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UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

E.S., by and through her parents and guardians, To.S. and Ti.S., individually, on behalf of similarly situated individuals, and derivatively on behalf of the MARSH & MCLENNAN COMPANIES, HEALTH & WELFARE BENEFITS PROGRAM, Plaintiff, vs. MARSH & MCLENNAN COMPANIES, INC. BENEFITS ADMINISTRATION COMMITTEE THE MARSH & MCLENNAN COMPANIES HEALTH & WELFARE BENEFITS PROGRAM, MARSH & MCLENNAN COMPANIES, INC., AND AETNA LIFE INSURANCE COMPANY Defendants.	Civil Action No. **COMPLAINT** (CLASS ACTION)

I. PARTIES

1. ***E.S.*** Plaintiff E.S. is the seventeen-year-old daughter and dependent of To.S. and Ti.S. and resides in Kitsap County, Washington. E.S. is a beneficiary, as defined by ERISA § 3(8), 29 U.S.C. § 1002(8), of Marsh & McLennan Companies Health & Welfare Plan, of which her $1,500 Deductible Plan is a component benefit. E.S.'s health coverage is through To.S.'s employment.

2. ***Marsh & McLennan Companies Health & Welfare Benefits Program.*** The Marsh McLennan Companies Health & Welfare Benefits Program (hereinafter, the "Plan") provides component benefits under a single Plan and is an employee welfare benefit plan under the Employment Retirement Security of Act of 1974 ("ERISA"). The Plan included in 2016, as a component benefit, the $350, $800, $1,500 and $2,850 Deductible Plans. Based upon information and belief, the schedules of benefits in the Deductible Plans differ only in the amount of deductible, and, at least as administered by Aetna, the claims administrator, provide the same terms and conditions for coverage, regardless of the deductible amount. In addition, based upon information and belief, the various component schedules of benefits have changed their names in 2017 to reflect changes in the amount of deductible, but are, for all other purposes, the same component schedules of benefits under the Plan.

3. ***Marsh & McLennan Companies, Inc. Benefits Administration Committee.*** According to the Plan Document, the Marsh & McLennan Companies, Inc. Benefits Administration Committee is the "Plan Administrator" and is a named fiduciary under ERISA. According to the Plan document, the Plan Administrator has "full discretion and authority to control and manage the operation and administration of each individual welfare plans that form the Marsh & McLennan Health & Welfare Benefits Program except to the extent authority has been granted to the Claims Administrator [Aetna] for adjudication of claims under such welfare plans." The Marsh & McLennan Companies, Inc. Benefits Administration Committee is located in Hoboken, New Jersey.

4. ***Marsh & McLennan Companies, Inc.*** According to the Plan Document, the Marsh & McLennan Companies, Inc. is the "Plan Sponsor" and is a named fiduciary under ERISA. The Marsh & McLennan Companies, Inc. is located in Hoboken, New Jersey.

5. ***Aetna Life Insurance Company.*** According to the Plan Document, Aetna Life Insurance Company ("Aetna") is the Claims Administrator for at least some of the

component benefits in the Plan, including the component benefit in which E.S. is enrolled. According to the Plan document, Aetna, as the Claims Administrator, is a fiduciary related to the adjudication of claims for benefits that it administers.

6. The Plan, Marsh & McLennan Companies, Inc. Benefits Administration Committee, Marsh & McLennan Companies, Inc. and Aetna shall be collectively referred to as Defendants."

II. JURISDICTION AND VENUE

7. Jurisdiction of this Court arises pursuant to ERISA § 502(e)(1), 29 U.S.C. § 1132(e)(1).

8. Venue is proper under ERISA § 502(e)(2), 29 U.S.C. § 1132(e)(2), because, *inter alia*, a defendant resides or may be found in this district.

III. NATURE OF THE CASE

9. The Plan document purports to cover medically necessary out-of-network residential psychiatric treatment albeit such coverage is provided at a lower percentage than in-network treatment. E.S. seeks to end the Defendants' standard practice of excluding coverage of medically necessary residential psychiatric treatment based upon a hidden, "administrative" exclusion.

10. When E.S. sought coverage for medically necessary treatment at a properly licensed out-of-network residential psychiatric treatment facility, Defendants denied coverage, claiming that the treatment was excluded under the terms of the Plan. Defendants did not dispute that the treatment was medically necessary. Rather, Defendants asserted that the out-of-network treatment facility did not meet staffing and credentialing required by the Plan document. A true copy of the Plan document is attached as Exhibit A to this Complaint.

11. The exclusion relied upon by Defendants to deny E.S.'s request for coverage is not part of the "terms" of the Plan document. The exclusion does not appear in the Plan document at all.

12. The Defendants' use of a hidden, undisclosed exclusion that is not part of the Plan document is arbitrary and capricious. Exclusions must be "conspicuous, clear and plain" in order to be applied. Exclusions that are not codified as part of the "terms of the Plan" are unenforceable.

13. The use of a hidden exclusion to limit access to psychiatric treatment also violates the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 29 U.S.C. § 1185a, commonly known as the Federal Parity Act. The Federal Parity Act requires that the exclusions and limitations imposed on mental health services be "no more restrictive" than those applied to substantially all medical and surgical benefits. *See* 29 U.S.C. § 1185a(a)(3)(A)(ii). The hidden exclusion is not applied to medical/surgical services, such as skilled nursing facilities.

14. Defendants' application of a hidden exclusion based upon a provider's lack of credentials other than state licensure or certification also violates the provider non-discrimination provision of the Affordable Care Act. 42 U.S.C. § 300gg-5(a); 29 U.S.C. §1185d. This provision prohibits Defendants from discriminating against a health care provider that is acting within the scope of the provider's license under applicable state law. *Id.*

15. Defendants' exclusion of medically necessary residential psychiatric treatment based upon a hidden exclusion not present in the Plan, violates ERISA. It also violates both the Federal Parity Act and the Affordable Care Act, whose requirements are incorporated in to the "terms of the Plan." To the extent Defendants systematically and uniformly applied this exclusion to Plan participants and beneficiaries, they breached their fiduciary duties to Plaintiff and other members of the proposed Class.

16. This lawsuit seeks remedies under ERISA arising out of Defendants' failure to comply with the terms of the Plan and applicable federal law. It further seeks to recover the benefits that have been wrongfully denied to E.S. and the class she seeks to represent. It also seeks a court order declaring the Defendants' hidden and discriminatory exclusion illegal and void. The lawsuit further seeks an injunction to prevent any future or ongoing efforts by Defendants to use and enforce the same or similar hidden, discriminatory exclusions. Finally, it seeks to require Defendants to provide accurate information to all participants concerning the coverage of out-of-network residential psychiatric treatment services under the Plan.

IV. CLASS ALLEGATIONS

17. ***Definition of Class***. E.S. proposes the following class:

All individuals:

(1) who have been, are, or will be participants or beneficiaries in the Marsh McLennan Companies Health & Welfare Benefit Programs administered by Aetna at any time since January 1, 2014 and/or the relevant statute of limitations;

(2) who have received, require, or are expected to require out-of-network residential psychiatric treatment services; and

(3) whose request for coverage of the out-of-network residential psychiatric treatment was "administratively excluded" based upon requirements that are not part of the terms of the Plan document.

18. ***Size of Class***. The Class of persons who have received, require or are expected to require residential psychiatric treatment services is expected to number over 40 individuals and is so large that joinder of all members is impracticable.

19. ***Class Representative E.S.*** Named plaintiff E.S. is an enrollee in the Plan. E.S. is diagnosed with a psychiatric condition that required medically necessary treatment at an out-of-network residential psychiatric treatment facility. Defendants denied E.S.'s request for coverage of her out-of-network residential psychiatric

treatment as "administratively excluded" under the Plan, even though the exclusion is not part of the Plan document. Her claims are typical of the claims of the other members of the Class, and through her parents, she will fairly and adequately represent the interests of this class.

20. ***Common Questions of Law and Fact***. This action requires a determination of whether the Defendants' application of a hidden exclusion to deny coverage of out-of-network treatment facilities violates the Federal Parity Act, the Affordable Care Act and the terms of the Plan as modified by applicable federal law. Adjudication of this issue will in turn determine whether the Defendants are liable under ERISA for their conduct.

21. ***Separate suits would create risk of varying conduct requirements***. The prosecution of separate actions by class members against the Plan would create a risk of inconsistent or varying adjudications with respect to individual class members that would establish incompatible standards of conduct. Certification is therefore proper under Federal Rule of Civil Procedure 23(b)(1).

22. ***Defendants have acted on grounds generally applicable to the Class.*** Defendants, by applying policies and practices that result in the improper exclusion of out-of-network coverage of residential psychiatric treatment services, have acted on grounds generally applicable to the Class, rendering declaratory relief appropriate respecting the entire class. Certification is therefore proper under Federal Rule of Civil Procedure 23(b)(2).

23. ***Questions of law and fact common to the class predominate over individual issues.*** Issues as to the Defendants' conduct in applying standard policies and practices towards all members of the class predominate over questions, if any, unique to individual members of the Class. The claims of the individual Class members are more efficiently adjudicated on a class-wide basis. Any interest that individual members of the classes may have in individually controlling the prosecution of separate

actions is outweighed by the efficiency of the class action mechanism. Certification is therefore additionally proper under Federal Rule of Civil Procedure 23(b)(3).

24. ***No pending class action.*** Upon information and belief, there is no pending class action suit filed against these defendant for the same relief requested in this action, for a class of ERISA insureds.

25. ***Venue.*** This action can be most efficiently prosecuted as a class action in the District of New Jersey, where Defendants are located.

26. ***Class Counsel***. E.S. has retained experienced and competent class counsel.

V. FACTUAL BACKGROUND

27. During certain time periods, E.S. and members of the Class have been, are or will be participants or beneficiaries of the Plan, which is subject to ERISA pursuant to 29 U.S.C. § 1003.

28. Since October 3, 2009, and continuing to the present, E.S. and other members of the Class have been diagnosed with psychiatric conditions that are covered by the federal Mental Health Parity Act.

29. Since January 1, 2014 and continuing to the present, E.S. and other members of the Class have sought treatment from or may in the future require treatment at out-of-network residential psychiatric treatment facilities.

30. E.S. and other members of the class have required, currently require or will require medically necessary out-of-network residential psychiatric treatment services. As defined by the Plan and relevant state and federal law, these services are "mental health services." Defendants, however, have denied coverage of such treatment through the application of a hidden exclusion that does not exist in the Plan document.

31. The application of this hidden exclusion is arbitrary and capricious. It is also not "at parity" with the Plan's coverage of medical/surgical services. The application of the hidden exclusion also discriminates against providers who are acting within the scope of their license or certification.

32. As a result, E.S. and other members of the Class have paid for out-of-network residential psychiatric treatment services out of their own pockets, or face the imminent threat that they will have to do so in the near future. Other Class members have been forced to forgo needed treatment due to the Defendants' conduct.

33. In light of the established Plan documents, statements and written representations by the Defendants to the parents of E.S. and other members of the Class, any attempt by Class members to pursue administrative remedies is futile. Nonetheless, E.S. has completed the internal appeal process within the Plan over its application of a hidden exclusion of coverage for residential psychiatric treatment, to no avail. She exhausted her administrative remedies on September 30, 2016.

VI. CLAIMS FOR RELIEF

FIRST CLAIM:
BREACH OF FIDUCIARY DUTIES
ERISA § 404(a)(1); §502(a)(2), 29 U.S.C. § 1104(a)

34. E.S. re-alleges all paragraphs above.

35. Defendant Marsh & McLennan Companies, Inc. Benefits Administration Committee is a fiduciary under ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A), because it is the Plan Administrator and exercises discretionary authority or discretionary control with respect to the Plan.

36. Defendant Marsh & McLennan Companies, Inc. is a fiduciary under ERISA § 3(21)(A), 29 U.S.C. § 1002(21)(A), because it is the Plan Sponsor and exercises discretionary authority or discretionary control with respect to the Plan.

37. Defendant Aetna is a fiduciary under ERISA because it has been delegated discretionary authority to make claims determinations, and exercised that discretionary authority to adjudicate claims submitted on behalf of E.S. and members of the Class.

38. ERISA imposes strict fiduciary duties upon plan fiduciaries. ERISA § 404(a)(1)(C), 29 U.S.C. § 1104(a)(1)(C), states, in relevant part, that a plan fiduciary must discharge its duties with respect to a plan "solely in the interest of the participants and beneficiaries and … in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this title and Title IV."

39. ERISA § 409(a), 29 U.S.C. § 1109(a), states, in relevant part:

> Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this title shall be personally liable to make good to such plan any losses to the Plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the Plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

40. The terms of an ERISA plan include applicable provisions of substantive law, such as the requirements in the Federal Parity Act and certain provisions of the Affordable Care Act. Defendants have failed to comply with the terms of the Plan, which include the applicable requirements of the Federal Parity Act, the Affordable Care Act and their implementing regulations. Under ERISA, Defendants have both a fiduciary and a legal duty to ensure that the Plan complies with the applicable federal law.

41. Defendants violated their obligations under ERISA § 404(a)(1), 29 U.S.C. § 1104(a)(1), by failing to act in accordance with the documents and instruments

governing the Plan, as governed by applicable federal law, and thereby breached their fiduciary duties to the Plan, E.S. and all Class members.

42. As a direct and proximate result of these acts and omissions, E.S., Class members and the Plan have suffered harm and losses and are entitled to relief under ERISA against Defendants.

43. E.S., Class members and the Plan seek recovery of all losses to the Plan, including, but not limited to, relief compelling Defendants to restore to the Plan all losses, including interest, arising from the breaches of fiduciary duties when treatment required by the terms of the Plan as governed by the Federal Parity Act and the Affordable Care Act was denied.

SECOND CLAIM:
CLAIM FOR RECOVERY OF BENEFITS, CLARIFICATION OF RIGHTS UNDER TERMS OF THE PLANS AND CLARIFICATION OF RIGHT TO FUTURE BENEFITS UNDER THE PLAN
ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)

44. E.S. re-alleges all the paragraphs above.

45. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), provides that a participant or beneficiary may bring an action to "recover benefits due to [her] under the terms of [her] plan, to enforce [her] rights under the terms of the plan, or to clarify [her] rights to future benefits under the terms of the plan."

46. E.S. and the Class are entitled to recover benefits due them under the terms of the Plan. They are also entitled to a declaration of present and future rights to coverage of medically necessary out-of-network residential psychiatric treatment services without the application of hidden, invalid exclusions.

THIRD CLAIM:
CLAIM TO ENJOIN ACTS AND PRACTICES IN VIOLATION OF THE TERMS OF THE PLANS, TO OBTAIN OTHER EQUITABLE RELIEF AND TO ENFORCE THE TERMS OF THE PLANS
ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3)

47. E.S. re-alleges all the paragraphs above.

48. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), provides that a participant or beneficiary may "enjoin any act or practice which violates any provision of this subchapter or the terms of the plan." E.S. and the Class seek to enjoin Defendants from continuing to apply a hidden, illegal exclusion on out-of-network residential psychiatric treatment services. E.S. and the Class also seek to have Defendants provide the Class with corrective notice and reformation of the relevant Plan documents.

49. ERISA § 502(a)(3), 29 U.S.C. § 1132(a)(3), further provides that a participant or beneficiary may obtain other appropriate equitable relief to redress violations of ERISA or enforce plan terms. To the extent full relief is not available under ERISA § 502(a)(1)(b), 29 U.S.C. § 1132(a)(1)(B) or ERISA § 502(a)(2), 29 U.S.C. § 1132(a)(2), then E.S. and the Class seek equitable remedies including, without limitation, unjust enrichment, disgorgement, restitution, surcharge and consequential damages arising out of the Defendants' failure to administer the terms of the Plan as governed by the applicable provisions of the Federal Parity Act and the Affordable Care Act.

