedHealthcare Comprehensive Medical Plan ("Post-65 Retiree Medical Plan")
MMC Retiree Reimbursement Account Plan		2015	<ul style="list-style-type: none"> ▪ MMC Retiree Reimbursement Account Plan

2014 SARs

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies 401(k) Savings and Investment Plan		2014	<ul style="list-style-type: none"> ▪ Marsh & McLennan Companies 401(k) Savings and Investment Plan
Marsh McLennan Agency 401(k) Savings and Investment Plan		2014	<ul style="list-style-type: none"> ▪ Marsh & McLennan Agency 401(k) Savings and Investment Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Health & Welfare Benefits Program		2014	<ul style="list-style-type: none"> ▪ Aetna PPO ▪ Aetna CDHP ▪ MetLife Dental Plan ▪ Blue Cross Blue Shield EPO ▪ UnitedHealthcare EPO ▪ Express Scripts Pharmacy Plan ▪ Basic Long-Term Disability Plan ▪ Basic Life Insurance Plan ▪ Health Care Flexible Spending Account ▪ Limited Purpose Health Care Flexible Spending Account ▪ Dependent Care Flexible Spending Account ▪ Fully Insured HMO and PPO (Kaiser and HMSA Plans) ▪ Optional Long-Term Disability Plan ▪ Optional Life Insurance Plan
Marsh & McLennan Companies, Inc. Group Benefits Plans		2014	<ul style="list-style-type: none"> ▪ Hyatt Legal Plan ▪ American International Life (Accidental Death and Dismemberment Plan) ▪ Vision Service Plan (VSP) ▪ American International Life (Business Travel Accident Plan) ▪ Connecticut General Life Insurance Company (Employee Assistance Program) ▪ Long Term Disability Bonus Income Plan ▪ Dependent Children Life Insurance Plan ▪ Spouse Life Insurance Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Mercer HR Services Retirement Plan		2014	<ul style="list-style-type: none"> ▪ Mercer HR Services Retirement Plan
The Comprehensive Medical Plan		2014	<ul style="list-style-type: none"> ▪ UnitedHealthcare Comprehensive Medical Plan (“Post-65 Retiree Medical Plan”)

2013 SARs

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies 401(k) Savings and Investment Plan	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/003 - Marsh & McLennan Companies 401(k) Savings and Investment Plan - 2013.pdf	2013	<ul style="list-style-type: none"> ▪ Marsh & McLennan Companies 401(k) Savings and Investment Plan
Marsh & McLennan Agency 401(k) Savings and Investment Plan	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/006 - Marsh & McLennan Agency 401(k) Savings and Investment Plan - 2013.pdf	2013	<ul style="list-style-type: none"> ▪ Marsh & McLennan Agency 401(k) Savings and Investment Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Health & Welfare Benefits Program	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/501 - MMC Health & Welfare and Group Benefits 2013.pdf	2013	<ul style="list-style-type: none"> ▪ Aetna PPO ▪ Aetna CDHP ▪ MetLife Dental Plan ▪ Blue Cross Blue Shield EPO ▪ UnitedHealthcare EPO ▪ Express Scripts Pharmacy Plan ▪ Basic Long-Term Disability Plan ▪ Basic Life Insurance Plan ▪ Health Care Flexible Spending Account ▪ Limited Purpose Health Care Flexible Spending Account ▪ Dependent Care Flexible Spending Account ▪ Fully Insured HMO and PPO (Kaiser and HMSA Plans) ▪ Optional Long-Term Disability Plan ▪ Optional Life Insurance Plan
Marsh & McLennan Companies, Inc. Group Benefits Plans	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/503 - Marsh & McLennan Companies Inc. Group Benefits Plan - 2013 Summary Annual Report.pdf	2013	<ul style="list-style-type: none"> ▪ Hyatt Legal Plan ▪ American International Life (Accidental Death and Dismemberment Plan) ▪ Vision Service Plan (VSP) ▪ American International Life (Business Travel Accident Plan) ▪ Connecticut General Life Insurance Company (Employee Assistance Program) ▪ Long Term Disability Bonus Income Plan ▪ Dependent Children Life Insurance Plan ▪ Spouse Life Insurance Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Mercer HR Services Retirement Plan	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/handbook.connect.mmc.com/Prod/CURR/004-Mercer-HR-Services-Retirement-Plan-2013-Summary-Annual-Report.pdf	2013	<ul style="list-style-type: none"> ▪ Mercer HR Services Retirement Plan
The Comprehensive Medical Plan	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/504 - Marsh & McLennan Companies Comprehensive Medical Plan - 2013 Summary Annual Report.pdf	2013	<ul style="list-style-type: none"> ▪ UnitedHealthcare Comprehensive Medical Plan ("Post-65 Retiree Medical Plan")

2012 SARs

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies 401(k) Savings and Investment Plan	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/003- Marsh & McLennan Companies 401(K) Savings & Investment Plan-2012 Summary Annual Report.pdf	2012	<ul style="list-style-type: none"> ▪ Marsh & McLennan Companies 401(k) Savings and Investment Plan
Marsh & McLennan Agency 401(k) Savings and Investment Plan	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/006- Marsh & McLennan Agency 401(K) Savings & Investment Plan-2012 Summary Annual Report.pdf	2012	<ul style="list-style-type: none"> ▪ Marsh & McLennan Agency 401(k) Savings and Investment Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Health & Welfare Benefits Program	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/501- Marsh & McLennan Companies, Inc. Health & Welfare Benefits Program- 2012 Summary Annual Report.pdf	2012	<ul style="list-style-type: none"> ▪ Aetna PPO ▪ Aetna CDHP ▪ MetLife Dental Plan ▪ Blue Cross Blue Shield EPO ▪ UnitedHealthcare EPO ▪ Medco Pharmacy Plan ▪ Basic Long-Term Disability Plan ▪ Basic Life Insurance Plan ▪ Health Care Flexible Spending Account ▪ Limited Purpose Health Care Flexible Spending Account ▪ Dependent Care Flexible Spending Account ▪ Fully Insured HMO and PPO (Kaiser and HMSA Plans) ▪ Optional Long-Term Disability Plan ▪ Optional Life Insurance Plan
Marsh & McLennan Companies, Inc. Group Benefits Plans	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/503- Marsh & McLennan Companies, Inc. Group Benefits Plan- 2012 Summary Annual Report.pdf	2012	<ul style="list-style-type: none"> ▪ Hyatt Legal Plan ▪ American International Life (Accidental Death and Dismemberment Plan) ▪ Vision Service Plan (VSP) ▪ American International Life (Business Travel Accident Plan) ▪ Connecticut General Life Insurance Company (Employee Assistance Program) ▪ Long Term Disability Bonus Income Plan ▪ Dependent Children Life Insurance Plan ▪ Spouse Life Insurance Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Mercer HR Services Retirement Plan	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/004- Mercer HR Services Retirement Plan-2012 Summary Annual Report.pdf	2012	<ul style="list-style-type: none"> ▪ Mercer HR Services Retirement Plan
The Comprehensive Medical Plan	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/504- Marsh & McLennan Companies, Inc. Comprehensive Medical Plan-2012 Summary Annual Report.pdf	2012	<ul style="list-style-type: none"> ▪ UnitedHealthcare Comprehensive Medical Plan (“Post-65 Retiree Medical Plan”)