VII. DEMAND FOR RELIEF

WHEREFORE, E.S. requests that this Court:

1. Certify this case as a class action, designate named plaintiff E.S., by and through her parents, as class representative, and designate SIRIANNI YOUTZ SPOONEMORE HAMBURGER, Richard E. Spoonemore, and Eleanor Hamburger and DAVID TYKULSKER & ASSOCIATES, David Tykulsker as class counsel;

2. Enter judgment on behalf of the Plan, E.S. and the Class for harms and losses sustained by such Plan due to Defendants' breaches of fiduciary duty and failure to pay Plan benefits;

3. Declare that Defendants may not apply the hidden exclusion of certain out-of-network residential psychiatric treatment services, since such exclusions and/or limitations are not predominantly applied to medical and surgical services;

4. Enjoin Defendants from further violations of the terms of the Plan as modified by the Federal Parity Act and certain provisions of the Affordable Care Act;

5. Enter judgment in favor of E.S. and the Class for damages in an amount to be proven at trial due to the failure to provide benefits due under the Plan as modified by the Federal Parity Act and certain provisions of the Affordable Care Act;

6. Award E.S. and the Class their attorney fees and costs under ERISA § 502(g), 29 U.S.C. § 1132(g); and

7. Award such other relief as is just and proper.

Dated: May 11, 2017

DAVID TYKULSKER & ASSOCIATES

By: *s/ David Tykulsker*

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By: *s/ Richard E. Spoonemore*
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CERTIFICATION REGARDING OTHER ACTIONS AND PARTIES

Pursuant to L.Civ.R. 11.2, the undersigned are unaware of any other action, arbitration or administrative claim related to the matters in controversy set forth in the instant Complaint.

Pursuant to 28 U.S.C. § 1746(2), the undersigned certify under penalty of perjury that the foregoing is true and correct.

Dated: May 11, 2017

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EXHIBIT A

Benefits Handbook Date September 1, 2016

Aetna Medical Plan Options

Marsh & McLennan Companies

MARSH & McLENNAN
COMPANIES

Aetna Medical Plan Options

Selecting a medical plan option for 2016 involves three key choices for eligible individuals.

- Select one of four medical plan design options. A range of coverage levels and costs is offered.
- Select coverage for:
  - yourself only — Employee
  - yourself and your spouse or domestic partner — Employee + Spouse
  - yourself and your child or children — Employee + Child(ren)
  - yourself, your spouse or domestic partner, and children — Family
- Select your medical plan carrier:
  - All eligible individuals resident in any state except Hawaii may choose from among:
    - Aetna
    - Anthem BlueCross BlueShield (Anthem BCBS)
    - United Healthcare (UHC)

Note: This section of the Benefits Handbook provides information about the Aetna administered medical plan options only.

Information about the Anthem BlueCross BlueShield and UnitedHealthcare administered medical plan options is covered in a separate section of the Benefits Handbook.

  - Eligible individuals resident in CA, CO, GA, MD, VA, OR, WA, and Washington DC have an additional choice to consider:
    - Kaiser Permanente (Kaiser)

Information about the Kaiser administered medical plan options is covered in a separate section of the Benefits Handbook.

  - Eligible individuals who are resident in Hawaii, may only choose between:
    - HMSA's Health Plan Hawaii Plus (HMO)

SPD and Plan Document

This section provides a summary of the Medical Plan (the "Plan") options available through Aetna as of January 1, 2016.

This section, together with the *Administrative Information* section and the applicable section about participation, forms the Summary Plan Description and plan document of the Plan.

- HMSA's Preferred Provider Plan (PPP)

Information about the Hawaii medical plan options is covered in a separate section of the Benefits Handbook.

All medical plan options described in this section of the Benefits Handbook offer:

- comprehensive health services
- the freedom to select between a health care provider that participates in your chosen medical plan carrier's network, generally at a lower cost to you, or a provider that does not participate in your chosen medical plan carrier's network, generally at a higher cost to you.

Note: Be sure to read about Health Care Flexible Spending Accounts (HCFSAs), Health Savings Accounts (HSAs) and Limited Purpose Health Care Flexible Spending Accounts (LPHCFSAs). Understanding these tax-advantaged arrangements may be important to your selection of a medical plan.

A Note about ERISA

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

Contents

The Medical Plan Options at a Glance

The chart below outlines some important Plan features and coverage information that distinguish the four available Aetna medical plan options. Additional information is provided throughout this section of the Benefits Handbook including the "Detailed List of Covered Services" on page 46.

Plan feature	$350 Deductible Plan[1]	$800 Deductible Plan[1]	$1,500 Deductible Plan[1]	$2,850 Deductible Plan[1]
Annual Deductible	***In-network:*** Employee: $350 Family[4]: $700[5] ***Out-of-network:*** Employee: $2,000 Family[4]: $4,000[5]	***In-network:*** Employee: $800 Family[4]: $1,600[5] ***Out-of-network:*** Employee: $2,400 Family[4]: $4,800[5]	***In-network:*** Employee: $1,500 Family[4]: $3,000[2] ***Out-of-network:*** Employee: $3,000 Family[4]: $6,000[2]	***In-network:*** Employee: $2,850 Family[4]: $5,700[5] ***Out-of-network:*** Employee: $5,700 Family[4]: $11,400[5]
Out-of-Pocket Maximum (including DEDUCTIBLE)	***In-network:*** Employee: $2,000 Family[4]: $4,000[5] ***Out-of-network:*** Employee: $4,000 Family[4]: $8,000[5]	***In-network:*** Employee: $2,400 Family[4]: $4,800[5] ***Out-of-network:*** Employee: $4,800 Family[4]: $9,600[5]	***In-network:*** Employee: $3,000 Family[4]: $6,000[2] ***Out-of-network:*** Employee: $6,000 Family[4]: $12,000[2]	***In-network:*** Employee: $5,500 Family[4]: $11,000[5] ***Out-of-network:*** Employee: $11,000 Family[4]: $22,000[5]
Plan Coinsurance	***In-network:*** 80% COINSURANCE after deductible ***Out-of-network:*** 60% coinsurance after deductible (Out-of-network benefits are based on reasonable and customary charges)			***In-network:*** 70% coinsurance after deductible ***Out-of-network:*** 50% coinsurance after deductible (Out-of-network benefits are based on reasonable and customary charges)
Physician office visits				
Preventive Visit	***In-network:*** *Covered at 100%* ***Out-of-network:*** 60% coinsurance after deductible	***In-network:*** *Covered at 100%* ***Out-of-network:*** 60% coinsurance after deductible	***In-network:*** *Covered at 100%* ***Out-of-network:*** 60% coinsurance after deductible	***In-network:*** *Covered at 100%* ***Out-of-network:*** 50% coinsurance after deductible
Primary Care Physician (PCP)/Specialist Visit	***In-network:*** *$15 copay*[3] ***Out-of-network:*** 60% coinsurance of R&C after deductible Copay amounts do not apply to the deductible.	***In-network:*** 80% coinsurance after deductible ***Out-of-network:*** 60% coinsurance of R&C after deductible	***In-network:*** 80% coinsurance after deductible ***Out-of-network:*** 60% coinsurance of R&C after deductible	***In-network:*** 70% coinsurance after deductible ***Out-of-network:*** 50% coinsurance of R&C after deductible

Plan feature	$350 Deductible Plan[1]	$800 Deductible Plan[1]	$1,500 Deductible Plan[1]	$2,850 Deductible Plan[1]
Specialist Visit	***In-network:*** *$30 copay*[3] ***Out-of-network:*** 60% coinsurance of R&C after deductible Copay amounts do not apply to the deductible.	***In-network:*** 80% coinsurance after deductible ***Out-of-network:*** 60% coinsurance of R&C after deductible	***In-network:*** 80% coinsurance after deductible ***Out-of-network:*** 60% coinsurance of R&C after deductible	***In-network:*** 70% coinsurance after deductible ***Out-of-network:*** 50% coinsurance of R&C after deductible
Hospital Facility				
Inpatient	***In-network:*** 80% coinsurance after deductible ***Out-of-network:*** 60% coinsurance after deductible	***In-network:*** 80% coinsurance after deductible ***Out-of-network:*** 60% coinsurance after deductible	***In-network:*** 80% coinsurance after deductible ***Out-of-network:*** 60% coinsurance after deductible	***In-network:*** 70% coinsurance after deductible ***Out-of-network:*** 50% coinsurance after deductible
Outpatient	***In-network:*** 80% coinsurance after deductible ***Out-of-network:*** 60% coinsurance after deductible	***In-network:*** 80% coinsurance after deductible ***Out-of-network:*** 60% coinsurance after deductible	***In-network:*** 80% coinsurance after deductible ***Out-of-network:*** 60% coinsurance after deductible	***In-network:*** 70% coinsurance after deductible ***Out-of-network:*** 50% coinsurance after deductible
Emergency Room (waived if admitted)	***In and Out-of-network:*** *$100 copay per visit, 80% coinsurance after deductible*	***In and Out-of-network:*** *80% coinsurance after deductible*	***In and Out-of-network:*** *80% coinsurance after deductible*	***In and Out-of-network:*** *70% coinsurance after deductible*
Prescription drugs	There is a pharmacy network for retail and Express Scripts by Mail for mail order PRESCRIPTION DRUGS.			
Retail Prescriptions (30-day supply)				
▪ Generic	$10 copay[3] (These amounts do not apply to the deductible)	70% coinsurance (These amounts do not apply to the deductible; minimum $10/maximum $20)[3]	80% coinsurance after deductible	70% coinsurance after deductible
▪ Formulary Brand	$30 copay[3] (These amounts to do not apply to the deductible)	70% coinsurance (These amounts do not apply to the deductible; minimum $25/maximum $50)[3]	80% after coinsurance deductible	70% coinsurance after deductible
▪ Non-Formulary Brand	$60 copay[3] (These amounts do not apply to the deductible)	55% (These amounts do not apply to the deductible; minimum $40/maximum $80)	80% after insurance deductible	70% coinsurance after deductible
Mail-order Prescriptions (90-day supply)				

Plan feature	$350 Deductible Plan[1]	$800 Deductible Plan[1]	$1,500 Deductible Plan[1]	$2,850 Deductible Plan[1]
▪ Generic	$25 copay[3] (These amounts do not apply to the deductible)	70% coinsurance (These amounts do not apply to the deductible; minimum $25/maximum $50)[3]	80% coinsurance after deductible	70% coinsurance after deductible
▪ Formulary Brand	$75 copay[3] (These amounts do not apply to the deductible)	70% coinsurance (These amounts do not apply to the deductible; minimum $62.50/maximum $125)[3]	80% coinsurance after deductible	70% coinsurance after deductible
▪ Non-Formulary Brand	$150 copay[3] (These amounts do not apply to the deductible)	55% coinsurance (These amounts do not apply to the deductible; minimum $100/maximum $200)[3]	80% coinsurance after deductible	70% coinsurance after deductible
Contact Information for Carrier options:	Contact for Medical Service: Aetna (Claims Administrator) P.O. Box 981106 El Paso, TX 79998-1106 Aetna Customer Service: +1 866 210 7858 Website: www.aetna.com/docfind/custom/mmc Contact for Prescription Service: Express Scripts (Pharmacy Benefits Manager) Phone: +1 800 987 8360 Website (for members): www.express-scripts.com Express Scripts Group #: MMCRX05 Marsh & McLennan Companies does not administer claims under this plan. For medical claims, the Claims Administrators' decisions are final and binding. For prescription drug claims, the Pharmacy Benefits Manager's decisions are final and binding.			

[1] These plans are named for the deductible applicable to the "individual" for in-network service providers. The deductibles applicable to any other coverage level (for example, "Family coverage") or for services provided by out-of-network service providers will be significantly higher than (in many instances, double) the amounts captured in the names of the plans.

[2] This plan does not require that you or a covered eligible family member meet the "individual" deductible in order to satisfy the family deductible. If more than one person in a family is covered under this plan, benefits begin for any one covered family member only after the family deductible is satisfied. The family deductible may be met by one family member or a combination of family members. The out-of-pocket maximum functions in the same way. If more than one person in a family is covered under this plan, the out-of-pocket maximum is satisfied for any one covered family member when the family out-of-pocket maximum is satisfied. The family out-of-pocket maximum may be met by one family member or a combination of family members.

[3] Office visit and prescriptions do not apply toward the annual deductible.

[4] "Family" applies to all coverage levels except Employee-Only.

[5] If more than one person in a family is covered under this plan, there are two ways the plan will begin to pay benefits for a covered family member. When a family member meets his or her individual deductible, benefits begin for that family member only, but not for the other family members. When the family deductible is met, benefits begin for every covered family member whether or not they have met their own individual deductibles. The family deductible may be met by a combination of family members, as amounts counted toward individual deductibles count toward the larger family deductible. The out-of-pocket maximum functions in the same way. When a family member meets his or her individual out-of-pocket maximum, the out-of-pocket maximum is satisfied for that family member only, but not for the other family members. When the family out-of-pocket maximum is met, the out-of-pocket maximum is satisfied for every covered family member whether or not they have met their own individual out-of-pocket maximums. The family out-of-pocket maximum may be met by a combination of family members, as amounts counted toward individual out-of-pocket maximums count toward the larger family out-of-pocket maximum.

Participating in the Plan

You are eligible to participate in the Plan if you meet the eligibility requirements described in the *Participating in Healthcare Benefits* section.

You have the option to cover your family members who meet the eligibility requirements that are described in the *Participating in Healthcare Benefits* section.

Retiree Eligibility

Certain retirees and their ELIGIBLE FAMILY MEMBERS that are not yet deemed to be eligible for MEDICARE may also be eligible for coverage under this plan. For information on the eligibility requirements, how to participate and the cost of coverage, see the *Participating in Pre-65 Retiree Medical Coverage* section.

Enrollment

To participate in this Plan, you must enroll for coverage. You may enroll only:

- within 30 days of the date you become eligible to participate
- during Annual Enrollment (generally in November with respect to coverage for the following calendar year)
- within 60 days of a qualifying change in family status that makes you eligible to enroll
- within 30 days of losing other coverage that you had relied upon when you waived your opportunity to enroll in this Plan.

Enrollment procedures for you and your ELIGIBLE FAMILY MEMBERS are described in the *Participating in Healthcare Benefits* section.

Cost of Coverage

You and the Company share the cost of coverage for both you and your ELIGIBLE FAMILY MEMBERS.

The cost of your coverage depends on the plan option and level of coverage you choose.

You can choose from four levels of coverage. Cost for each coverage level for eligible Marsh & McLennan Companies Employees (other than Marsh & McLennan Agency LLC – Southwest (including Prescott Pailet Benefits) (collectively MMA Southwest) (MMA-Southwest), Marsh &

McLennan Agency LLC – Northeast (MMA-Northeast), or Security Insurance Services of Marsh & McLennan Agency) is shown below.

You pay the HealthyMe rate on your annual medical plan contributions, if you and your spouse/domestic partner both enroll in the Plan and if you and your spouse/domestic partner **both** completed the three Know Your Numbers steps within the designated required time period.

Note: Employees hired on or after July 1, 2015, will receive the 2016 HealthyMe rate even if they did not complete the required Know Your Numbers steps.

HealthyMe Rates	**$350 Deductible Plan**		**$800 Deductible Plan**		**$1,500 Deductible Plan**		**$2,850 Deductible Plan**	
Eligible Marsh & McLennan Companies Employees	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***
Employee Only	$105.38	$48.63	$78.76	$36.35	$46.39	$21.41	$19.93	$9.20
Employee + Spouse	$263.29	$121.52	$199.75	$92.19	$122.75	$56.65	$58.74	$27.11
Employee + Child(ren)	$210.75	$97.27	$157.53	$72.71	$92.77	$42.81	$39.86	$18.40
Family	$379.21	$175.02	$286.38	$132.18	$173.77	$80.20	$80.66	$37.23

You pay the Blended rate on your annual medical plan contributions if you and your spouse/domestic partner enroll in the Plan **but only one of you** completed the three Know Your Numbers steps within the designated required time period.

Blended Rates	**$350 Deductible Plan**		**$800 Deductible Plan**		**$1,500 Deductible Plan**		**$2,850 Deductible Plan**	
Eligible Marsh & McLennan Companies Employees	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***	***Semi-monthly cost***	***Weekly cost***
Employee Only	$105.38	$48.63	$78.76	$36.35	$46.39	$21.41	$19.93	$9.20
Employee + Spouse	$288.29	$133.06	$224.75	$103.73	$147.75	$68.19	$83.74	$38.65
Employee + Child(ren)	$210.75	$97.27	$157.53	$72.71	$92.77	$42.81	$39.86	$18.40
Family	$404.21	$186.56	$311.38	$143.71	$198.77	$91.74	$105.66	$48.77

You pay the Standard rate on your annual medical plan contributions if you and your spouse/domestic partner enroll in the Plan **but neither you nor your spouse/domestic partner** completed the three Know Your Numbers steps within the designated required time period.

Standard Rates	$350 Deductible Plan		$800 Deductible Plan		$1,500 Deductible Plan		$2,850 Deductible Plan	
Eligible Marsh & McLennan Companies Employees	*Semi-monthly cost*	*Weekly cost*	*Semi-monthly cost*	*Weekly cost*	*Semi-monthly cost*	*Weekly cost*	*Semi-monthly cost*	*Weekly cost*
Employee Only	$130.38	$60.17	$103.76	$47.89	$71.39	$32.95	$44.93	$20.74
Employee + Spouse	$313.29	$144.60	$249.75	$115.27	$172.75	$79.73	$108.74	$50.19
Employee + Child(ren)	$235.75	$108.81	$182.53	$84.24	$117.77	$54.35	$64.86	$29.94
Family	$429.21	$198.09	$336.38	$155.25	$223.77	$103.28	$130.66	$60.30

Medical rates are not available for employees of MMA-Southwest, MMA-Northeast, or Security Insurance Services of Marsh & McLennan Agency. For contribution rates, contact the Employee Service Center at +1 866 374 2662, any business day, from 8:00 a.m. to 8:00 p.m. Eastern time.

See the *Participating in Healthcare Benefits* section for more information on the cost of your coverage, such as information about taxes.

Imputed Income for Domestic Partner Coverage

If you cover your domestic partner or your domestic partner's children, there may be imputed income for the value of the coverage for those family members. See the *Participating in Healthcare Benefits* section for more information on imputed income for domestic partner coverage.

Section 152 Dependents

If your domestic partner (or his or her child(ren)) qualifies as a dependent under IRS Section 152, imputed income does not apply.

The table below shows the imputed income amounts for all ELIGIBLE Marsh & McLennan Companies EMPLOYEES (including MMA-Southwest, MMA-Northeast, or Security Insurance Services of Marsh & McLennan Agency):

Imputed Income Rates								
Imputed Income for Domestic Partner Coverage	$350 Deductible Plan		$800 Deductible Plan		$1,500 Deductible Plan		$2,850 Deductible Plan	
Eligible Marsh & McLennan Companies Employees	*Semi-monthly cost*	*Weekly cost*	*Semi-monthly cost*	*Weekly cost*	*Semi-monthly cost*	*Weekly cost*	*Semi-monthly cost*	*Weekly cost*

Imputed Income Rates								
Imputed Income for Domestic Partner Coverage	**$350 Deductible Plan**		**$800 Deductible Plan**		**$1,500 Deductible Plan**		**$2,850 Deductible Plan**	
Eligible Marsh & McLennan Companies Employees	*Semi-monthly cost*	*Weekly cost*	*Semi-monthly cost*	*Weekly cost*	*Semi-monthly cost*	*Weekly cost*	*Semi-monthly cost*	*Weekly cost*
Employee + Domestic Partner (non-qualified)	$402.11	$185.59	$375.97	$173.53	$342.27	$157.97	$298.51	$137.77
Employee + Child(ren) (non-qualified)	$287.22	$132.57	$268.55	$123.95	$244.47	$112.83	$213.22	$98.40
Employee + Domestic Partner (non-qualified) & Child(ren)	$430.83	$198.84	$402.82	$185.92	$366.72	$169.25	$319.83	$147.62
Employee + Domestic Partner & Child(ren) (Domestic Partner and Child(ren) (non-qualified)	$718.05	$331.41	$671.37	$309.87	$611.19	$282.08	$533.04	$246.02

ID Cards

If you are enrolled in employee only coverage you will automatically be sent one ID card for your medical coverage and one ID card for your prescription drug coverage. You will be sent one additional ID card if you enroll one or more family members in the Plan. Each ID card will list the employee's name and the names of up to five covered family members.

You will be sent your ID card(s) within two to four weeks of your enrollment.

You may request additional ID cards directly from the Claims Administrator.

How the Medical Plan Options Work

All of the medical plan options help you and your family to pay for medical care. As a participant, you may choose, each time you need medical treatment, to use:

- Any physician, hospital or lab, or
- A provider who participates in the Aetna Choice POSII network and has agreed to charge reduced fees to the Plan members. Using the network is more cost effective than using non-network providers because their fees are typically less than those charged by non-network providers.

If you use an in-network provider, you do not need to submit a claim form. IN-NETWORK PROVIDERS bill the Claims Administrator directly.

Under the $350 Deductible Plan

Generally, the Plan's reimbursement is 80% for in-network providers and 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS after the Plan's DEDUCTIBLE has been met. You pay the remainder of the fee. (There are some in-network services that don't apply to the deductible and only require copays).

Under the $800 Deductible Plan

Generally, the Plan's reimbursement is 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. You pay the remainder of the fee.

Under the $1,500 Deductible Plan

Generally, the Plan's reimbursement is 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. You pay the remainder of the fee.

Under the $2,850 Deductible Plan

Generally, the Plan's reimbursement is 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. You pay the remainder of the fee.

See the "Detailed List of Covered Services" on page 46 for more detailed information.

Certain expenses are not covered or reimbursed by the Plan, such as any deductible you are required to meet and your share of the amounts above the reasonable and customary charge.

Some services have specific limits or restrictions; see individual service for more information.

Refer to the "What's Not Covered" on page 61 to find out about the services that are not covered under the Plan.

Benefits are only paid for MEDICALLY NECESSARY charges or for specified wellness care expenses.

Preauthorization may be required in order to receive coverage for certain services. It is the Plan participant's responsibility (not the provider or facility) to obtain preauthorization for out-of-network

services. For more information on the preauthorization process and applicable services, refer to the description under "Utilization Review" on page 18.

Health Savings Account and Flexible Spending Accounts

If you are a participant in the $350 DEDUCTIBLE Plan or $800 Deductible Plan, you can elect a Flexible Spending Account (FSA) that allows you to put aside money before taxes are withheld so that you can pay for eligible medical, dental and vision expenses that are not reimbursed by any other coverage that you and your qualifying family members have. If you elect the $1,500 Deductible Plan or the $2,850 Deductible Plan, you can elect to participate instead in a Health Savings Account (HSA) and, if you choose, a Limited Purpose Health Care Flexible Spending Account (LPHCFSA).

For details about the FSA, HSA, or the LPHCFSA, see the *Health Care Flexible Spending Account, Health Savings Account, or Limited Purpose Health Care Flexible Spending Account* sections.

Deductibles

The DEDUCTIBLE is the amount that must be paid before the Plan will reimburse any benefits.

The deductibles vary under each of the medical plan options available to you (as shown in the table below.

Plan feature	$350 Deductible Plan	$800 Deductible Plan	$1,500 Deductible Plan	$2,850 Deductible Plan
Deductible	***In-network:*** Employee: $350 Family[4]: $700[5] ***Out-of-network:*** Employee: $2,000 Family[4]: $4,000[5]	***In-network:*** Employee: $800 Family[4]: $1,600[5] ***Out-of-network:*** Employee: $2,400 Family[4]: $4,800[5]	***In-network:*** Employee: $1,500 Family[4]: $3,000[2] ***Out-of-network:*** Employee: $3,000 Family[4]: $6,000[2]	***In-network:*** Employee: $2,850 Family[4]: $5,700[5] ***Out-of-network:*** Employee: $5,700 Family[4]: $11,400[5]

[2] This plan does not require that you or a covered eligible family member meet the "individual" deductible in order to satisfy the family deductible. If more than one person in a family is covered under this plan, benefits begin for any one covered family member only after the family deductible is satisfied. The family deductible may be met by one family member or a combination of family members. The out-of-pocket maximum functions in the same way. If more than one person in a family is covered under this plan, the out-of-pocket maximum is satisfied for any one covered family member when the family out-of-pocket maximum is satisfied. The family out-of-pocket maximum may be met by one family member or a combination of family members.

[4] "Family" applies to all coverage levels except Employee-Only.

[5] If more than one person in a family is covered under this plan, there are two ways the plan will begin to pay benefits for a covered family member. When a family member meets his or her individual deductible, benefits begin for that family member only, but not for the other family members. When the family deductible is met, benefits begin for every covered family member whether or not they have met their own individual deductibles. The family deductible may be met by a combination of family members, as amounts counted toward individual deductibles count toward the larger family deductible. The out-of-pocket maximum functions in the same way. When a family member meets his or her individual out-of-pocket maximum, the out-of-pocket maximum is satisfied for that family member only, but not for the other family members. When the family out-of-pocket maximum is met, the out-of-pocket maximum is satisfied for every covered family member whether or not they have met their own individual out-of-pocket maximums. The family out-of-pocket maximum may be met by a combination of family members, as amounts counted toward individual out-of-pocket maximums count toward the larger family out-of-pocket maximum.

Do in-network claims apply toward the out-of-network deductible?

Yes. In-network claims apply toward the out-of-network deductible. Also, out-of-network claims apply toward the out-of-network deductible.

Do out-of-network claims apply toward the in-network deductible?

Yes. Out-of-network claims apply toward the in-network deductible. Also, in-network claims apply toward the in-network deductible.

How do deductibles work?

Under the $350 Deductible Plan

The Plan will begin reimbursing benefits for a covered family member (including a newborn) once he or she has met the individual deductible (even if the entire family deductible has not been met). The family deductible is the maximum amount you have to pay before the Plan will reimburse any benefits. Copays for doctor visits (including ER and urgent care) and PRESCRIPTION DRUGS do not count toward the deductibles for the $350 Deductible Plan.

Under the $800 Deductible Plan

The Plan will begin reimbursing benefits for a covered family member (including a newborn) once he or she has met the individual deductible (even if the entire family deductible has not been met). The family deductible is the maximum amount you have to pay before the Plan will reimburse any benefits. Prescription drugs do not count toward the deductibles for the $800 Deductible Plan.

Under the $1,500 Deductible Plan

If the "employee" coverage level is elected, the Plan will begin reimbursing benefits for the one covered individual once he or she has met the individual deductible. For any other coverage level (employee + spouse, employee + child(ren) or family, the Plan will begin reimbursing benefits for a covered family member (including a newborn) once the family deductible is met. In meeting your family deductible, each family member's (including a newborn's) covered expenses (medical and prescription drug expenses) count toward the family deductible. Once this family deductible is met, the Plan will pay benefits for all family members.

Under the $2,850 Deductible Plan

The Plan will begin reimbursing benefits for a covered family member (including a newborn) once he or she has met the individual deductible (even if the entire family deductible has not been met). The family deductible is the maximum amount you have to pay before the Plan will reimburse any benefits.

Do I have to meet a new deductible every year?

You and your family members will have to meet a new deductible each year.

What expenses apply toward the deductible?

Most of your medical expenses apply toward the deductible. Office visits (including ER and urgent care) and Prescription drug expenses do not apply to the deductible for the $350 Deductible Plan. Prescription drug expenses do not apply to the deductible for the $800 Deductible Plan.

Under the $1,500 Deductible Plan and the $2,850 Deductible Plan, prescription drug expenses (other than preventive drug expenses) also apply toward the deductible.

Refer to "Do preventive drug expenses apply toward the deductible?" on page 15 for further details.

Your payments for the following don't apply toward the Plan deductible:

- Amounts in excess of a reasonable and customary charge
- Preauthorization penalties
- Services not covered by the Plan

Under the $350 Deductible Plan

- Prescription Drugs
- Office visit copays

Under the $800 Deductible Plan

- Prescription Drugs

Under the $1,500 Deductible Plan

- Amounts exceeding the network negotiated price for prescription drugs (other than preventive drugs)

Under the $2,850 Deductible Plan

- Amounts exceeding the network negotiated price for prescription drugs (other than preventive drugs)

Do preventive drug expenses apply toward the deductible?

Preventive drugs as defined by the Patient Protection Affordable Care Act for the $350 Deductible Plan, the $800 Deductible Plan, the $1,500 Deductible Plan and $2,850 Deductible Plan are covered with no cost sharing (i.e. deductible, COINSURANCE, copay). Certain examples include: aspirin products, fluoride products, iron supplements, folic acid products, immunizations, contraceptive methods, smoking cessation products, vitamin D supplements, bowel preps and primary prevention of breast cancer.

If you enrolled in the $1,500 Deductible Plan or the $2,850 Deductible Plan, there are certain preventive medications that are not subject to the deductible. Certain examples include: hypertension, diabetes, asthma, and cholesterol lowering drugs.

Call Express Scripts at +1 800 987 8360 for more information about preventive drugs or log on to the Drug Pricing Tool. Follow the provided steps to access the Drug Pricing Tool.

- Log on to express-scripts.com.
- Login or create an account.
- Manage prescriptions.
- Price a medication.
- Choose a pharmacy and enter drug name.

Out-of-Pocket Maximums

The maximum amount you have to pay toward the cost of the medical care you receive in the course of one year (excluding your per paycheck contributions to participate in the Plan). The out-of-pocket maximums vary under each of the medical plan options as follows:

Plan feature	$350 Deductible Plan	$800 Deductible Plan	$1,500 Deductible Plan	$2,850 Deductible Plan
Out-of-pocket maximum (including DEDUCTIBLE)	*In-network:* Employee: $2,000 Family[4]: $4,000[5] *Out-of-network:* Employee: $4,000 Family[4]: $8,000[5]	*In-network:* Employee: $2,400 Family[4]: $4,800[5] *Out-of-network:* Employee: $4,800 Family[4]: $9,600[5]	*In-network:* Employee: $3,000 Family[4]: $6,000[2] *Out-of-network:* Employee: $6,000 Family[4]: $12,000[2]	*In-network:* Employee: $5,500 Family[4]: $11,000[5] *Out-of-network:* Employee: $11,000 Family[4]: $22,000[5]

[2] This plan does not require that you or a covered eligible family member meet the "individual" deductible in order to satisfy the family deductible. If more than one person in a family is covered under this plan, benefits begin for any one covered family member only after the family deductible is satisfied. The family deductible may be met by one family member or a combination of family members. The out-of-pocket maximum functions in the same way. If more than one person in a family is covered under this plan, the out-of-pocket maximum is satisfied for any one covered family member when the family out-of-pocket maximum is satisfied. The family out-of-pocket maximum may be met by one family member or a combination of family members.

[4] "Family" applies to all coverage levels except Employee-Only.

[5] If more than one person in a family is covered under this plan, there are two ways the plan will begin to pay benefits for a covered family member. When a family member meets his or her individual deductible, benefits begin for that family member only, but not for the other family members. When the family deductible is met, benefits begin for every covered family member whether or not they have met their own individual deductibles. The family deductible may be met by a combination of family members, as amounts counted toward individual deductibles count toward the larger family deductible. The out-of-pocket maximum functions in the same way. When a family member meets his or her individual out-of-pocket maximum, the out-of-pocket maximum is satisfied for that family member only, but not for the other family members. When the family out-of-pocket maximum is met, the out-of-pocket maximum is satisfied for every covered family member whether or not they have met their own individual out-of-pocket maximums. The family out-of-pocket maximum may be met by a combination of family members, as amounts counted toward individual out-of-pocket maximums count toward the larger family out-of-pocket maximum.

Prescription drug expenses apply toward the out-of-pocket maximum.

The out-of-pocket maximum doesn't apply to:

- Amounts exceeding Plan limits
- Amounts in excess of a reasonable and customary charge
- Expenses for non-emergency use of the emergency room
- Expenses incurred for non-urgent use of an **urgent care provider**
- Preauthorization penalties
- Services not covered by the Plan

- Amounts exceeding the network negotiated price for PRESCRIPTION DRUGS.

Your deductible applies toward your out-of-pocket maximum.

Do in-network claims apply toward the out-of-network out-of-pocket maximum?

Yes. In-network claims apply toward the out-of-network out-of-pocket maximum. Also, out-of-network claims apply toward the out-of-network out-of-pocket maximum.

Do out-of-network claims apply toward the in-network out-of-pocket maximum?

Yes. Out-of-network claims apply toward the in-network out-of-pocket maximum. Also, in-network claims apply toward the in-network out-of-pocket maximum.