2011 SARs

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies 401(k) Savings and Investment Plan	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/MMC-401k-Savings-and-Investment-Plan-2011-SAR.pdf	2011	<ul style="list-style-type: none"> ▪ Marsh & McLennan Companies 401(k) Savings and Investment Plan
Marsh & McLennan Agency 401(k) Savings and Investment Plan	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/MMA-401k-Savings-and-Investment-Plan-2011-SAR.pdf	2011	<ul style="list-style-type: none"> ▪ Marsh & McLennan Agency 401(k) Savings and Investment Plan
Marsh & McLennan Companies, Inc. Employee Funded Welfare Benefit Trust	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/MMC-Employee-Funded-Welfare-Benefits-Plan-2011-SAR.pdf	2011	<ul style="list-style-type: none"> ▪ Optional Long-Term Disability Plan ▪ Optional Life Insurance Plan ▪ Long-Term Care Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/MMC-Employer-Funded-Welfare-Benefit-Plan-2011-SAR.pdf	2011	<ul style="list-style-type: none"> ▪ Aetna PPO ▪ Aetna CDHP ▪ MetLife Dental Plan ▪ Blue Cross Blue Shield EPO ▪ UnitedHealthcare EPO ▪ Medco Pharmacy Plan ▪ Basic Long-Term Disability Plan ▪ Basic Life Insurance Plan ▪ Health Care Flexible Spending Account ▪ Limited Purpose Health Care Flexible Spending Account ▪ Dependent Care Flexible Spending Account ▪ Fully Insured HMO and PPO (Kaiser and HMSA Plans)
Marsh & McLennan Companies, Inc. Group Benefits	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/MMC-Group-Benefits-Plans-2011-SAR.pdf	2011	<ul style="list-style-type: none"> ▪ Hyatt Legal Plan ▪ American International Life (Accidental Death and Dismemberment Plan) ▪ Vision Service Plan (VSP) ▪ American International Life (Business Travel Accident Plan) ▪ Connecticut General Life Insurance Company (Employee Assistance Program) ▪ Long Term Disability Bonus Income Plan ▪ Dependent Children Life Insurance Plan ▪ Spouse Life Insurance Plan
Mercer HR Services Retirement Plan	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/Mercer-HR-Services-Retirement-Plan-2011-SAR.pdf	2011	<ul style="list-style-type: none"> ▪ Mercer HR Services Retirement Plan
The Comprehensive Medical Plan	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/MMC-Comprehensive-Medical-Plan-2011-SAR.pdf	2011	<ul style="list-style-type: none"> ▪ UnitedHealthcare Comprehensive Medical Plan (“Post-65 Retiree Medical Plan”)

Plan Summaries

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

- The Choice Auto and Home Insurance Program
- The Group Umbrella Liability Insurance Program
- The Health Advocate Program
- The Identity Protection Benefit Program
- The MSK Direct Program
- The Personal Life Insurance Plan
- The Pet Insurance Program
- The Short Term Disability Benefits Payroll Policy
- The Stock Purchase Plan
- The Accident Insurance Plan
- The Critical Illness Insurance Plan
- The Hospital Indemnity Insurance Plan
- The Transportation Reimbursement Incentive Program
- The Health Savings Account
- The Dependent Care Flexible Spending Account Plan (DCFSA)

Top Hat Plans

- The Benefit Equalization Plan
- The Supplemental Retirement Plan
- The Supplemental Savings & Investment Plan

Official Plan Documents

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

- The \$1,600 and \$3,200 Deductible Plans (through Aetna and Anthem BCBS)
- The Surest Copay Plan
- The Basic Life Insurance Plan
- The Basic Long Term Disability Plan
- The Teladoc Medical Experts Program
- The Business Travel Accident Insurance Plan
- The Dental Plan
- The Employee Assistance Plan (EAP)
- The Group Variable Universal Life Insurance (GVUL) Plan
- The Hawaii HMSA's Health Plan Hawaii Plus Plan (HMO)
- The Hawaii HMSA's Preferred Provider Plan (PPP)
- The Health Care Flexible Spending Account Plan (HCFSA)
- The Individual Disability Insurance Plan
- The MSK Direct Program
- The Legal Assistance Plan
- The Limited Purpose Health Care Flexible Spending Account Plan (LPHCFSA)
- The Long Term Disability Bonus Income Plan
- The Optional Long Term Disability Plan
- The Voluntary AD&D Plan
- The Retiree Reimbursement Account Plan (RRA)
- The Vision Care Plan

How to Obtain Plan Documents

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

Plan Amendments

Health & Welfare Plans

The Company reserves the right to modify or amend, at any time and to any extent, any or all of the health & welfare plans (whether self-insured or insured) described in this Benefits Handbook. Amendments to any health or welfare plan provision, such as those regarding eligibility for coverage and the benefits provided under a plan, are made in writing by updating this Benefits Handbook and, where applicable, the plan's Guide to Benefits. Any such amendments are communicated to you by revising the Benefits Handbook, or through Marsh McLennan's internal employee communication channels.