How does the annual out-of-pocket maximum (limit) work for family members?

Under the $350 Deductible Plan

The Plan will begin reimbursing benefits for a covered family member (including a newborn) at 100% once he or she has met the individual out-of-pocket maximum (even if the entire family out-of-pocket maximum has not been met).

Under the $800 Deductible Plan

The Plan will begin reimbursing benefits for a covered family member (including a newborn) at 100% once he or she has met the individual out-of-pocket maximum (even if the entire family out-of-pocket maximum has not been met).

Under the $1,500 Deductible Plan

In meeting your family out-of-pocket maximum, each family member's (including a newborn's) covered expenses (medical and prescription drug expenses) count toward the family out-of-pocket maximum.

If you cover ELIGIBLE FAMILY MEMBERS, you must meet the family out-of-pocket maximum. Once this out-of-pocket maximum has been met, the Plan will pay benefits for all family members at 100% for IN-NETWORK PROVIDERS and 100% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS.

Under the $2,850 Deductible Plan

The Plan will begin reimbursing benefits for a covered family member (including a newborn) at 100% once he or she has met the individual out-of-pocket maximum (even if the entire family out-of-pocket maximum has not been met).

Networks

Is there a network of doctors and hospitals that I have to use?

Using the network is not mandatory, but generally, you will receive a higher reimbursement when using the network. If you use an in-network provider, you will be reimbursed 80% (70% under the $2,850 DEDUCTIBLE Plan). If you use an out-of-network provider, you will be reimbursed 60% (50%

under the $2,850 Deductible Plan) of reasonable and customary charges for covered expenses after the Plan's deductible has been met.

In the event that you receive care from an out-of-network doctor (such as an anesthesiologist) while being treated at an in-network facility, benefits will be paid at the in-network level.

The network includes general practitioners, as well as specialists and hospitals. These network providers are selected by and contracted with the Claims Administrator.

Where can I get a directory that lists all the doctors and hospitals in the network?

The doctors and hospitals in the network are listed in a provider directory. The Claims Administrator provides an online directory of providers available at www.aetna.com/docfind/custom/mmc. You may also call the Claims Administrator.

Is there a network of providers for mental health treatment?

There is a network of mental health providers. Providers in the network are listed in a provider directory. The Claims Administrator provides an online directory available at www.aetna .com/docfind/custom/mmc. You may also call the Claims Administrator.

Is there a network of pharmacies?

There is a pharmacy network associated with this Plan. You must use a pharmacy in the network to receive coverage under this Plan.

The Pharmacy Benefits Manager provides an online directory of network pharmacies available at http://www.express-scripts.com/. You may also call the Pharmacy Benefits Manager.

Utilization Review

Which utilization review services are offered?

The Plan offers preauthorization and case management review.

You may obtain more information about these review services by calling the Claims Administrator.

What is Preauthorization

Preauthorization is a utilization review service performed by licensed healthcare professionals. The intent is to determine medical necessity and appropriateness of proposed treatment, level of care assessment, benefits and eligibility and appropriate treatment setting.

In many cases, your Non-Network Benefits will be reduced if the Claims Administrator has not provided preauthorization

What services require preauthorization?

The following types of medical expenses require preauthorization:

- Inpatient Hospital
- Interventional Pain Management (Outpatient)

- Skilled Nursing Facility
- Rehabilitation Facility
- Hip Procedures (Inpatient and Outpatient)
- Home Health Care
- Hospice
- Obesity Surgery
- Knee Procedures (Inpatient and Outpatient)
- Private Duty Nursing Care
- Residential Treatment for treatment of mental disorders and substance abuse

You must also receive preauthorization for:

- All hospital admissions including
  - Mental Health
  - Alcohol and Substance Abuse
  - Organ Transplant
  - All inpatient surgeries
- Visiting Nurses
- Infertility Services

Additional Behavioral Health Services

1. Amytal Interview
2. Biofeedback
3. Intensive Outpatient Programs
4. Electroconvulsive Therapy
5. Partial Hospitalization
6. Psychiatric Home Health Care
7. Psychological & Neurological Testing

- Maternity Admission if inpatient stay exceeds 48 hours after vaginal delivery and 96 hours after a cesarean delivery.

- Home Infusion Therapy (billed by home infusion specialist)

- Air Ambulance (air ambulance only suspends for medical review, there is no penalty applied)

If you have an emergency hospital admission, surgery or specified procedure, you, a family member, your physician or the hospital must preauthorize within 48 hours of service.

If the procedure or treatment is performed for any condition other than an emergency condition, the call must be made at least 14 days before the date the procedure is to be performed or the treatment is to start. If it is not possible to make the call during the specified time, it must be made as soon as reasonably possible before the date the procedure or treatment is to be performed.

Do I need to have my maternity coverage preauthorized?

No. Preauthorization within 48 hours is not required for the initial hospital admission.

You must notify the preauthorization service if the mother or her newborn stay in the hospital longer than 48 hours after a vaginal delivery or 96 hours after a Cesarean birth. This notification must occur within 24 hours of the determination to extend the stay.

When do I obtain preauthorization?

You, your family member or health care professional must obtain preauthorization as soon as you know you need a service requiring preauthorization, but not less than 14 days prior to the procedure or treatment.

Note: You are responsible for ensuring your service has been preauthorized.

How do I obtain preauthorization?

Initiate the preauthorization process by calling the Claims Administrator.

What happens if I fail to obtain preauthorization?

If you fail to obtain preauthorization, your out-of-network benefits will be reduced by $400 of covered expenses for inpatient hospital, treatment facility, skilled nursing facility, home health care, private duty nursing and hospice. (Preauthorization penalties do not apply towards your DEDUCTIBLE or out-of-pocket maximum.)

You are responsible for preauthorizing out-of-network services only. Your in-network provider will preauthorize all other services.

What approvals do I need if I am going into the hospital?

You must obtain preauthorization as soon as possible but at least 14 days before you are admitted for a non-emergency hospital admission or stay.

If you have an emergency hospital admission, surgery or specified procedure, you, a family member, your physician or the hospital must preauthorize within 48 hours of the service.

Case Management Review

When the preauthorization service identifies a major medical condition, that condition will be subject to case management review. Case management review aims at identifying major medical conditions early in the treatment plan and makes recommendations regarding the medical necessity of requested health care services.

Case managers with experience in intensive medical treatment and rehabilitation provide case management services. The case manager works with the patient's physician to identify available resources and develop the best treatment plan. Case management review may even recommend services and equipment that the Plan would not ordinarily cover.

In addition, the case manager can coordinate the various caregivers, such as occupational or physical therapists, required by the patient.

Situations that may benefit from case management include severe illnesses and injuries such as:

- Head trauma
- Organ transplants
- Burn cases
- Neo-natal high risk infants
- Multiple fractures
- HIV-related conditions
- Brain injuries
- Cancer
- Prolonged illnesses
- Degenerative neurological disorders (e.g. multiple sclerosis).

To best help the patient, the case managers should be involved from the earliest stages of a major condition. This service gives you access to a knowledgeable case manager who will use his or her expertise to assist you and your physician in considering your treatment options.

If the case managers questions the necessity of the proposed hospital admission or procedure, a physician advisor may contact your physician to discuss your case and suggest other treatment options that are generally utilized for your condition. You, your physician, and the case manager will be informed of the outcome of the review, and the Claims Administrator will determine the level of benefit coverage you will receive. You and your physician will be notified of the utilization reviewer's recommendation by telephone and in writing. You will also be informed of the appeal process if the procedures your physician ultimately recommends are not covered under the Plan (as determined by the Claims Administrator).

What's Covered

Pre-existing Conditions

There are no exclusions, limitations or waiting periods for PRE-EXISTING CONDITIONS for you or any covered family members.

Are immunizations for business travel covered under the Plan?

The Plan does not cover immunizations for business travel.

Is acupuncture covered under the Plan?

The Plan covers acupuncture when it is:

- performed by a physician as a form of anesthesia in connection with surgery or dental procedure that is covered under the Plan.
- a form of Alternative Treatment as long as it is rendered by a certified/licensed individual.

Coverage is limited to 12 visits per year.

Are insulin pump syringes covered under the medical coverage?

Yes. Insulin pump syringes are covered under the medical coverage. Insulin pump syringes are not covered under the prescription drug coverage.

Can a prosthetic device be replaced?

The Plan covers the replacement of prosthetic devices when MEDICALLY NECESSARY.

Are wigs covered?

The Plan will pay benefits for wigs when medically necessary up to a maximum of $300 per year per covered member.

Preventive/Wellness Care

How is preventive/wellness care covered?

The Plan covers PREVENTIVE/WELLNESS CARE at:

Under the $350 Deductible Plan

- 100% for IN-NETWORK PROVIDERS with no DEDUCTIBLE and 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS after the Plan's deductible has been met. Plan limits apply. Contact the Claims Administrator for specific details.

Under the $800 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. Plan limits apply. Contact the Claims Administrator for specific details.

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. Plan limits apply. Contact the Claims Administrator for specific details.

Under the $2,850 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met. Plan limits apply. Contact the Claims Administrator for specific details.

Hearing screenings are covered when provided as part of a preventive/wellness visit.

What services are considered preventive/wellness care?

The Plan considers physician, testing and diagnostic fees for the following specific wellness expenses to be preventive/wellness care:

- Blood cell counts
- Blood tests for prostate screening
- Cholesterol tests
- Mammograms
- Pap smears
- Routine physical exams, including one pelvic exam each calendar year
- Sigmoidoscopy (covered if you are 50 and over.)
- Tuberculosis tests
- Urinalysis.

The following services are not considered preventive/wellness care:

- Services which are covered to any extent under any other group plan of your employer.
- Services which are for diagnosis or treatment of a suspected or identified injury or disease.
- Exams given while the person is confined in a hospital or other facility for medical care.
- Services which are not given by a physician or under his or her direct supervision.
- Medicines, drugs, appliances, equipment, or supplies.
- Psychiatric, psychological, personality or emotional testing or exams.
- Exams in any way related to employment.
- Premarital exams.
- Vision, hearing, or dental exams.

Does the Plan cover outpatient physician services?

The Plan covers charges for OUTPATIENT office visits at:

Under the $350 Deductible Plan

- $15 (PCP) or $30 (Specialist) per in-network office visit (no deductible) and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Under the $2,850 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Does the Plan cover gynecology visits?

The Plan covers one routine gynecological exam each calendar year at:

Under the $350 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $800 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $2,850 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

If the visit to the gynecologist is for treatment of a medical condition, it is not considered routine care and will be covered at:

Under the $350 Deductible Plan

- $15 (PCP) per office visit for in-network providers (no deductible) and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan deductible has been met.

Under the $2,850 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers under after the Plan deductible has been met.

Does the Plan cover mammograms?

The Plan covers routine mammograms at:

Under the $350 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

There are no age or frequency limitations. It is recommended that members follow the American Cancer Society guidelines for age and frequency to determine when to receive preventive care services.

Does the Plan cover Pap smears?

The Plan covers one routine Pap smear each calendar year at:

Under the $350 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $800 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $2,850 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

If your doctor recommends a non-routine Pap smear as a follow up to a medical diagnosis, the Plan:

Under the $350 Deductible Plan

- requires a $15 copay for in-network providers (no deductible) and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- covers your Pap smear at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- covers your Pap smear at 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- covers your Pap smear at 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Does the Plan cover prostate specific antigen (PSA) tests and routine Annual Digital Rectal exams?

The Plan covers routine prostate specific antigen (PSA) tests for covered males (with no age limitations) and routine Annual Digital Rectal Exam (DRE).

Under the $350 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $800 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

Under the $2,850 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met as part of preventive/wellness care.

If your doctor recommends a non-routine DRE test as a follow-up to a medical diagnosis, the Plan covers your DRE test at:

Under the $350 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Maternity

Who is eligible for maternity coverage?

Maternity coverage is available to eligible covered female participants.

Do I need to have my maternity coverage preauthorized?

No. Preauthorization within 48 hours is not required for the initial hospital admission.

You must notify the preauthorization service if the mother or her newborn stay in the hospital longer than 48 hours after a vaginal delivery or 96 hours after a Cesarean birth. This notification must occur within 24 hours of the determination to extend the stay.

Does the Plan cover prenatal visits?

Note that routine prenatal care, as defined by the Department of Health and Human Services, is covered with no cost sharing (i.e. deductibles, COINSURANCE, copays) for all plans.

The Plan covers prenatal visits in-network at:

Under the $350 Deductible Plan

- No charge for the first office visit.

Under the $800 Deductible Plan

- 80% for IN-NETWORK PROVIDERS after the Plan DEDUCTIBLE has been met; first visit only.

Under the $1,500 Deductible Plan

- 80% for in-network providers after the Plan deductible has been met; first visit only.

Under the $2,850 Deductible Plan

- 70% for in-network providers after the Plan deductible has been met; first visit only.

After the first visit, subsequent visits are typically billed as part of doctor's delivery fee, which is also reimbursed at:

Under the $350 Deductible Plan

- 80% after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 70% after the Plan's deductible has been met.

The Plan covers prenatal visits out-of-network at:

Under the $350 Deductible Plan

- 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

What will the Plan pay for the doctor's charge for delivering the baby?

The Plan covers charges for delivery of the baby at:

Under the $350 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

What will the Plan pay for the doctor's charge for examining the baby?

The Plan covers the charges for your baby's first examination in the hospital at:

Under the $350 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

A child is covered at birth as long as the baby meets the child eligibility requirements and is enrolled within 60 days of the birth.

What will the Plan pay for hospital charges for the mother and the baby?

The Plan covers hospital charges for maternity admissions at:

Under the $350 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

The Plan covers newborn nursery care at:

Under the $350 Deductible Plan

- 80% for in-network providers with 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

A child is covered at birth as long as the baby meets the child eligibility requirements and is enrolled within 60 days of the birth.

The mother and the newborn child are covered for a minimum of 48 hours of care following a vaginal delivery and 96 hours following a Cesarean section. However, the mother's provider may — after consulting with the mother — discharge the mother earlier than 48 hours following a vaginal delivery (96 hours following a Cesarean section).

You must notify the precertification review service within 24 hours of a determination to extend the stay.

Does the Plan cover midwife services?

The Plan covers midwives who are in practice with a network group at:

Under the $350 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers in association with a supervising physician after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers in association with a supervising physician after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers in association with a supervising physician after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers in association with a supervising physician after the Plan's deductible has been met.

What is the wellness program for Maternity?

The Aetna Beginning Right Maternity® Program provides tools and information to help your whole family have a successful pregnancy. Use this program throughout your pregnancy and after your baby is born to:

- Learn what's best for a healthy pregnancy
  - Receive materials on prenatal care, labor and delivery, newborn care and more
  - Get information for the father or domestic partner
  - Take a pregnancy risk survey and find out if you have any issues or risk factors that could affect your pregnancy
- If you have issues or risk factors that need special attention, the program's nurses provide personal case management to determine ways to lower your risks
- Get support to help quit smoking
- Reduce your risk for pre-term labor.

For more information, call the Beginning Right Maternity Program at +1 800 CRADLE 1 (+1 800 272 3531).

If my dependent child has a baby does the Plan cover the newborn child?

Unless the newborn meets the definition of an eligible child and is covered under the Plan, medical care for the newborn, whether in or out of the hospital, is not covered.

Family Planning

Does the Plan cover infertility treatment?

The Plan covers infertility treatments at:

Under the $350 Deductible Plan

- Subject to office visit copays (no DEDUCTIBLE) for IN-NETWORK PROVIDERS and 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Benefits for infertility treatment are limited to a medical lifetime maximum of $15,000 per person.

Infertility treatments are covered as follows:

- Assisted reproduction procedures (including facility charges and related expenses) due to infertility
- Ovulation induction and monitoring
- Artificial Reproductive Technology (ART)
  - In vitro fertilization
  - Gamete intrafallopian transfer (GIFT)
  - Zygote intrafallopian transfer (ZIFT)
  - Cryopreserved embryo transfers
  - Intracytoplasmic sperm injection (ICSI) or ovum microsurgery.

Artificial insemination is considered an infertility treatment and is limited to the overall infertility medical lifetime maximum of $15,000 per person as noted in the infertility treatment sub-section.