Tax-qualified Retirement and Savings Plans

The Company reserves the right to modify or amend, at any time and to any extent, any or all of the retirement and savings plans described in this Benefits Handbook. Amendments to any retirement or savings plan provision, including amendments regarding eligibility for participation and the benefits provided under a plan, are made only by written amendments to the applicable plan document. Amendments may be made by the Board of Directors of Marsh McLennan. The Board of Directors has delegated to certain officers the authority to adopt amendments necessary to keep these plans tax qualified or to make certain changes reasonably expected to have no more than a *de minimis* effect on MMC. Any material amendments are communicated to you by revising this section of the Benefits Handbook, or through Marsh McLennan's internal employee communication channels, including the distribution of a Summary of Material Modifications.

Plan Termination

Health & Welfare Plans

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

Retirement and Savings Plans

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

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

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

- The Marsh & McLennan Companies 401(k) Savings & Investment Plan
- The MMA 401(k) Savings & Investment Plan

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

Your accrued benefits under the Marsh & McLennan Companies Retirement Plan are insured by the PBGC. If the plan terminates (ends) without enough money to pay all benefits, the PBGC will step in and may pay all or a portion of the pension benefits shortfall. If this were to occur some people may lose certain benefits.

The PBGC guarantee generally covers:

- normal and early retirement benefits;
- disability benefits if you become disabled before the plan terminates; and
- certain benefits for your survivors.

The PBGC guarantee generally does *not* cover:

- benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates;
- some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates;

- benefits that are not vested because you have not worked long enough for the Company;
- benefits for which you have not met all of the requirements at the time the plan terminates;
- certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan's normal retirement age; and
- non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

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

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

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

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

Limits on Plan Amendments

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

The Internal Revenue Code provides that no plan amendment may retroactively reduce your previously accrued benefit under a tax qualified plan, unless necessary to keep the plan tax qualified. This means, for example, that if the benefit formula is changed in the future by an amendment to the tax-qualified plan, your accrued benefit after the amendment may never be less than your accrued benefit before the amendment. These

rules also currently provide that certain changes in the actuarial factors used to calculate your benefits and the options and early retirement subsidies available under that plan may not be applied to your accrued benefit prior to the change. In addition to being notified of any future changes in the benefit formula, you will be notified when tax qualified plan assumptions or options are changed if you need to be informed of any rights you have that were protected by law as of the date of the change.

Claims, Reviews, and Appeals

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

Authority over Benefit Determinations and Appeals

Health and Welfare Plans

The Claims Administrator or Plan Administrator, as applicable, has full discretion and authority to determine all claims for benefits under the Marsh & McLennan Companies Health & Welfare Benefits Program, Marsh & McLennan Companies Group Benefits Plan, and the Marsh & McLennan Companies Retiree Reimbursement Account. Claims concerning plan eligibility or enrollment, rather than payment of specific benefits, should be addressed to the Plan Administrator. Any action or determination in this review procedure will be final, conclusive, and binding on the Claims Administrators, the Plan Administrators, the Company, the plan participant or beneficiary and his or her legal representative, and the participant or beneficiary's family members and their legal representatives.

Claims for reimbursement under the Health Care Flexible Spending Account Plan, Limited Purpose Health Care Flexible Spending Account Plan, or Dependent Care Flexible Spending Account must be for expenses incurred no later than December 31st and submitted no later than March 31st of the year following the Plan Year to which the expense was attributable.

The determination as to whether you should receive the pending health service is determined by you and your physician.

No legal action for benefits may be brought by any participant or beneficiary unless the plan's claim review procedure has been exhausted (that is, all appeals of adverse decisions have been made). Any such action (whether at law, in equity or otherwise) must be commenced within one year. This one-year period shall be computed from the earlier of (a) the date a final determination denying such benefit, in whole or in part, is issued under the plan's claim review procedure and (b) the date such individual's cause of action first accrued.

Tax-qualified Retirement and Savings Plans

The Plan Administrator of the Marsh & McLennan Companies 401(k) Savings and Investment Plan, the Marsh & McLennan Companies Retirement Plan, and the Marsh & McLennan Agency 401(k) Savings & Investment Plan use the claims procedure described in this section of the Benefits Handbook to make determinations on claims for benefits under the applicable retirement or savings plan. The Plan Administrator has full discretion and the maximum authority permitted by law to interpret the applicable plan and make all initial claims/benefits determinations.

No legal action for benefits may be brought by any participant or beneficiary unless the plan's claim review procedure has been exhausted (that is, all appeals of adverse decisions have been made). Any such action (whether at law, in equity or otherwise) must be commenced within one year. This one-year period shall be computed from the earlier of (a) the date a final determination denying such benefit, in whole or in part, is issued under the plan's claim review procedure and (b) the date such individual's cause of action first accrued.

Healthcare and Welfare Plans

Claims Concerning Eligibility or Enrollment

If your claim concerns whether or not you or a family member is eligible for coverage under the plan or whether you or a family member has properly enrolled in the plan, you may file a claim with the Plan Administrator for coverage. The claim should be in writing and specify the circumstances under which you do not have coverage, why you believe you should have coverage and include any mitigating factors, documents, records or other information that you believe are relevant to your claim.

Claims for eligibility or enrollment, rather than claims for benefits, should be addressed to the Plan Administrator at the following address:

1166 Avenue of the Americas
31st floor – Global Benefits
New York, NY 10036

Timing of Notification of Eligibility or Enrollment Determination

The plan will evaluate and decide your claim for eligibility or enrollment within 60 days of receipt. If, due to special circumstances, the plan needs more time to decide your claim, the plan will notify you within the 60-day period that more time is needed, why it is needed, and the date by which you can expect a decision. The Plan Administrator can have up to 30 additional days to decide your claim.

The Plan Administrator will send you written notice of its decision within 60 days (or 90 days if an extension applies). This notice must be in plain language that can be understood. It must include all the specific reasons for the denial, refer you to the plan provisions on which the decision is based., If more information is needed from you to decide the claim, it will tell you what that information is, and why it is needed. It also

must describe the plan's procedures and deadlines for submitting an appeal of your claim for a full and fair review.

Appeal of Denial of Claim For Eligibility or Enrollment

If you believe your claim for eligibility or enrollment was improperly decided, you may file a written appeal with the Benefits Administration Committee within 180 days for the Medical, Dental, Vision, and Long Term Disability plans or within 60 days for all other plans of your notification of a claim denial. A written appeal of a denied claim should include any additional information you would like the Benefits Administration Committee to consider.

The Benefits Administration Committee will make a benefit determination on your appeal no later than the date of the meeting of the committee that immediately follows the plan's receipt of an appeal, unless the appeal is filed within 30 days before the date of the meeting. In such case, the Benefits Administration Committee will make the benefit determination on an appeal no later than the date of the Benefits Administration Committee's second meeting following the plan's receipt of the appeal. If special circumstances require a further extension of time for processing an appeal, a benefit determination on an appeal shall be rendered not later than the third meeting of the Benefits Administration Committee following receipt of the appeal.

Once a final decision on your appeal is made, you will receive a written explanation of the decision. The explanation must be in plain language that can be understood. If your appeal is denied, the explanation will:

- include all the specific reasons for denial of your appeal,
- refer you to the plan provisions on which the decision is based,
- tell you if the plan has any additional or voluntary levels of appeal,
- explain your right to receive all documents that are relevant to your claim free of charge, and
- describe your rights to seek judicial review of the plan's decision.

Healthcare Plans

Claims for Benefits

Fully Insured Medical Plans

Refer to Kaiser's Evidence of Coverage for information on the benefits determination process including claims and appeals, for the medical plans insured by Kaiser.

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

For all other health care plans, your claim for benefits or your appeal will be processed under the procedures described below.

Medical, Dental, Vision, Health Care Flexible Spending Account, Limited Purpose Health Care Flexible Spending Account, Teladoc Medical Experts, RRA and EAP Benefit Determinations

This section applies to the following health care plans:

- \$1,600 and \$3,200 Deductible Plans (unless insured by Kaiser)
- The Surest Copay Plan
- Marsh & McLennan Companies Dental Plan
- Marsh & McLennan Companies Vision Care Plan
- Marsh & McLennan Companies Health Care Flexible Spending Account Plan
- Marsh & McLennan Companies Limited Purpose Health Care Flexible Spending Account Plan
- Teladoc Medical Experts Program
- Marsh & McLennan Companies RRA
- Marsh & McLennan Companies Employee Assistance Program

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

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

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

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

Timing of Notification of Pre-service Claim Benefit Determination

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

Timing of Notification of Post-service Claim Benefit Determination

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

Timing of Notification of Benefit Determinations Involving Urgent Care Claims

In the case of a claim involving urgent care, the Claims Administrator will notify you of the benefit determination (whether adverse or not) no later than 72 hours after your claim is received. If additional information is needed to process the claim, the Claims Administrator will notify you within 24 hours after receipt of your claim of the specific information necessary to complete the claim. Once notified of the extension, you then have 48 hours to provide this information. If all of the needed information is received within the 48-hour timeframe, the Claims Administrator will notify you of the determination within 48 hours after the information is received. If you don't provide the needed information within the 48-hour period, your claim will be denied.

Ongoing Treatment Involving Urgent Care Claims

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

Ongoing Treatment Not Involving Urgent Care Claims

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

Improper Filing of Pre-Service Claims and Urgent Care Claims

If you filed an urgent care claim improperly, within 24 hours of receipt, the Claims Administrator will notify you of the improper filing and how to correct it.

If you filed a pre-service claim improperly, within five days of receipt, the Claims Administrator will notify you of the improper filing and how to correct it.

Appeal of Benefit Determinations Not Involving Urgent Care Claims

If you believe your benefits under a plan were denied improperly, you may file a written appeal for the unpaid amount within 180 days of your receipt of notification of the adverse benefit determination. The written appeal should specify the nature and amount of the claim, include any other written comments, documents, records or other information that may be pertinent and should be sent to the Claims Administrator. Your appeal will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination.

If your claim involves a medical judgment question, the Claims Administrator will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the Claims Administrator will provide you with the identification of any medical expert whose advice was obtained on behalf of the Plan in connection with your appeal.

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

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

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

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

Appeal of Benefit Determinations Involving Urgent Care Claims

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

Your appeal will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination.

If your claim involves a medical judgment question, the Claims Administrator will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, the Claims Administrator will provide you with the identification of any medical expert whose advice was obtained on behalf of the plan in connection with your appeal.

Notice of Determination

If your claim or appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will:

- state specific reason(s) of the adverse determination
- reference specific plan provision(s) on which the benefit determination is based
- describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary (initial claim only)
- describe the plan's claims review procedures and the time limits applicable to such procedures (initial claim only)
- include a statement of your right to bring a civil action under section 502(a) of ERISA following appeal
- state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits (appeal only)

- describe any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures (appeal only)
- disclose any internal rule, guidelines, or protocol relied on in making the adverse determination (or state that such information will be provided free of charge upon request)
- if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination (or state that such information will be provided free of charge upon request)
- include information sufficient to identify the claim involved, including date of service, health care provider, and claim amount (for \$1,600 and \$3,200 Deductible Plans and Surest Copay Plan only)
- include the denial code and corresponding meaning (for \$1,600 and \$3,200 Deductible Plans and Surest Copay Plan only)
- include a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning and treatment code and its corresponding meaning (for \$1,600 and \$3,200 Deductible Plans and Surest Copay Plan only)
- describe the Claims Administrator's or Insurer's standard, if any, used in denying the claim (for \$1,600 and \$3,200 Deductible Plans and Surest Copay Plan only)
- describe the external review process, if applicable (for \$1,600 and \$3,200 Deductible Plans and Surest Copay Plan only)
- include a statement about the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under health care reform laws to assist individuals with internal claims and appeals and external review processes (for \$1,600 and \$3,200 Deductible Plans and Surest Copay Plan only)

External Appeals Review

Only with respect to the \$1,600 and \$3,200 Deductible Plans and the Surest Copay Plan, you may have the right to request an independent review with respect to any claim that involves medical judgment or a rescission of coverage. Your external review will be conducted by an independent review organization not affiliated with the plans. This independent review organization may overturn the plans' decision, and the independent review organization's decision is binding on the plans. Your appeal denial notice will include more information about your right to file a request for an external review and contact information. You must file your request for external review within four months of receiving your final internal appeal determination. Filing a request for external review will not affect your ability to bring a legal claim in court. When filing a request for external review, you will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision on the external review.

Dependent Care Flexible Spending Account Plan

This section applies to the Marsh & McLennan Companies Dependent Care Flexible Spending Account Plan.