You should obtain a PREDETERMINATION OF BENEFITS to determine your coverage and benefits for these services.

PRESCRIPTION DRUGS related to infertility are covered under the prescription drug benefit.

Are contraceptive devices covered under the Plan?

The Plan covers contraceptive devices at:

Under the $350 Deductible Plan

- 100% for in-network providers (no deductible) and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 100% for in-network providers (no deductible) and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 100% for in-network providers (no deductible) and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 100% for in-network providers (no deductible) and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Oral and injectable contraceptives are covered under the prescription drug plan.

Does the Plan cover vasectomy?

The Plan covers vasectomies at:

Under the $350 Deductible Plan

- Subject to office visit copays (no deductible) for in-network providers if performed in an office visit setting and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

You must obtain preauthorization before you are admitted to the hospital.

Vasectomy reversals are not covered under the Plan.

Does the Plan cover tubal ligation?

The Plan covers in-patient and OUTPATIENT tubal ligation at:

Under the $350 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 100% for in-network providers with no deductible and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 100% for in-network providers with no deductible and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

You must obtain preauthorization before you are admitted to the hospital.

Tubal ligation reversals are not covered.

Inpatient Hospital and Physician Services

What will the Plan pay if I have to go to the hospital?

The Plan pays INPATIENT hospital charges at:

Under the $350 Deductible Plan

- 80% for IN-NETWORK PROVIDERS and 60% of reasonable and customary charges for OUT-OF-NETWORK PROVIDERS per admission after the Plan's DEDUCTIBLE has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers per admission after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers per admission after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers per admission after the Plan's deductible has been met.

The Plan will cover the cost of a semi-private room. If you use a private room, the Plan will cover the amount up to the semi-private room rate.

You must obtain preauthorization as soon as possible but at least 14 days before you are admitted for a non-emergency hospital stay.

What approvals do I need if I am going into the hospital?

Preauthorization as soon as possible but at least 14 days before you are admitted for a non-emergency hospital admission or stay.

If you have an emergency hospital admission, surgery or specified procedure, you, a family member, your physician or the hospital must preauthorize within 48 hours of the service.

Does the Plan cover hospital visits by a physician?

While you are in the hospital, the Plan covers hospital visits by a physician at:

Under the $350 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Does the Plan cover ambulance charges?

The Plan covers transportation by ambulance to a medical facility at:

Under the $350 Deductible Plan

- 80% for in-network providers and 80% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 80% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 80% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 70% for in-network providers and 70% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Coverage includes charges for transportation to a hospital by air or water ambulance when:

- Ground ambulance transportation is not available.
- Your condition is unstable and requires medical supervision and rapid transport.
- In a medical emergency, transportation from one hospital to another hospital; when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital and the above two conditions are met.

Does the Plan cover hospice care?

The Plan covers charges for HOSPICE at:

Under the $350 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $800 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $1,500 Deductible Plan

- 80% for in-network providers and 60% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

Under the $2,850 Deductible Plan

- 70% for in-network providers and 50% of reasonable and customary charges for out-of-network providers after the Plan's deductible has been met.

You must obtain preauthorization before you receive hospice care.

Mastectomy – Reconstructive Surgery

Does the Plan cover mastectomy-related services?

Yes, the Plan covers mastectomy-related services. Coverage will be provided in a manner determined by the attending physician and the patient. The covered services include:

- All stages of reconstruction of the breast on which the mastectomy was performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance,
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedema.

What are the applicable deductibles and coinsurance for mastectomy-related benefits under the Plan?

The mastectomy-related benefits are subject to the same deductibles and COINSURANCE applicable to other medical and surgical benefits provided under this Plan. See the "Detailed List of Covered Services" on page 46 for the applicable mastectomy – reconstructive surgery coverage.

Obesity Surgery

The plan covers surgical treatment of obesity provided by or under the direction of a physician. Coverage is limited to once per person per lifetime.

Prior authorization under the condition of meeting the medical definition of morbid obesity is required. All services, including surgery, must be obtained from a recognized in-network Institute of Quality (IOQ). Contact the Claims Administrator for specific details on requirements and how to find a facility.

Travel and lodging expenses to and from your home will be reimbursed as defined below.

- The patient is eligible for reimbursement if the facility is 100 miles or more from the patient's home.
- The reimbursement for lodging expenses is limited to $50 per night.
- The maximum reimbursement for all travel and lodging expenses is $10,000 per episode of care.

Occupational Therapy

The plan covers the treatment to:

- Learn or re-learn daily living skills (e.g., bathing, dressing and eating) or compensatory techniques to improve the level of independence in the activities of daily living

- Provide task-oriented therapeutic activities designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease.

Coverage includes services, treatment, education testing or training related to developmental delays.

OUTPATIENT coverage is limited to 60 visits per year (combined in-network and out-of-network) per covered person (including physical therapy, occupational therapy, and speech therapy combined).

Prior authorization for occupational therapy is recommended. Contact the Claims Administrator for specific details.

Orthognathic Coverage

The Plan covers the diagnosis or treatment of the jawbones, including orthognathic surgery (procedure to correct underbite or overbite), and jaw alignment. Prior authorization is required. Contact the Claims Administrator for specific details.

See "What's Not Covered" on page 61 for orthognathic coverage exclusion.

Prescription Drugs

How does the Plan cover prescription drugs?

PRESCRIPTION DRUGS are covered as follows:

Prescription drugs	There is a pharmacy network for retail and Express Scripts by Mail for mail order prescription drugs.			
	$350 Deductible Plan	**$800 Deductible Plan**	**$1,500 Deductible Plan**	**$2,850 Deductible Plan**
Retail Prescriptions (30-day supply)				
▪ Generic	$10 copay (These amounts do not apply to the DEDUCTIBLE)	70% COINSURANCE (These amounts do not apply to the deductible; minimum $10/maximum $20)	80% coinsurance after deductible	70% coinsurance after deductible
▪ Formulary Brand	$30 copay (These amounts do not apply to the deductible)	70% coinsurance (These amounts do not apply to the deductible; minimum $25/maximum $50)	80% coinsurance after deductible	70% coinsurance after deductible
▪ Non-Formulary Brand	$60 copay (These amounts do not apply to the deductible)	55% coinsurance (These amounts do not apply to the deductible; minimum $40/maximum $80)	80% coinsurance after deductible	70% coinsurance after deductible

Mail-order Prescriptions (90-day supply)				
▪ Generic	$25 copay (These amounts do not apply to the deductible)	70% coinsurance (These amounts do not apply to the deductible; minimum $25/maximum $50)	80% coinsurance after deductible	70% coinsurance after deductible
▪ Formulary Brand	$75 copay (These amounts do not apply to the deductible)	70% coinsurance (These amounts do not apply to the deductible; minimum $62.50/maximum $125)	80% coinsurance after deductible	70% coinsurance after deductible
▪ Non-Formulary Brand	$150 copay (These amounts do not apply to the deductible)	55% coinsurance (These amounts do not apply to the deductible; minimum $100/maximum $200)	80% coinsurance after deductible	70% coinsurance after deductible

Does the Plan cover formulary and non-formulary brand-name prescription drugs?

The Plan covers formulary and non-formulary prescription drugs purchased via the Plan's mail order service or a participating retail pharmacy.

To price medications and check formulary, visit www.express-scripts.com.

Unless your physician specifically prescribes a brand-name medication without substitution, prescriptions will be filled with the generic equivalent when allowed by state law.

Does the Plan cover generic drugs?

The Plan covers generic prescription drugs purchased via the Plan's mail order service or a participating retail pharmacy.

What happens if I buy a brand-name prescription drug when a generic drug is available?

Unless your physician specifically prescribes a brand name medicine without substitution, prescriptions will be filled with the generic equivalent when allowed by state law.

If you or your physician requests the brand-name prescription drug when a generic prescription drug is available and there is no medical reason for the brand-name prescription drug, you pay your share of the cost for the generic drug in addition to the difference between the brand-name prescription drug and generic prescription drug gross cost.

How does the Plan cover generic and brand-name contraceptive medications with no generic equivalent?

The Plan will cover generic and brand-name contraceptive medications **with no generic equivalent** at 100% in-network with no cost sharing as long as a valid prescription is submitted.

What is the Plan coverage for preventive drugs?

Preventive drugs as defined by the Patient Protection Affordable Care Act for the $350 Deductible Plan, the $800 Deductible Plan, the $1,500 Deductible Plan and $2,850 Deductible Plan are covered with no cost sharing (i.e. deductible, coinsurance, copay). Certain examples include: aspirin products, fluoride products, iron supplements, folic acid products, immunizations, contraceptive methods, smoking cessation products, vitamin D supplements, bowel preps and primary prevention of breast cancer.

If you enrolled in the $1,500 Deductible Plan or the $2,850 Deductible Plan, there are certain preventive medications that are not subject to the deductible. Certain examples include: hypertension, diabetes, asthma, and cholesterol lowering drugs.

Call Express Scripts at +1 800 987 8360 for more information about preventive drugs or log on to the Drug Pricing Tool. Follow the provided steps to access the Drug Pricing Tool.

- Log on to express-scripts.com.
- Login or create an account.
- Manage prescriptions.
- Price a medication.
- Choose a pharmacy and enter drug name.

The Pharmacy Benefits Manager provides an online directory of network pharmacies available at www.express-scripts.com. You may also call the Pharmacy Benefits Manager.

Is there a mail-order program?

The Plan's mail order service allows participants to order up to a 90-day supply of prescription medication by mail for certain medications. Using the mail order service for these medications will generally cost you less than using a retail pharmacy.

If I buy more than three fills of a prescription drug at a retail pharmacy, will I have to pay more?

For all maintenance prescription drugs, after purchasing the first three fills of a prescription drug (the initial fill plus two refills) at a participating retail pharmacy, if you choose to continue to fill the prescription at a retail pharmacy, you pay 100% of the negotiated price for up to a 30-day supply for all subsequent refills.

If I purchase a specialty medication at retail, will the prescription be covered?

If a specialty medication is filled at retail, the prescription will not be covered and amounts you pay for the not covered prescription will not accumulate to the out-of-pocket maximum.

Are any prescription drugs or drug supplies subject to limitations?

You may be subject to several different types of drug management programs. These include quantity management, prior authorization and qualification by history or step therapy.

Quantity Management

To ensure safe and effective drug therapy, certain covered medications may have quantity restrictions. These quantity restrictions are based on manufacturer and/or clinically approved guidelines and are **subject to periodic review and change**.

Select drug categories include:

- Antiemetic agents
- Antifungal agents
- Cancer therapy
- Cardiovascular agents
- Diabetic agents
- Fertility agents
- Hypnotic agents
- Migraine therapy
- Narcotic analgesics
- Non-narcotic analgesics
- Rheumatological agents
- Specialty medications.

The following are additional examples of prescription drugs or supplies that are covered with quantity limitations:

Drug or Supply	Quantity Limit
Erectile dysfunction drugs such as Viagra®, Cialis®, or Caverject®	6 units per prescription*
Inhaler spacers	2 spacers per year
Diabetic devices (blood glucose monitors)	1 monitor per year

* The maximum quantity of 6 units at retail or 18 units at mail order can be reached with one medication or any combination of many medications.

Prior Authorization

Certain medical treatments and prescription medicines need prior approval before the Plan will cover them. This requirement is to ensure the treatment or medication is appropriate and effective. If you do not receive approval, you will be responsible for paying the full cost.

Select drug categories include:

- Androgens and anabolic steroids
- Anorexiants
- Antinarcoleptics
- Cancer therapy
- Dermatologicals
- Specialty medications – require prior authorization under the Plan and are subject to quantity limitations as well
  - Examples of drug categories include: Botulinum Toxins (Botox), Growth Hormones, Hepatitis, Immune Globulins, Multiple Sclerosis, Myeloid Stimulants, Psoriasis, Pulmonary Arterial Hypertension (PAH), Rheumatoid Arthritis, RSV agents.

As new drugs become available or new indications are approved for already available drugs, the drugs that require prior authorization may be modified. To obtain prior authorization for coverage ask your doctor to call Express Scripts at +1 800 753 2851. After they receive the necessary information, you and your doctor will be notified confirming whether or not coverage has been approved.

Qualification by History (Step Therapy)

Some medications require the trial of another drug and/or require certain criteria such as age, sex, or condition (determined by previous claims history) to receive coverage. In these cases, a coverage review will be required if certain criteria cannot be determined from past history.

Select drug categories include:

- Cardiovascular agents
- COX-II Inhibitors
- Dermatologicals
- Migraine therapy
- Osteoporosis agents
- Specialty medications

- Examples of drug categories include: Erythroid Stimulant, Fertility, Growth Hormone, Hepatitis, Multiple Sclerosis, Pulmonary Arterial Hypertension (PAH) agents.

As new drugs become available or new indications are approved for already available drugs, the drugs that may become subject to qualification by history rules may be modified.

Contact the Pharmacy Benefits Manager at +1 800 987 8360 for more information about any of these programs.

Are there any limitations on specialty prescription drugs?

The Accredo Recommended Days Supply Program maintains quantity limitations for certain specialty prescription drugs in accordance with FDA approval limits and to help reduce drug waste and prescription drug costs.

The first time you submit a claim for a specialty medication on this list, you will be limited to a 30-day supply for four months, even if your physician prescribed a 90-day supply. Your COPAYMENT will be prorated, so you will not be penalized for filling the prescription in 30-day supply increments instead of a 90-day supply.

An Accredo Representative will contact both you and your physician to explain why the prescription has been limited to a 30-day supply, discuss therapy and the disease state and discuss the importance of compliance.

In addition, specialty medications require prior authorization under the Plan and are subject to quantity limitations. These limits are subject to change and are discussed above.

Contact the Pharmacy Benefits Manager at +1 800 987 8360 for more information about any of these programs.

What prescription drugs and drug supplies are excluded from prescription drug coverage?

The following drugs and drug supplies are excluded from prescription drug coverage:

- Over-the-counter drugs (including topical contraceptives, nicotine products, vitamins and minerals, nutritional products including enteral products and infant formulas, homeopathic products and herbal remedies). Certain drugs will be covered with a prescription under Health Care Reform.
- Medical equipment and devices – insulin pumps, insulin pump syringes
- Home diagnostic kits
- All injectables (other than self-administered injectables and injectable drugs in connection with approved infertility treatment)
- Vaccines (except for zoster vaccine for shingles for adults age 60 and over) – [Note, these vaccines may be included under the medical coverage.]
- Allergy serums

- Plasma and blood products
- Drugs for cosmetic use
- Prescription products with an over the counter equivalent
- Investigational drugs, experimental use drugs, non-FDA approved drugs and compounds.

Note, you can receive the Pharmacy Benefits Manager's discounted price when you fill a prescription for a non-covered drug through the Pharmacy Benefits Manager's mail order program. You will pay 100% of the cost at the negotiated rate.

Is there a network of pharmacies?

There is a pharmacy network associated with this Plan. You must use a pharmacy in the network to receive coverage under this Plan.

The Pharmacy Benefits Manager provides an online directory of network pharmacies. You may also call the Pharmacy Benefits Manager.

How do I file a claim for benefits for prescription drugs?

All prescriptions filled at a participating retail pharmacy require you to provide an ID card for coverage under the Plan. You are responsible for the applicable copayment or coinsurance. Rarely will you need to file a claim with the Pharmacy Benefits Manager (one example may be a prescription filled at retail before you have received your ID card). To file a claim, contact the Pharmacy Benefits Manager.

Claim forms are available on the Pharmacy Benefits Manager's website. If you file a claim within 60 days of your effective date with the Plan, you will be reimbursed 100% of your out of pocket expense minus the appropriate coinsurance. After your 60 day grace period, you have 12 months from the date the expense was incurred to submit a claim. You are responsible for the difference between the discounted in-network price and the out-of-network price and the appropriate coinsurance.

Is there a separate ID card for the prescription drug program?

Yes, there is a separate ID card for the prescription drug program. If you are enrolled in medical coverage, you will automatically be sent a prescription drug ID card in addition to your medical plan ID card. You will be sent one additional prescription ID card if you enroll one or more family members in the program. Each ID card will list the names of all covered family members.