Timing of Notification of Benefits Determination

In the case of a claim, the Claims Administrator will notify you of the benefit determination (whether adverse or not) no later than 90 days after your claim was received. This period may be extended one time by the Claims Administrator for up to 90 days, provided that the extension is necessary due to matters beyond the control of the Claims Administrator and you are notified prior to the expiration of the initial 90-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If additional information is needed to process the claim, the Claims Administrator will notify you within this 90-day period and may request a one-time extension of not more than 90 days and suspend your claim until all information is received.

Appeal of Benefits Determinations

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

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

Disability Plans

This section applies to the following plans:

- Marsh & McLennan Companies Basic Long Term Disability Plan
- Marsh & McLennan Companies Optional Long Term Disability Plan
- Marsh & McLennan Companies Long Term Disability Bonus Income Plan
- Marsh & McLennan Companies Individual Disability Insurance Plan

Unless otherwise provided in the applicable insurance policy/evidence of coverage, your claim for benefits or your appeal will be processed under the procedures described below.

Timing of Notification of Claim for Disability Benefits Determinations

In the case of a claim for disability benefits, the Claims Administrator will notify you of the benefit determination (whether adverse or not) no later than 45 days after your claim was properly filed and received. This period may be extended one time by the Claims Administrator for up to 30 days, provided that the extension is necessary due to matters beyond the control of the Claims Administrator and you are notified prior to the expiration of the initial 45-day period of the circumstances requiring the extension and the date by which the Claims Administrator expects to render a decision. If prior to the end of the first 30-day extension period, the administrator determines that, due to matters beyond the control of the plan, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the Plan Administrator notifies the claimant, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date as of which the plan expects to render a decision.

If additional information is needed to process the claim, the Claims Administrator will notify you of the information needed within this 45-day period and may request a one-time extension not longer than 45 days and suspend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all of the needed information is received within the 45-day timeframe, the Claims Administrator will notify you of the determination within 30 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

Timing of Appeal of Claim for Disability Benefits Determinations

If you believe your claim for disability benefits under the plan was denied improperly, you may file a written claim for the unpaid amount within 180 days of receipt of the denial. The written claim should specify the amount of the claim and any other written comments, documents, records or other information that may be pertinent and should be sent to the Claims Administrator. Your appeal will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination. The Claims Administrator's review on appeal shall take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You have a right to review and respond to new or additional evidence or rationales developed by the Claims Administrator during the pendency of your appeal.

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

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

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

Notice of Determination

If your claim or appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will:

- state specific reason(s) of the adverse determination
- reference specific plan provision(s) on which the benefit determination is based
- describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary (initial claim only)
- describe the plan's claims review procedures and the time limits applicable to such procedures (initial claim only)
- include a statement of (a) your right to bring a civil action under section 502(a) of ERISA following appeal and (b) describing any contractual limitations period that applies to your right to bring such an action, including the calendar date on which the contractual limitations period expires for the claim
- discussion of the decision, including an explanation of the basis for disagreeing or not with the following:
 - the views presented by you to the Claims Administrator of health care professionals treating you and vocational professionals who evaluated you
 - the views presented of medical or vocational experts whose advice was obtained on behalf of the Claims Administrator in connection with the adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, and
 - a disability determination regarding you presented by you to the Claims Administrator made by the Social Security Administration
- state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits (appeal only)

- disclose any specific internal rules, guidelines, standards, protocols or other similar criteria of the Claims Administrator relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Claims Administrator do not exist (or a statement that such information will be provided free of charge upon request)
- if the denial is based on a medical necessity or experimental treatment or similar limit, explain the scientific or clinical judgment for the determination, applying the terms to the plan to your medical circumstances, or a statement that such information will be provided free of charge upon request
- describe any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures (appeal only)
- a statement prominently displayed in an applicable non-English language clearly indicating how to access the language services provided by the Claims Administrator
- any other notice(s), statement(s) or information required by applicable law.

Life Insurance, Accident Insurance and Legal Assistance Plans

This section applies to the following plans:

- Marsh & McLennan Companies Basic Life Insurance Plan
- Marsh & McLennan Companies Group Variable Universal Life Insurance Plan
- Marsh & McLennan Companies Business Travel Accident Insurance Plan
- Marsh & McLennan Companies Voluntary AD&D Plan
- Marsh & McLennan Companies Legal Assistance Plan

Timing of Notification of Benefits Determination

In the case of a claim, the Claims Administrator will notify you of the benefit determination (whether adverse or not) no later than 90 days after your claim was received. If an extension of time for processing is required due to special circumstances, this time may be extended for an additional 90 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the Claims Administrator expects to render a determination.

Timing of Appeal of Benefits Determination

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

request for appeal of a denied claim. If the Claims Administrator determines that an extension is necessary due to special circumstances, this time may be extended for an additional 60 days. You will receive notice prior to the extension that indicates the special circumstances requiring the extension and the date by which the Claims Administrator expects to render a determination.

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

Notice of Determination

If your claim or appeal is in part or wholly denied, you will receive notice of an adverse benefit determination that will:

- state specific reason(s) of the adverse determination
- reference specific plan provision(s) on which the benefit determination is based
- describe additional material or information, if any, needed to perfect the claim and the reasons such material or information is necessary (initial claim only)
- describe the plan's claims review procedures and the time limits applicable to such procedures (initial claim only)
- include a statement of your right to bring a civil action under section 502(a) of ERISA following appeal
- state that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits (appeal only)
- describe any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures (appeal only).

Retirement and Savings Plans

Claims Concerning Eligibility and Enrollment in the Tax-Qualified Retirement and Savings Plans

If your claim concerns whether or not you are eligible to participate in a plan, you may file a claim with the Plan Administrator for enrollment. The claim should be in writing and specify why you believe you are eligible to participate in a plan, include any mitigating factors, documents, records or other information that you believe are relevant to your claim.

Claims concerning plan eligibility or enrollment, rather than claims for benefits (see “Claims for Benefits” on page 100 for more information), should be addressed to the Plan Administrator at the following address:

1166 Avenue of the Americas
31st floor – Global Benefits
New York, NY 10036.

Timing of Notification of Eligibility or Enrollment Determination

The plan will evaluate and decide your claim for eligibility or enrollment within 90 days. If, due to special circumstances, the plan needs more time to decide your claim, the plan will notify you within the 90-day period that more time is needed, why it is needed, and the date by which you can expect a decision. The Plan Administrator can have up to 90 additional days to decide your claim.

The Plan Administrator will send you written notice of its decision within 90 days (or 180 days if an extension applies). This notice must be in plain language that can be understood. It must include all the specific reasons for the denial, refer you to the plan provisions on which the decision is based. If more information is needed from you to decide the claim, it must tell you what that information is, and why it is needed. It also must describe the plan’s procedures and deadlines for submitting an appeal of your claim for a full and fair review.

Appeal of Denial of A Claim For Eligibility or Enrollment

If you believe your claim for eligibility or enrollment was improperly decided, you may file a written appeal with the Benefits Administration Committee within 60 days of your notification of a claim denial. A written appeal of a denied claim should include any additional information you would like the Benefits Administration Committee to consider.

The Benefits Administration Committee will make a benefit determination on your appeal no later than the date of the meeting of the committee that immediately follows the plan’s receipt of an appeal, unless the appeal is filed within 30 days before the date of the meeting. In such case, the Benefits Administration Committee will make the benefit determination no later than the date of the Benefits Administration Committee’s second meeting following the plan’s receipt of the appeal. If special circumstances require a further extension of time for processing an appeal, a benefit determination will be rendered not later than the third meeting of the Benefits Administration Committee following receipt of the appeal.

Once a final decision on your appeal is made, you will receive a written explanation of the decision. The explanation must be in plain language that can be understood. If your appeal is denied, the explanation will:

- include all the specific reasons for denial of your appeal,
- refer you to the plan provisions on which the decision is based,
- tell you if the plan has any additional or voluntary levels of appeal,

- explain your right to receive all documents that are relevant to your claim free of charge, and
- describe your rights to seek judicial review of the plan's decision.

Claims for Benefits

If your claim concerns whether or not you are eligible for a benefit under a plan, you may file a claim with the Plan Administrator for a benefit. The claim should be in writing and specify the circumstances under which you do not have a benefit, why you believe you should the benefit and include any mitigating factors, documents, records or other information that may be pertinent and should be sent to the Plan Administrator.

Claims concerning plan benefits under the Retirement or Savings Plans, should be addressed to the Plan Administrator at the following address:

1166 Avenue of the Americas
31st floor – Global Benefits
New York, NY 10036.

Timing of Notification of Benefits Determination

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

Appeal of Benefits Determinations

If you believe a benefit under a retirement or savings plan was denied improperly by the Plan Administrator, you or your representative may file a written appeal for the unpaid amount within 60 days of receipt of notification of the adverse benefit determination. The written appeal should specify the nature and amount of the claim, include any other written comments, documents, records or other information that may be pertinent and should be sent to the Plan Administrator. A written decision will usually be issued by the Plan Administrator within 60 days of your written appeal. This period may be extended for up to 60 days by the Plan Administrator if the Plan Administrator determines that the extension is necessary. You will be notified prior to the expiration of the initial 60-day period of the circumstances requiring the extension and the date by which the Plan

Administrator expects to render a decision. If your appeal is denied, the written decision will explain the reason for denial, refer to the section of the plan on which the denial is based, inform you that, if you request, you are entitled to receive, at no cost, reasonable access and copies of all relevant documents, and include a statement of your right to bring a civil action under section 502(a) of ERISA if your appeal is denied.

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

Right of Recovery/Subrogation

Unless otherwise stated in the applicable insurance policy/evidence of coverage or benefits booklet/summary, any benefits under the Marsh & McLennan Companies Health & Welfare Benefits Program, Marsh & McLennan Companies Group Benefits Plan and Marsh & McLennan Companies Retiree Reimbursement Account (the "Plans") will be subject to the reimbursement and subrogation rules below. This section applies to your eligible dependents the same as it applies to you.

Reimbursement to Plans if You Recover Payment for an Injury or Illness

This section applies if you or your legal representative, estate or heirs recover money or other property for an injury, sickness or other condition, or if you have made, or in the future may make, such a recovery, including a recovery from any insurance carrier.

The Plans will not cover either the reasonable value of the services to treat such an injury, sickness, or other condition or the treatment of such an injury, sickness, or other condition. These benefits are specifically excluded.

The Plans may, however, advance moneys or provide benefits for such an injury, sickness, or other condition, and, if so, you must promptly convey moneys or other property from any settlement, arbitration award, verdict, insurance payment, or other recovery from any party to the Plans in the amount of moneys or of the benefits advanced or provided by the Plans to you, regardless of whether or not (1) you have been fully compensated or made whole for your loss, (2) liability is admitted by you or any other party, or (3) your recovery is itemized or specified as a recovery for medical expenses incurred.

If a recovery is made, the Plans shall have first priority in payment over you or any other party to receive reimbursement of the moneys and value of the other benefits advanced on your behalf. This reimbursement shall be from any recovery made by you and includes, but is not limited to, uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners, or otherwise), workers' compensation settlement, compromises or awards, other group insurance (including student plans), and direct recoveries from liable parties.

You must assign to the Plans any benefits you may have under any automobile policy or other coverage, to the extent of the Plans' claim for reimbursement. You must sign and

deliver, at the request of the Plans or its agents, any documents needed to effectuate such assignment of benefits.

You must cooperate with the Plans and its agents and shall sign and deliver such documents as the Plans or its agents reasonably request to protect the Plans' right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plans making a full recovery of the reasonable value of the moneys or other benefits provided.

You shall not take any action that prejudices the Plans' rights of reimbursement and consents to the right of the Plans, by and through its agent, to impress an equitable lien or constructive trust on the proceeds of any recovery to enforce the Plans' rights under this section, and/or to set off from any future benefits otherwise payable under the Plans the value of moneys and other benefits advanced under this section to the extent not recovered by the Plans.

The Plans shall be responsible only for those legal fees and expenses to which it agrees in writing. You shall not incur any expenses on behalf of the Plans in pursuit of the Plans' rights. Specifically, no court costs or attorney's fees may be deducted from the Plans' recovery without the express written consent of the Plan. Any so-called "Fund Doctrine," "Common Fund Doctrine," "Attorney's Fund Doctrine," or other equitable defenses shall not defeat this right.