You may request additional ID cards directly from the Pharmacy Benefits Manager.

Mental Health/Substance Abuse

Does the Plan cover mental health/substance abuse services?

The Plan covers inpatient and outpatient mental health/substance abuse treatment services, including residential treatment.

Does the Plan cover services in connection with autism?

The Plan covers treatments provided in connection with autism, except for education and experimental and investigational treatments.

Speech Therapy

The plan covers the treatment of:

- A speech impediment or speech dysfunction that results from injury, stroke or a congenital anomaly
- Delays in speech development.

OUTPATIENT coverage is limited to 60 visits per year per covered person (including physical therapy, occupational therapy, and speech therapy combined).

Prior authorization for speech therapy is recommended. Contact the Claims Administrator for specific details.

Gender Reassignment Surgery

Does the Plan cover transgender surgery?

Transgender surgery is covered for persons that meet all of the following conditions:

- You are at least 18 years old
- You have been diagnosed with "true" transsexualism
- You have completed a recognized program at a specialized gender identity treatment center.

Coverage is limited to one procedure per lifetime up to a maximum of $75,000 per person.

What transgender surgery benefits will the Plan pay?

The Plan will provide MEDICALLY NECESSARY benefits in connection with transgender surgery including transgender surgery travel expenses. The maximum individual limit is $75,000.

Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan.

Temporomandibular Joint (TMJ) Coverage

The Plan covers services for diagnostic and surgical treatment of conditions affecting the temporomandibular joint when provided by and under the direction of a physician. Coverage includes the diagnostic or surgical treatment required as a result of an accident, trauma, congenital defect, developmental defect or pathology.

- Diagnostic coverage includes examination, radiographs and applicable imaging studies, and consultation.
- Non-surgical treatment includes clinical examinations, oral appliances (orthotic splints), arthrocentesis and trigger-point injections. Surgical treatment* includes arthrocentesis, arthroscopy, arthroplasty, arthrotomy, open or closed reduction of dislocations and TMJ implants.

  *Surgical treatment is provided if the following criteria are met:

  – There is clearly demonstrated radiographic evidence of significant joint abnormality.

- Non-surgical treatment has failed to adequately resolve the symptoms.
- Pain or dysfunction is moderate or severe.

See "What's Not Covered" on page 61 for TMJ exclusions.

Virtual Medicine

What is Teladoc?

Teladoc lets you talk to a US board-certified doctor through your mobile device or a computer with a webcam. The doctor can diagnose, recommend treatment and prescribe medication, when appropriate, for many medical issues. You can use this service for common health concerns like colds, the flu, fevers, rashes, infections, allergies, etc.

When is Teladoc available?

Doctors are available on Teladoc 24/7, 365 days a year.

How does Teladoc work?

When you need to see a doctor, go to Teladoc.com/Aetna or access the Teladoc mobile app to set up an account. Establishing an account allows you to securely store your personal and health information. Once connected, you can talk and interact with the doctor.

If you are using Teladoc for the first time, you will be asked to answer a brief questionnaire about your health before you speak with a doctor. Then the information from your first online visit will be available for future online visits.

Do doctors have access to my health information?

Doctors can only access your health information and review previous treatment recommendations and information from your prior Teladoc visits.

How do I access the Teladoc mobile app?

You can download the mobile app for free on your mobile device by visiting the App Store or Google Play.

How do I pay for the online doctor's visit?

Teladoc accepts Visa, MasterCard and Discover cards as payment for an online visit with a doctor. Prescriptions aren't included in the cost of your doctor's visit.

Can I get online care from a doctor if I'm traveling or in another state?

If you are located in a state where Teladoc is available, you can get online care. To determine if online visits with a doctor are available in your state, visit Teladoc.com/Aetna and view the state map at the bottom of the home page.

Who do I contact for additional information?

You can call +1 800 Teladoc.

Detailed List of Covered Services

The Plan reimburses MEDICALLY NECESSARY covered services and supplies for the diagnosis and treatment for an illness or injury. The Claims Administrator determines whether the service or supply is covered and determines the amount to be reimbursed.

Most services and supplies are subject to a DEDUCTIBLE and COINSURANCE.

Your costs for out-of-network services apply toward the in-network deductible and out-of-pocket maximum. However, your costs for in-network services do not apply toward the out-of-network deductible and out-of-pocket maximum.

$350 Deductible Plan and $800 Deductible Plan

	$350 Deductible Plan		**$800 Deductible Plan**	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Alcohol and substance abuse	***Inpatient and Residential Treatment:*** 80% after deductible Preauthorization is required ***Outpatient:*** $15 per visit (no deductible)	***Inpatient and Residential Treatment:*** 60% of R&C after deductible Preauthorization is required ***Outpatient:*** 60% after deductible	***Inpatient and Residential Treatment:*** 80% after deductible Preauthorization is required ***Outpatient:*** 80% after deductible	***Inpatient and Residential Treatment:*** 60% of R&C after deductible Preauthorization is required ***Outpatient:*** 60% after deductible
Allergy testing and treatment	PCP: $15 per visit; Specialist: $30 per visit	60% of R&C after deductible	80% after deductible	60% of R&C after deductible

	$350 Deductible Plan		$800 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Alternative medicine (Acupuncture)	Coverage limitations: ▪ Performed by a physician as a form of anesthesia in connection with surgery or dental procedure that is covered under the Plan. ▪ A form of Alternative Treatment as long as it is rendered by a certified/licensed individual. ▪ Limited to 12 visits per calendar year (combined in-network/out-of-network).		Coverage limitations: ▪ Performed by a physician as a form of anesthesia in connection with surgery or dental procedure that is covered under the Plan. ▪ A form of Alternative Treatment as long as it is rendered by a certified/licensed individual. ▪	
Ambulance charges	80% after deductible	80% of R&C after deductible	80% after deductible	80% of R&C after deductible
Artificial insemination	$30 copay (no deductible) if service is performed in an office All other places of service: 80% after deductible Limited to overall infertility maximum of $15,000 per lifetime	60% of R&C after deductible Limited to overall infertility maximum of $15,000 per lifetime	80% after deductible Limited to overall infertility maximum of $15,000 per lifetime	60% of R&C after deductible Limited to overall infertility maximum $15,000 per lifetime
CAT / PET scans	80% after deductible CAT scans subject to preauthorization	60% of R&C after deductible	80% after deductible CAT scans subject to preauthorization	60% of R&C after deductible
Chiropractors	$30 per visit (no deductible) 30 visits per calendar year (combined in-network/out-of-network)	60% of R&C after deductible for up to 30 visits per calendar year (combined in-network/out-of-network)	80% after deductible for up to 30 visits per calendar year (combined in-network/out-of-network)	60% of R&C after deductible for up to 30 visits per calendar year (combined in-network/out-of-network)
Contraceptive devices (as defined as Preventive Prescriptions)	Covered at 100%, without deductible	60% of R&C after deductible	Covered at 100%, without deductible	60% of R&C after deductible
Cosmetic surgery	Not covered	Not covered	Not covered	Not covered
Dental treatment (covered only for accidental injury to sound	80% after deductible; subject to office visit copay in office	60% of R&C after deductible	80% after deductible	60% of R&C after deductible

	$350 Deductible Plan		$800 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
teeth within 12 months)				
Doctor delivery charge for newborns	80% after deductible	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Durable medical equipment	80% after deductible Preauthorization is required for purchase or rentals of certain DME	60% of R&C after deductible Preauthorization is required for purchase or rentals of certain DME	80% after deductible Preauthorization is required for purchase or rentals of certain DME	60% of R&C after deductible Preauthorization is required for purchase or rentals of certain DME
EKG Testing	Covered at 100% (not subject to deductible). Considered preventive if performed as part of a routine exam or associated with a preventive diagnosis code.	60% of R&C after deductible. Considered preventive if performed as part of a routine exam or associated with a preventive diagnosis code.	Covered at 100% (not subject to deductible). Considered preventive if performed as part of a routine exam or associated with a preventive diagnosis code.	60% of R&C after deductible. Considered preventive if performed as part of a routine exam or associated with a preventive diagnosis code.
Emergency room	$100, then 80% after deductible for life-threatening injury or illness (See "Life-threatening Illness or Injury in the "Glossary" on page 72).	$100, then 80% of R&C after deductible for life-threatening injury or illness (See "Life-threatening Illness or Injury in the "Glossary" on page 72).	80% after deductible for life-threatening injury or illness (See "Life-threatening Illness or Injury in the "Glossary" on page 72).	80% of R&C after deductible for life-threatening injury or illness (See "Life-threatening Illness or Injury in the "Glossary" on page 72).
Gynecology visits	Covered at 100% (not subject to deductible) for one routine exam each calendar year Subsequent visits – $15 copay	60% of R&C after deductible	Covered at 100% (not subject to deductible) for one routine exam each calendar year Subsequent visits – 80% after deductible	60% of R&C after deductible
Hearing care	80% after deductible; subject to office visit copays Routine hearing screenings are covered at 100% when provided as part of a preventive/wellness visit. Covered hearing aids limited to $1,000 a year per ear.	60% of R&C after deductible Covered hearing aids limited to $1,000 a year per ear.	80% after deductible; subject to office visit copays Routine hearing screenings are covered at 100% when provided as part of a preventive/wellness visit. Covered hearing aids limited to $1,000 a year per ear.	60% of R&C after deductible Covered hearing aids limited to $1,000 a year per ear.

	$350 Deductible Plan		$800 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Home health care	80% after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Preauthorization is required	60% of R&C after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Preauthorization is required	80% after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Preauthorization is required	60% of R&C after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Preauthorization is required
Hospice care	80% after deductible Preauthorization is required	60% of R&C after deductible Preauthorization is required	80% after deductible Preauthorization is required	60% of R&C after deductible Preauthorization is required
Immunizations (routine)	Covered at 100% (not subject to deductible)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	60% of R&C after deductible
Infertility Services	$30 copay (no deductible) if service is performed in an office 80% after deductible for all other places of service Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network) Coverage requires a diagnosis for infertility. Claims prior to 01/01/2015 will not apply to the lifetime maximum on new plans–2015 claims will apply to lifetime maximum. Prior authorization required	60% of R&C after deductible Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network) Coverage requires a diagnosis for infertility. Claims prior to 01/01/2015 will not apply to the lifetime maximum on new plans–2015 claims will apply to lifetime maximum. Prior authorization required	80% after deductible Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network) Coverage requires a diagnosis for infertility. Claims prior to 01/01/2015 will not apply to the lifetime maximum on new plans–2015 claims will apply to lifetime maximum. Prior authorization required	60% of R&C after deductible Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network) Coverage requires a diagnosis for infertility. Claims prior to 01/01/2015 will not apply to the lifetime maximum on new plans–2015 claims will apply to lifetime maximum. Prior authorization required
Inpatient hospital services	80% after deductible Preauthorization is required	60% of R&C after deductible Preauthorization is	80% after deductible Preauthorization is required	60% of R&C after deductible Preauthorization is

	$350 Deductible Plan		$800 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
		required		required
Laboratory charges	80% after deductible	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Magnetic resonance imaging – MRI	80% after deductible Preauthorization is required for MRIs	60% of R&C after deductible is required	80% after deductible is required for MRIs	60% of R&C after deductible Preauthorization is required
Mammograms (Routine)	Covered at 100% (not subject to deductible)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	60% of R&C after deductible
Mastectomy – reconstructive surgery	80% after deductible	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Maternity hospital stay	80% after deductible	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Mental health	***Inpatient and Residential Treatment*** 80% after deductible Subject to preauthorization ***Outpatient:*** $15 per visit	***Inpatient and Residential Treatment*** 60% after deductible Subject to preauthorization ***Outpatient:*** 60% after deductible	***Inpatient and Residential Treatment*** 80% after deductible Subject to preauthorization ***Outpatient:*** 80% after deductible	***Inpatient and Residential Treatment*** 60% after deductible Subject to preauthorization ***Outpatient:*** 60% after deductible
Obesity Surgery	80% after deductible Copays apply if there are office visits Once per lifetime All services must be obtained from a recognized in-network IOQ.	All services must be obtained from a recognized in-network IOQ.	80% after deductible Once per lifetime Preauthorization required	All services must be obtained from a recognized in-network IOQ.
Occupational therapy	$30 per visit; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)	80% after deductible; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)
Organ transplant	100% after deductible in Centers of Excellence as determined by the	60% of R&C after deductible Preauthorization is	100% after deductible in Centers of Excellence (as determined by the	60% of R&C after deductible Preauthorization is

	$350 Deductible Plan		$800 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
	Claims Administrator. 80% after deductible Non-Centers of Excellence Preauthorization is required	required	Claims Administrator) 80% after deductible Non-Centers of Excellence Preauthorization is required	required
Outpatient physician services	Preventive: 100% PCP: $15 per visit Specialist: $30 per visit OUTPATIENT facility 80% after deductible	60% of R&C after deductible	Preventive: 100% Non-preventive: 80% after deductible	60% of R&C after deductible
Physical exams for adults (routine)	Covered at 100% (not subject to deductible or copays) for one physical exam each calendar year	60% of R&C after deductible for one physical exam each calendar year	Covered at 100% (not subject to deductible) for one physical exam each calendar year	60% of R&C after deductible for one physical exam each calendar year
Physical exams for children (routine)	Covered at 100% (not subject to deductible or copays) Subject to Plan limits	60% of R&C after deductible Subject to Plan limits	Covered at 100% (not subject to deductible) Subject to Plan limits	60% of R&C after deductible Subject to Plan limits
Physical therapy	$30 per visit; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)	80% after deductible; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)
Pregnancy termination	Subject to office visit copay, with no deductible in office 80% after deductible in other places of service	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Prenatal visits	$15 copay (not subject to deductible) for first visit Routine Prenatal Care covered at 100%	60% of R&C after deductible	80% after deductible Routine Prenatal Care covered at 100%	60% of R&C after deductible
Private Duty Nursing	80% after deductible Maximum of 60 visits (8-hour shifts) per	60% of R&C after deductible Maximum of 60 visits	80% after deductible Maximum of 60 visits (8-hour shifts) per	60% of R&C after deductible Maximum of 60 visits

	$350 Deductible Plan		$800 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
	calendar year (Combined in-network/out-of-network)	(8-hour shifts) per calendar year (Combined in-network/out-of-network)	calendar year (Combined in-network/out-of-network)	(8-hour shifts) per calendar year (Combined in-network/out-of-network)
Prostate specific antigen test— PSA (routine)	Covered at 100% (not subject to deductible or copay)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	60% of R&C after deductible
Prescription drugs (see "Drugs" on page 63	There is a pharmacy network for retail and mail order PRESCRIPTION DRUGS.	There is a pharmacy network for retail and mail order prescription drugs.	There is a pharmacy network for retail and mail order prescription drugs.	There is a pharmacy network for retail and mail order prescription drugs.
Sex transformation change (and related costs)	80% after deductible Service in physician office subject to COPAYMENT Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000) (combined in-network/out-of-network)	60% of R&C after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000) (combined in-network/out-of-network)	80% after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000) (combined in-network/out-of-network)	60% of R&C after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000) (combined in-network/out-of-network)
Skilled nursing facility	80% after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Preauthorization is required	60% of R&C after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Preauthorization is required	80% after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Preauthorization is required	60% of R&C after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Preauthorization is required
Speech therapy	$30 per visit; up to 60 visits per calendar year combined with occupational and physical therapy (combined in-	60% of R&C after deductible; up to 60 visits per calendar year combined with occupational and physical therapy	80% after deductible; up to 60 visits per calendar year combined with occupational and physical therapy	60% of R&C after deductible; up to 60 visits per calendar year combined with occupational and physical therapy