The Plans shall recover the full amount of moneys and the value of the benefits advanced and paid hereunder, without regard to any claim or fault on the part of any beneficiary of yours, whether under comparative negligence or otherwise.

Plans' Right to Subrogation

This section applies if another party is, or may be considered, liable for your injury, sickness, or other condition (including insurance carriers who are financially liable).

The Plans will not cover either the reasonable value of the services to treat such an injury, sickness, or other condition or the treatment of such an injury, sickness, or other condition. These benefits are specifically excluded.

The Plans may, however, advance moneys or provide benefits for such an injury, sickness, or other condition, and, if so, the Plans are subrogated to all of your rights against any party liable for your injury, sickness, or other condition, or who is or may be liable for the payment for the medical treatment of such injury, sickness, or other condition (including any insurance carrier), in the amount of moneys or value of other benefits advanced or provided by the Plans to you. The Plans may assert this right independently of you. This right includes, but is not limited to, your rights under uninsured and underinsured motorist coverage, any no-fault insurance, medical payment coverage (auto, homeowners, or otherwise), workers' compensation coverage, or other insurance. The Plans are not obligated in any way to pursue this right independently or

on your behalf, but may choose to pursue its rights to reimbursement under the Plans, at its sole discretion.

You are obligated to cooperate with the Plans and its agents to protect the Plans' subrogation rights. Your obligations include, but are not limited to, providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plans or its agents reasonably request to enforce the Plans' subrogation right, and obtaining the consent of the Plans or its agents before releasing any party from liability for payment of medical expenses.

If you enter into litigation or settlement negotiations relating to your injury, sickness or other condition, you must not prejudice, in any way, the subrogation rights of the Plans under this section. If you fail to cooperate as provided in this section, including executing any documents required in this section, the Plans may, in addition to remedies provided elsewhere in the Plans and/or under the law, set off from any future benefits otherwise payable under the Plans the money and value of other benefits advanced under this section to the extent not recovered by the Plans.

The costs of legal representation of the Plans in matters related to subrogation shall be borne solely by the Plans. The costs of your legal representation shall be borne solely by you.

Equitable Lien

By accepting any benefits advanced by the Plans under this section, you acknowledge that any proceeds of settlement or judgment, including your claim to such proceeds held by another person or held by you, are being held for the benefit of the Plans under these provisions. If the Plans advance moneys or provide benefits for an injury, sickness, or other conditions, and you recover moneys or benefits from a third party in the amount of the moneys or benefits advanced, the Plans have an equitable lien in connection with any such payments. Failure to hold such received funds in trust, and in a separate, identifiable account, will be deemed a breach of your fiduciary duty to the Plans.

Notice

You specifically agree to notify the Plans in writing whenever benefits are paid under the Plans that arise out of any injury, sickness, or other condition that provides or may provide the Plans subrogation or reimbursement rights. Furthermore, you specifically agree to notify the Plans: (1) within 30 days of the date any notice is given by any party, including an attorney, of its intent to pursue or investigate a claim to recover damages or obtain compensation due to an injury, sickness, or other condition; or (2) within 30 days of the date any party, including an attorney, undertakes, pursues, or investigates a claim to recover damages or obtain compensation due to an injury, sickness, other condition.

Waiver

The Plan Administrator in its sole and absolute discretion may waive or modify any or all of the provisions of this rule.

Conversion or Portability Rights

Basic Life Insurance Plan

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

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

Group Variable Universal Life (GVUL) Insurance Plan

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

The Plan includes a portability feature that allows you to continue coverage on a direct bill basis at retirement or termination of employment. Conversion to a personal policy of insurance is also available if portability is not elected, under certain circumstances.

Legal Assistance Plan

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

Voluntary AD&D Plan

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

Individual Disability Insurance Plan

If you are enrolled in Individual Disability Insurance and leave the Company, you will have the option of continuing your coverage on a direct bill basis at your current premium rate.

The Plan includes a portability feature that allows you to continue coverage on a direct bill basis at termination of employment. Upon termination, you will be sent a packet of information explaining your portability options. You must contact the Claims Administrator to arrange for continuation of premium payments directly to Unum Group.

Non-Assignment of Benefits

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

Qualified Medical Child Support Order (QMCSO)

A qualified medical child support order, also known as a QMCSO, is any judgment, decree or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible, and that the Plan Administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return, and children who don't reside with you. The plan won't provide coverage it doesn't otherwise offer—for example, children who are no longer eligible due to their age can't be added under a QMCSO.

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

Qualified Domestic Relations Order (QDRO)

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

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

QDRO Consultants Co.
Attention: Marsh McLennan QDRO Compliance Team
3071 Pearl Street
Medina, Ohio 44256
+1 800 527 8481

About Plan Coverage

Healthcare Plans

Important Information About Your Personal Health Information

- The Company does not collect, maintain, or report on any personal health information pertaining to you or any covered dependents.
- As a participant in our health plan, your personal health information is protected by federal law.
- Our medical Third Party Administrators (or carriers with respect to the insured programs) are required to protect your personal health information in accordance with federal law and data privacy agreements with the Company and/or plan fiduciaries.
- Please note that states seeking to prohibit or limit certain services covered under Company-sponsored plans might attempt to challenge your right to privacy under federal law. If a state's legal challenge is successful, there may be legal consequences associated with you procuring a service covered under a Company-sponsored plan that is or may become prohibited or limited under state law. If you have any questions regarding potential risks, please seek professional legal advice.

If You No Longer Satisfy the Plan's Eligibility Requirements

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

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

If You Die

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

If Your Family Member Loses Eligibility Status

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

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

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

If You Become Disabled

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

If You Have an Authorized Unpaid Leave of Absence

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

If you elect to revoke coverage and you return to employment, your participation will be reinstated automatically in the same benefit option in effect before you left, on the same terms as prior to taking the leave, subject to any changes in benefit levels that may have taken place while you were on leave.

If You Leave and Are Rehired

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

If the Company Ends the Benefit

While the Company intends to maintain the plans, the Company reserves the right to terminate or amend these plans, in whole or part, at any time and for any reason as it deems advisable, as to any and all employees covered. In fact, as a matter of prudent business planning, the Company periodically evaluates the plans. If the Company ends a benefit under the plan or terminates the plan, your coverage for that benefit or under the plan, as applicable, ends on that date.

Health Care Flexible Spending Account and Limited Purpose Health Care Flexible Spending Account

If You No Longer Satisfy the Plan's Eligibility Requirements

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

If You Leave and Are Rehired

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

If You Die

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

If You Become Disabled

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

If You Have an Authorized Unpaid Leave of Absence

Your before-tax contributions to the plan will cease on the day you begin leave. (In some circumstances, COBRA participation may be available.)

Upon return to work, your before-tax contributions will resume. The amount of your before-tax contributions will be recalculated for the remainder of the year to "catch-up" for your missed contributions while on leave. The balance of your annual election will be divided by your remaining pay dates, spreading the balance over the rest of your paychecks for the year. This will increase you per pay period contribution upon return from leave. Any eligible expenses you incur while on leave will be paid.

If the Company Ends the Benefit

While the Company intends to maintain the plans, the Company reserves the right to terminate or amend these plans, in whole or part, at any time and for any reason as it deems advisable, as to any or all employees covered. In fact, as a matter of prudent business planning, the Company periodically evaluates the plans. If the Company terminates the plan, your coverage under the plan ends on the date of termination.

Dependent Care Flexible Spending Account

If You No Longer Satisfy the Plan's Eligibility Requirements

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

If You Leave and Are Rehired

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

If You Die

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

If You Discontinue Contributions While in Active Service

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

If You Become Disabled

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

If You Have an Authorized Unpaid Leave of Absence

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

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

If the Company Ends the Benefit

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

Health Savings Account

If You No Longer Satisfy the Eligibility Requirements

Your before-tax contributions to an HSA will end on the date you no longer satisfy the eligibility requirements to make before-tax contributions, for example, if you do not have medical coverage under a high deductible health plan. However, after that date, you may make contributions directly to the HSA Administrator which may be deductible on your federal tax return. Please consult your personal tax advisor. You may also receive reimbursements from your account. Amounts contributed to an HSA belong to you and are completely portable. You cannot roll the HSA funds over into an IRA. You may keep your HSA with the current provider or you can roll the HSA funds into another HSA account with another provider.

If You Leave and Are Rehired

If you leave salaried employment and are rehired as a salaried employee within 30 days in the same calendar year, your HSA contribution election will be reinstated automatically with the same before-tax contributions in effect before you left. You are permitted to change your election amount at any time.

If You Die

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

If You Discontinue Contributions

If you discontinue before-tax contributions to the HSA, you may continue to receive reimbursements from your account. Any unused balance in your account at the end of the calendar year will be carried forward to the next calendar year, even if you do not elect to make before-tax contributions to the HSA in the next year. You may also make after-tax contributions directly to the Health Savings Account Administrator which may be deductible on your federal tax return. Please consult your personal tax advisor.

If You Become Disabled

Your before-tax contributions will continue to the HSA while you are receiving Short Term Disability benefits. If you then become eligible for Long Term Disability benefits, your before-tax contributions to your account will cease, but you may make contributions directly to the HSA Administrator, which may be deductible on your federal tax return. Please consult your personal tax advisor. You may continue to receive reimbursements from your account.

If You Have an Authorized Unpaid Leave of Absence

Your before-tax contributions to your HSA will cease on the day you begin leave. However, your contributions may be made on an after-tax basis directly to the HSA Administrator during the leave, which may be deductible on your federal tax return. Please consult your personal tax advisor.

You may continue to receive reimbursements from your account, regardless of whether you make any contributions during the leave.

If you return to active employment within the same plan year, your participation will be reinstated automatically with the same before-tax contribution in effect before you left. However, you may change your election at any time.

If the Company Ends the Before-Tax HSA Contribution Option

While the Company intends to maintain the ability to make before-tax contributions via payroll deduction to the HSA, the Company reserves the right to terminate or amend the ability to contribute via payroll deduction to the HSA, at any time and for any reason as it deems advisable, as to any or all employees covered. In fact, as a matter of prudent business planning, the Company periodically evaluates its before-tax benefits offerings.

Other Important Information about the Plans

Not a Contract of Employment

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

If a Mistake Occurs

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

Another way that overpayments for medical benefits may be recovered would be to reduce future payments to the in-network medical provider by the amount of the overpayment. These future payments may involve a Company-sponsored plan or other

employer health plans that are administered by the Company-sponsored plan's third-party administrator. Under this process, the third-party administrator would reduce future payments to in-network medical providers by the amount of the overpayment they received, and then credit the recovered amount to the plan that overpaid that provider. This recovery process will not impact the cost sharing (i.e., deductibles, coinsurance, copay) that you may be required to pay for services received from an in-network medical provider.

Right of Recovery

Payments are made in accordance with the provisions of the plans. If it is determined that payment was made for benefits that are not covered by the applicable plan, for a participant who is not covered by the applicable plan, when other insurance is primary or other similar circumstances, the plan has the right to recover the overpayment. The plan will try to collect the overpayment from the party to whom the payment was made. However, the plan reserves the right to seek overpayment from you and/or your dependents or beneficiary. Failure to comply with this request will entitle the plan to withhold benefits due to you and/or your dependents or beneficiary. The plan has the right to refer the file to an outside collection agency if internal collection efforts are unsuccessful. The plan may also bring a lawsuit to enforce its rights to recover overpayments. For medical claims, the plan will not seek overpayments, except in the case of nonpayment of premiums, fraud, or intentional misrepresentation.

Other Documents Incorporated by Reference

The terms and conditions of the plans are set forth in this Benefits Handbook, insurance policies/evidence of coverage, and benefits booklets/summaries related to the benefits under the plans. Together, these documents are incorporated by reference into the formal plan documents and constitute the written instruments under which the plans are established and maintained. An amendment to one of these documents constitutes an amendment to the plans.

This summary should be read in connection with the applicable insurance policy/evidence of coverage or benefits booklet/summary provided by the applicable insurers or Claims Administrators. Unless otherwise noted, if there is a conflict between a specific provision under the Benefits Handbook and a benefit booklet/summary or insurance policy/evidence of coverage, the Benefits Handbook controls. If the Benefits Handbook is silent, the terms of the applicable insurance policy/evidence of coverage or benefits booklet/summary controls. However, with respect to fully insured benefits, the terms of the certificate of insurance coverage or insurance policy/evidence of coverage control when describing specific benefits that are covered or insurance-related terms.