	$350 Deductible Plan		$800 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
	network/out-of-network)	(combined in-network/out-of-network)	(combined in-network/out-of-network)	(combined in-network/out-of-network)
Surgery	80% after deductible Preauthorization is required if in-patient Predetermination of benefits is recommended for multiple surgical procedures	60% of R&C after deductible Preauthorization is required if in-patient Predetermination of benefits is recommended for multiple surgical procedures	80% after deductible Preauthorization is required if in-patient Predetermination of benefits is recommended for multiple surgical procedures	60% of R&C after deductible Preauthorization is required if in-patient Predetermination of benefits is recommended for multiple surgical procedures
Tubal ligation	Covered at 100%, deductible does not apply	60% of R&C after deductible	Covered at 100%, deductible does not apply	60% of R&C after deductible
Urgent Care	$50 per visit, deductible does not apply	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Vasectomy	80% after deductible; subject to office visit copay if performed in an office	60% of R&C after deductible	80% after deductible	60% of R&C after deductible
Vision care (routine eye exam)	Not covered	Not covered	Not covered	Not covered
Vision Therapy/ Orthoptics	$30 copay per visit (maximum of 12 vision therapy visits or sessions medically necessary for treatment of convergence insufficiency)	60% of R&C after deductible (maximum of 12 vision therapy visits or sessions medically necessary for treatment of convergence insufficiency)	80% of R&C after deductible (maximum of 12 vision therapy visits or sessions medically necessary for treatment of convergence insufficiency)	60% of R&C after deductible (maximum of 12 vision therapy visits or sessions medically necessary for treatment of convergence insufficiency)
X-rays	80% after deductible	60% of R&C after deductible	80% after deductible	60% of R&C after deductible

$1,500 Deductible Plan and $2,850 Deductible Plan

	$1,500 Deductible Plan		$2,850 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**

	$1,500 Deductible Plan		$2,850 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Alcohol and substance abuse	***Inpatient and Residential Treatment:*** 80% after deductible Preauthorization is required ***Outpatient:*** 80% after deductible	***Inpatient and Residential Treatment:*** 60% of R&C after deductible Preauthorization is required ***Outpatient:*** 60% after deductible	***Inpatient and Residential Treatment:*** 70% after deductible Preauthorization is required ***Outpatient:*** 70% after deductible	***Inpatient and Residential Treatment:*** 50% of R&C after deductible Preauthorization is required ***Outpatient:*** 50% after deductible
Allergy testing and treatment	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Alternative medicine (Acupuncture)	Coverage limitations: ▪ Performed by a physician as a form of anesthesia in connection with surgery or dental procedure that is covered under the Plan. ▪ A form of Alternative Treatment as long as it is rendered by a certified/licensed individual. ▪ Limited to 12 visits per calendar year (combined in-network/out-of-network).		Coverage limitations: ▪ Performed by a physician as a form of anesthesia in connection with surgery or dental procedure that is covered under the Plan. ▪ A form of Alternative Treatment as long as it is rendered by a certified/licensed individual. ▪ Limited to 12 visits per calendar year (combined in-network/out-of-network).	
Ambulance charges	80% after deductible	80% of R&C after deductible	70% after deductible	70% of R&C after deductible
Artificial insemination	80% after deductible Limited to overall infertility maximum of $15,000 per lifetime (combined in-network/out-of-network)	60% of R&C after deductible Limited to overall infertility maximum of $15,000 per lifetime (combined in-network/out-of-network)	70% after deductible Limited to overall infertility maximum of $15,000 per lifetime (combined in-network/out-of-network)	50% of R&C after deductible Limited overall infertility maximum of to $15,000 per lifetime (combined in-network/out-of-network)
CAT / PET scans	80% after deductible CAT scans subject to preauthorization	60% of R&C after deductible	70% after deductible CAT scans subject to preauthorization	50% of R&C after deductible
Chiropractors	80% after deductible for up to 30 visits per calendar year combined in-network/out-of-network	60% of R&C after deductible for up to 30 visits per calendar year combined in-network/out-of-network	70% after deductible for up to 30 visits per calendar year combined in-network/out-of-network	50% of R&C after deductible for up to 30 visits per calendar year combined in-network/out-of-network
Contraceptive devices (as defined as Preventive Prescriptions)	Covered at 100%, without deductible	60% of R&C after deductible	Covered at 100%, without deductible	50% of R&C after deductible

	$1,500 Deductible Plan		$2,850 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Cosmetic surgery	Not covered	Not covered	Not covered	Not covered
Dental treatment (covered only for accidental injury to sound teeth within 12 months)	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Doctor delivery charge for newborns	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Durable medical equipment	80% after deductible Preauthorization is required for purchase or rentals of certain DME	60% of R&C after deductible Preauthorization is required for purchase or rentals of certain DME	70% after deductible Preauthorization is required for purchase or rentals of certain DME	50% of R&C after deductible Preauthorization is required for purchase or rentals of certain DME
EKG Testing	Covered at 100% (not subject to deductible). Considered preventive if performed as part of a routine exam or associated with a preventive diagnosis code.	60% of R&C after deductible. Considered preventive if performed as part of a routine exam or associated with a preventive diagnosis code.	Covered at 100% (not subject to deductible). Considered preventive if performed as part of a routine exam or associated with a preventive diagnosis code.	50% of R&C after deductible. Considered preventive if performed as part of a routine exam or associated with a preventive diagnosis code.
Emergency room	80% after deductible for life-threatening injury or illness [(See "Life-threatening Illness or Injury in the "Glossary" on page 72).	80% of R&C after deductible for life-threatening injury or illness (See "Life-threatening Illness or Injury in the "Glossary" on page 72).	70% after deductible for life-threatening injury or illness (See "Life-threatening Illness or Injury in the "Glossary" on page 72).	70% of R&C after deductible for life-threatening injury or illness (See "Life-threatening Illness or Injury in the "Glossary" on page 72).
Gynecology visits	Covered at 100% (not subject to deductible) for one routine exam each calendar year Subsequent visits – 80% after deductible	60% of R&C after deductible	Covered at 100% (not subject to deductible) for one routine exam each calendar year Subsequent visits – 70% after deductible	50% of R&C after deductible

	$1,500 Deductible Plan		$2,850 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Hearing care	80% (after deductible) Routine hearing screenings covered at 100% when provided as part of a preventive/ wellness visit. Covered hearing aids limited to $1,000 a year per ear.	60% of R&C after deductible Covered hearing aids limited to $1,000 a year per ear.	70% (after deductible) Routine hearing screenings covered at 100% when provided as part of a preventive/ wellness visit. Covered hearing aids limited to $1,000 a year per ear.	50% of R&C after deductible Covered hearing aids limited to $1,000 a year per ear.
Home health care	80% after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Preauthorization is required	60% of R&C after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Preauthorization is required	70% after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Preauthorization is required	50% of R&C after deductible for up to 120 home health care aid visits per calendar year for homebound patients (up to 4 hours each visit) Preauthorization is required
Hospice care	80% after deductible Preauthorization is required	60% of R&C after deductible Preauthorization is required	70% after deductible Preauthorization is required	50% of R&C after deductible Preauthorization is required
Immunizations (routine)	Covered at 100% (not subject to deductible)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	50% of R&C after deductible

	$1,500 Deductible Plan		$2,850 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Infertility Services	80% after deductible Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network) Coverage requires a diagnosis for infertility. Claims prior to 01/01/2015 will not apply to the lifetime maximum on new plans–2015 claims will apply to lifetime maximum. Prior authorization required	60% of R&C after deductible Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network) Coverage requires a diagnosis for infertility. Claims prior to 01/01/2015 will not apply to the lifetime maximum on new plans–2015 claims will apply to lifetime maximum. Prior authorization required	70% after deductible Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network) Coverage requires a diagnosis for infertility. Claims prior to 01/01/2015 will not apply to the lifetime maximum on new plans–2015 claims will apply to lifetime maximum. Prior authorization required	50% of R&C after deductible Artificial Insemination and Advanced Reproductive Technology are limited to overall infertility maximum of $15,000 per lifetime maximum (combined in-network/out-of-network) Coverage requires a diagnosis for infertility. Claims prior to 01/01/2015 will not apply to the lifetime maximum on new plans–2015 claims will apply to lifetime maximum. Prior authorization required
Inpatient hospital services	80% after deductible Preauthorization is required	60% of R&C after deductible Preauthorization is required	70% after deductible Preauthorization is required	50% of R&C after deductible Preauthorization is required
Laboratory charges	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Magnetic resonance imaging – MRI	80% after deductible Preauthorization is required for MRIs	60% of R&C after deductible is required	70% after deductible Preauthorization is required for MRIs	50% of R&C after deductible is required
Mammograms (Routine)	Covered at 100% (not subject to deductible)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	50% of R&C after deductible
Mastectomy – reconstructive surgery	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Maternity hospital stay	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible

	$1,500 Deductible Plan		$2,850 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Mental health	***Inpatient and Residential Treatment*** 80% after deductible Subject to preauthorization ***Outpatient:*** 80% after deductible	***Inpatient and Residential Treatment*** 60% after deductible Subject to preauthorization ***Outpatient:*** 60% after deductible	***Inpatient and Residential Treatment*** 70% after deductible Subject to preauthorization ***Outpatient:*** 70% after deductible	***Inpatient and Residential Treatment*** 50% after deductible Subject to preauthorization ***Outpatient:*** 50% after deductible
Obesity Surgery	80% after deductible Once per lifetime All services must be obtained from a recognized in-network IOQ Preauthorization required	All services must be obtained from a recognized in-network IOQ	80% after deductible Once per lifetime All services must be obtained from a recognized in-network IOQ Preauthorization required	All services must be obtained from a recognized in-network IOQ
Occupational therapy	80% after deductible; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)	70% after deductible; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)	50% of R&C after deductible; up to 60 visits per calendar year combined with physical and speech therapy (combined in-network/out-of-network)
Organ transplant	100% after deductible in Centers of Excellence as determined by the Claims Administrator 80% after deductible in Non-Centers of Excellence Preauthorization is required	60% of R&C after deductible Preauthorization is required	100% after deductible in Centers of Excellence as determined by the Claims Administrator 70% after deductible in Non-Centers of Excellence Preauthorization is required	50% of R&C after deductible Preauthorization is required
Outpatient physician services	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Physical exams for adults (routine)	Covered at 100% (not subject to deductible) for one physical exam each calendar year	60% of R&C after deductible for one physical exam each calendar year	Covered at 100% (not subject to deductible) for one physical exam each calendar year	50% of R&C after deductible for one physical exam each calendar year
Physical exams for children (routine)	Covered at 100% (not subject to deductible) Subject to Plan limits	60% of R&C after deductible Subject to Plan limits	Covered at 100% (not subject to deductible) Subject to Plan limits	50% of R&C after deductible Subject to Plan limits

	$1,500 Deductible Plan		$2,850 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Physical therapy	80% after deductible; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)	70% after deductible; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)	50% of R&C after deductible; up to 60 visits per calendar year combined with occupational and speech therapy (combined in-network/out-of-network)
Pregnancy termination	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Prenatal visits	80% after deductible Routine Prenatal Care covered at 100%	60% of R&C after deductible	70% after deductible Routine Prenatal Care covered at 100%	50% of R&C after deductible
Private Duty Nursing	80% after deductible Maximum of 60 visits (8-hour shifts) per calendar year (Combined in-network/out-of-network)	60% of R&C after deductible Maximum of 60 visits (8-hour shifts) per calendar year (Combined in-network/out-of-network)	80% after deductible Maximum of 60 visits (8-hour shifts) per calendar year (Combined in-network/out-of-network)	60% of R&C after deductible Maximum of 60 visits (8-hour shifts) per calendar year (Combined in-network/out-of-network)
Prostate specific antigen test – PSA (routine)	Covered at 100% (not subject to deductible)	60% of R&C after deductible	Covered at 100% (not subject to deductible)	50% of R&C after deductible
Prescription drugs	There is a pharmacy network for retail and mail order prescription drugs.	There is a pharmacy network for retail and mail order prescription drugs.	There is a pharmacy network for retail and mail order prescription drugs.	There is a pharmacy network for retail and mail order prescription drugs.

	$1,500 Deductible Plan		$2,850 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Sex transformation change (and related costs)	80% after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000; combined in-network/out-of-network)	60% of R&C after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000; combined in-network/out-of-network)	70% after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000; (combined in-network/out-of-network)	50% of R&C after deductible Call the Claims Administrator at the number on the back of your ID card for specifics on what is covered and excluded by the Plan. Subject to Plan limits (one per lifetime up to $75,000; combined in-network/out-of-network)
Skilled nursing facility	80% after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Preauthorization is required	60% of R&C after deductible for up to 120 days per calendar year) (combined in-network/out-of-network) Preauthorization is required	70% after deductible for up to 120 days per calendar year (combined in-network/out-of-network) Preauthorization is required	50% of R&C after deductible for 120 days per calendar year (combined in-network/out-of-network) Preauthorization is required
Speech therapy	80% after deductible; up to 60 visits per calendar year combined with occupational and physical therapy (combined in-network/out-of-network)	60% of R&C after deductible; up to 60 visits per calendar year combined with occupational and physical therapy (combined in-network/out-of-network)	70% after deductible; up to 60 visits per calendar year combined with occupational and physical therapy (combined in-network/out-of-network)	50% of R&C after deductible; up to 60 visits per calendar year combined with occupational and physical therapy (combined in-network/out-of-network)
Surgery	80% after deductible Preauthorization is required if in-patient Predetermination of benefits is recommended for multiple surgical procedures	60% of R&C after deductible Preauthorization is required if in-patient Predetermination of benefits is recommended for multiple surgical procedures	70% after deductible Preauthorization is required if in-patient Predetermination of benefits is recommended for multiple surgical procedures	50% of R&C after deductible Preauthorization is required if in-patient Predetermination of benefits is recommended for multiple surgical procedures

	$1,500 Deductible Plan		$2,850 Deductible Plan	
Services	**In-Network Coverage**	**Out-of-Network Coverage**	**In-Network Coverage**	**Out-of-Network Coverage**
Tubal ligation	Covered at 100%, deductible does not apply	60% of R&C after deductible	Covered at 100%, deductible does not apply	50% of R&C after deductible
Urgent Care	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Vasectomy	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible
Vision care (routine eye care)	Not covered	Not covered	Not covered	Not covered
Vision Therapy/ Orthoptics	80% after deductible (maximum of 12 vision therapy visits or sessions medically necessary for treatment of convergence insufficiency)	60% of R&C after deductible (maximum of 12 vision therapy visits or sessions medically necessary for treatment of convergence insufficiency)	70% after deductible (maximum of 12 vision therapy visits or sessions medically necessary for treatment of convergence insufficiency)	50% of R&C after deductible (maximum of 12 vision therapy visits or sessions medically necessary for treatment of convergence insufficiency)
X-rays	80% after deductible	60% of R&C after deductible	70% after deductible	50% of R&C after deductible

What's Not Covered

The Plan will not pay benefits for any of the services, treatments, items or supplies described in this section, even if either of the following is true:

- It is recommended or prescribed by a physician.
- It is the only available treatment for your condition.

The Claims Administrator may modify this list at their discretion, and you will be notified of any such change.

Alternative Treatments

- Acupressure
- Aroma therapy
- Hypnotism
- Massage therapy

- Rolfing
- Other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health.

Comfort or Convenience

- Television
- Telephone
- Beauty/barber service
- Guest service
- Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include:
  - Air conditioners
  - Air purifiers and filters
  - Batteries and battery chargers
  - Dehumidifiers
  - Humidifiers
  - Devices and computers to assist communication and speech
- Home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools).

Dental

- Dental care except when necessary because of accidental damage to an unrestored tooth. Such services must be performed by a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD). Dental services for final treatment to repair the damage must be started within three months of the accident and completed in the calendar year or within the following calendar year.
- Preventive care, diagnosis, treatment of or related to the teeth, jawbones or gums. Examples include all of the following:
  - Extraction, restoration and replacement of teeth
  - Medical or surgical treatments of dental conditions
  - Services to improve dental clinical outcomes
- Dental implants
- Dental braces

- Dental X-rays, supplies and appliances and all associated expenses, including hospitalization and anesthesia. The only exceptions to this are for any of the following:
  - Transplant preparation
  - Initiation of immunosuppressives
  - The direct treatment of acute traumatic injury, cancer or cleft palate
- Treatment of congenitally missing, malpositioned or super numerary teeth, even if part of a congenital anomaly.

Drugs

- Over-the-counter drugs and treatments

Experimental or Investigational Services or Unproven Services

Medical, surgical, diagnostic, psychiatric, substance abuse or health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time the Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the US Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopea Dispensing Information as appropriate for the proposed use
- Subject to review and approval by any institutional review board for the proposed use
- The subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Foot Care

- Except when needed for severe systemic disease:
  - Routine foot care (including the cutting or removal of corns and calluses)
  - Nail trimming, cutting, or debriding (surgical removal of tissue)
- Hygienic and preventive maintenance foot care. Examples include the following:
  - Cleaning and soaking the feet
  - Applying skin creams in order to maintain skin tone
  - Other services that are performed when there is not a localized illness, injury or symptom involving the foot
- Treatment of flat feet
- Treatment of subluxation (partial dislocation) of the foot

- Shoe orthotics

Medical Supplies and Appliances

- Devices used specifically as safety items or to affect performance in sports-related activities
- Prescribed or non-prescribed medical supplies and disposable supplies. Examples include:
  - Elastic stockings
  - Ace bandages
  - Gauze and dressings
  - Ostomy supplies
- Orthotic appliances that straighten or re-shape a body part (including some types of braces)

Tubings, nasal cannulas, connectors and masks are not covered except when used with durable medical equipment

Mental Health/Substance Abuse

- Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association
- Services for mental health and substance abuse that extend beyond the period necessary for short-term evaluation, diagnosis, treatment or crisis intervention
- Treatment for conduct and impulse control disorders, personality disorders, paraphilias and other mental illnesses that will not substantially improve beyond the current level of functioning, or that are not subject to favorable modification or management according to prevailing national standards of clinical practice, as reasonably determined by the Plan's preauthorization review service
- Services utilizing methadone treatment as maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents (only office visit covered)
- Treatment provided in connection with or to comply with commitments, police detentions and other similar arrangements, unless authorized by the Plan's preauthorization review service
- Services incurred for behavioral health treatment in a residential facility, which are paid the same as behavioral health INPATIENT benefits
- Services or supplies for the diagnosis or treatment of mental illness, alcoholism or substance disorders that, in reasonable judgment of the Plan's preauthorization review service, are any of the following:
  - Not consistent with prevailing national standards of clinical practice for the treatment of such conditions
  - Not consistent with prevailing professional research demonstrating that the services or supplies will have a measurable and beneficial health outcome

- Typically do not result in outcomes demonstrably better than other available treatment alternatives that are less intensive or more cost effective
- Not consistent with the Plan's preauthorization review service's guidelines or best practices as modified from time to time.

The Plan's preauthorization review service may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria

- Pastoral counselors
- Education and experimental investigational treatments provided in connection with autism; ABA
- Treatment provided in connection with tobacco dependency in excess of 8 visits per 12 months
- Routine use of psychological testing without specific authorization

Nutrition

- Megavitamin and nutrition based therapy
- Nutritional counseling for either individuals or groups, including weight loss programs, health clubs and spa programs, health clubs and spa programs except when necessary in treating chronic disease states in which dietary adjustment has a therapeutic role and is prescribed by a physician and furnished by a provider as preventive care (e.g., a registered dietician, licensed nutritionist or other qualified licensed health provision) recognized under the plan.

Nutritional and electrolyte supplements, including infant formula, donor breast milk, nutritional supplements, dietary supplements, diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins, and oral minerals except when sole source of nutrition or except when a certain nutritional formula treats a specific inborn error of metabolism.

Physical Appearance

- Cosmetic procedures. Examples include:
  - Pharmacological regimens (e.g., systematic course of drugs), nutritional procedures or treatments
  - Scar or tattoo removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures)
  - Skin abrasion procedures performed as a treatment for acne
  - Orthognathic surgery, for cosmetic reasons
- Replacement of an existing breast implant if the earlier breast implant was performed as a cosmetic procedure. Note: Replacement of an existing breast implant is considered reconstructive if the initial breast implant followed mastectomy.

- Physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
- Weight loss programs whether or not they are under medical supervision. Weight loss programs for medical reasons are also excluded.

Wigs are generally excluded except in cases of hair loss due a severe medical condition or treatment.

Providers

- Services performed by a provider who is a family member by birth or marriage, including spouse, brother, sister, parent or child. This includes any service the provider may perform on himself or herself.
- Services performed by a provider with your same legal residence
- Services provided at a free-standing or hospital-based diagnostic facility without an order written by a physician or other provider. Services that are self-directed to a free-standing or hospital-based diagnostic facility. Services ordered by a physician or other provider who is an employee or representative of a free-standing or hospital-based diagnostic facility, when that physician or other provider:
  - Has not been actively involved in your medical care prior to ordering the service, or
  - Is not actively involved in your medical care after the service is received.

This exclusion does not apply to mammography testing.

Reproduction

- Health services and associated expenses for infertility treatments (except those described under Infertility Treatment)
- Surrogate parenting
- The reversal of voluntary sterilization
- Fees or direct payment to a donor for sperm or ovum donations
- Monthly fees for maintenance and / or storage of frozen embryos.

Services Provided under Another Plan

- Health services for which other coverage is required by federal, state or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by workers' compensation, no-fault auto insurance, or similar legislation. If coverage under workers' compensation or similar legislation is optional for you because you could elect it, or could have it elected for you, benefits will not be paid for any injury, sickness or mental illness that would have been covered under workers' compensation or similar legislation had that coverage been elected

- Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you
- Health services while on active military duty.

TMJ

- Surface electromyography
- Doppler analysis
- Vibration analysis
- Computerized mandibular scan or jaw tracking
- Craniosacral therapy
- Orthodontics
- Occlusal adjustment
- Dental restorations
- Any charges for services that are dental in nature.

Transplants

- Health services for organ and tissue transplants, except those described under Organ Transplants
- Health services connected with the removal of an organ or tissue from you for purposes of a transplant to another person (Donor costs for removal are payable for a transplant through the organ recipient's benefits under the Plan)
- Health services for transplants involving mechanical or animal organs
- Any solid organ transplant (e.g. heart, lung, etc.; not blood, bone marrow, etc.) that is performed as a treatment for cancer
- Any multiple organ transplant not listed as a covered service.

Travel

- Health services provided in a foreign country, unless required as emergency health services
- Travel or transportation expenses to and from your home, even though prescribed by a physician.
  - Some travel expenses related to covered transplantation services may be reimbursed at the Claims Administrator's discretion. For example, travel for solid organ and bone marrow transplants or obesity surgery in an approved facility more than 100 miles from your home is covered up to $50 per night for lodging, and up to $10,000 per episode of care for travel and lodging combined.

Vision and Hearing

- Purchase cost of eye glasses, contact lenses, or hearing aids
- Fitting charge for hearing aids, eye glasses or contact lenses
- Orthoptics or other vision therapy
- Surgery that is intended to allow you to see better without glasses or other vision correction, including radial keratotomy, laser, and other refractive eye surgery.

Work-Related Accident and Illness

The Plan does not cover work-related accidents or illnesses. Work-related accidents and illnesses should be reported as soon as they occur to your Human Resources representative for consideration under the Worker's Compensation program.

All Other Exclusions

- Health services and supplies that do not meet the definition of a Covered Service
- Physical, psychiatric or psychological exams, testing, vaccinations, immunizations or treatments that are otherwise covered under the Plan when:
  - Required solely for purposes of career, education, sports or camp, travel, employment, insurance, marriage or adoption
  - Related to judicial or administrative proceedings or orders
  - Conducted for purposes of medical research
  - Required to obtain or maintain a license of any type
- Treatment for insomnia and other sleep disorders, dementia, neurological disorders and other disorders without a known physical basis
- Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the Plan
- In the event that a non-network provider waives copayments and/or the annual DEDUCTIBLE for a particular health service, no benefits are provided for the health service for which the copayments and/or annual deductible are waived
- Charges in excess of eligible expense or in excess of any specified limitation
- Custodial care
- Domiciliary care (e.g., group living arrangements)
- Respite care

- Rest cures
- Psychosurgery (brain surgery to treat psychiatric symptoms)
- Treatment of benign gynecomastia (abnormal breast enlargement in males)
- Medical and surgical treatment of excessive sweating (hyperhidrosis)
- Medical and surgical treatment for snoring, except when provided as a part of treatment for documented obstructive sleep apnea
- Appliances for snoring
- Any charges for missed appointments, room or facility reservations, completion of claim forms or record processing
- Any charges higher than the reasonable and customary charge
- Any charge for services, supplies or equipment advertised by the provider as free
- Any charges by a provider sanctioned under a federal program for reason of fraud, abuse or medical competency
- Any charges prohibited by federal anti-kickback or self-referral statues
- Any additional charges submitted after payment has been made and your account balance is zero
- Any charges by a resident in a teaching hospital where a faculty physician did not supervise services
- OUTPATIENT rehabilitation services, spinal treatment or supplies including, but not limited to spinal manipulations by a chiropractor or other doctor, for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring
- Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies
- Speech therapy to treat stuttering, stammering, or other articulation disorders.

Filing a Claim

How do I file a claim for benefits?

If you use an in-network provider, in almost all cases, you do not have to file a claim form. The provider will file a claim directly with the Claims Administrator. Once the claim is processed you will be billed for the appropriate COINSURANCE amount, DEDUCTIBLE (and applicable copays.

If you receive services from a provider who does not participate in the network, you need to file a claim form to receive benefits.

You can obtain a Medical Benefits Request Form on Colleague Connect (https://colleagueconnect.mmc.com). Click **Career & Rewards,** select **Career & Rewards Forms/Documents** under Resources and then click Medical/Dental/Prescription.

Read and follow the form's instructions. Be sure to file a separate claim form for each member of your family. Make copies of all itemized bills, and attach the originals to the claim form. You will also need to indicate whether you want the payment to go to the provider or to you.

Mail the completed claim form and all relevant documentation as the form instructs. You may include more than one bill with a claim, even if the bills are for different medical services.

You have 12 months following the date the expense was incurred to file a medical claim.

How long does it normally take to process a claim for benefits?

Most claims are normally processed within 10 business days after the claim is received by the Claims Administrator.

You can find out the status of your claims by visiting the Claims Administrator's website.

How do I file a prescription drug claim form?

All prescriptions filled at a participating retail pharmacy require you to provide an ID card for coverage under the Plan. You are responsible for the applicable COPAYMENT or coinsurance. Rarely will you need to file a claim with the Pharmacy Benefits Manager (one example may be a prescription filled at retail before you have received your ID card). Should you need to file a claim, contact the Pharmacy Benefits Manager.

Claim forms are available on the Pharmacy Benefits Manager's website. Should you need to file a claim you are responsible for the difference between the discounted and undiscounted price. You have 12 months from the date the expense was incurred to submit a claim.

How do I file a claim for hospital charges?

Hospitals will submit a claim from your hospital stay directly to the Claims Administrator. After receiving reimbursement from the Claims Administrator, the hospital will then bill you for any coinsurance or amount not eligible for reimbursement.

Be sure to review the hospital bill and to request an explanation of any charges that you question or do not understand. You should let the Claims Administrator know if you have a concern about the charges on your hospital bill.

You have up to 12 months following the date the expense was incurred to file a claim.

Can I be reimbursed for claims incurred outside the United States?

No, you cannot be reimbursed for services incurred outside the US unless they are considered emergency services. If you incur eligible emergency medical or prescription drug expenses while living or traveling outside of the US, your claim's processing will be expedited if the receipts are in English or if the person providing the services gives you a letter in English explaining the treatment. The Claims Administrator will convert the bill to US dollars using an exchange rate on the day the services were performed.

You have 12 months following the date the expense was incurred to file a claim.

What is an Explanation of Benefits (EOB)?

An Explanation of Benefits statement outlines how the amount of benefit, if any, was calculated. The statement also shows your year-to-date deductible and OUT-OF-POCKET EXPENSES. If you are due reimbursement, a check will be mailed to you with an explanation of benefits statement, or to the provider if you assigned payment.

An Explanation of Benefits statement lets you verify that the claim was processed correctly. Always read your statement carefully, checking to make sure that you were billed only for:

- Services you received, on the day(s) you received them, only from the provider of care
- The exact type of services you received (e.g., if you participated in a group therapy session, make sure that you are not billed for individual treatment)
- The amount you were told the treatment would cost
- The type of medication you received (e.g., if you receive generic medication, check that you are not billed for brand name medication).

If your statement lists services you did not receive, please notify the Claims Administrator.

If you authorize that reimbursement be made directly to your provider, both you and the provider will receive an Explanation of Benefits statement, and the provider receives payment.

What happens if I am overpaid for a claim?

If the Plan overpays benefits to you (or a covered family member), you are required to refund any benefit you receive from the Plan that:

- Was for an expense that you (or a covered family member) did not pay or were not legally required to pay;
- Exceeded the benefit payable under the Plan; or
- Is not covered by the Plan.

If a benefit payment is made to you (or a covered family member), which exceeds the benefit amount, this Plan has the right:

- To require the return of the overpayment on request; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of you or a covered family member.

For Flexible Spending Account Reimbursement

If you participate in the Health Care Flexible Spending Account and do not have a covered domestic partner, once your medical claim is processed, the Claims Administrator will automatically process your claim for reimbursement under your Health Care Flexible Spending Account.

If you cover a domestic partner, you receive services that are not covered under the Plan or you participate in the Limited Purpose Health Care Flexible Spending Account, your claims cannot be automatically reimbursed. Rather, you must submit a Flexible Spending Account (FSA) Claim Form.

Appealing a Claim

There are special rules, procedures and deadlines that apply to appeals of benefit determinations and denied claims and you have special legal rights under ERISA. Please refer to the *Administrative Information* section for a description of the appeal process.

Glossary

ACTIVELY-AT-WORK

If you are eligible for coverage and enroll as a new hire, you are "Actively-At-Work" on the first day that you begin fulfilling your job responsibilities with the Company at a Company-approved location. If you are absent for any reason on your scheduled first day of work, your coverage will not begin on that date. For example, if you are scheduled to begin work on August 3rd, but are unable to begin work on that day (e.g., because of illness, jury duty, bereavement or otherwise), your coverage will not begin on August 3rd. Thereafter, if you report for your first day of work on August 4th, your coverage will be effective on August 4th.

AFTER-TAX (POST-TAX) CONTRIBUTIONS

Contributions taken from your paycheck after taxes are withheld.

APPROVED SPOUSE AND DOMESTIC PARTNER

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

Spouse / Domestic Partner

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

Spouse Only

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

Domestic Partner Only

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

- Currently reside together, and have resided together for at least the previous 12 months, and intend to do so permanently
- Have agreed to share responsibility for each other's common welfare and basic financial obligations
- Not be related by blood to a degree of closeness that would prohibit marriage under applicable state law.

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

In order to cover the child(ren) of a spouse or domestic partner, you will be required to complete an Affidavit of Eligible Family Member. Go to Colleague Connect **(https://colleagueconnect.mmc.com)**, click **Career & Rewards** and select **Mercer Marketplace benefits enrollment website** under Resources.

Before-Tax (Pre-Tax) Contributions

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

Claims Administrator/Pharmacy Benefits Manager

Vendor that administers the Plan and processes claims; the vendor's decisions are final and binding.

Coinsurance

The percentage of expenses you are responsible for paying after you meet your deductible.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

A federal law that lets you and your eligible family members covered by a group health plan extend group health coverage temporarily, at their own expense, at group rates plus an administrative fee, in certain circumstances when their coverage would otherwise end due to a "qualifying event", as defined under COBRA.

A "qualifying event" under COBRA includes loss of coverage as a result of your leaving the Company (other than for gross misconduct); a reduction in hours, your death, divorce or legal separation; your eligibility for Medicare, or a dependent child's loss of dependent status; or, if you are a retiree, loss of coverage due to the Company filing for bankruptcy.

Coordination of Benefits

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

Copayment

The flat dollar amount you pay for a certain type of health care expense.

COVERED SERVICE(S)

Medically necessary health services provided for the purpose of preventing, diagnosing or treating a sickness, injury, mental illness, substance abuse, or their symptoms.

Covered health services must be provided:

- When the Plan is in effect,
- Prior to the effective date of any of the individual termination conditions set forth in this Summary Plan Description, and
- Only when the person who receives services is a covered person and meets all eligibility requirements specified in the Plan.

Decisions about whether to cover new technologies, procedures and treatments will be consistent with conclusions of prevailing medical research based on well-conducted randomized trials or group studies.

The Claims Administrator determines only the extent to which a service or goods or supplies is covered under the plan and not whether the service or goods or supplies should be rendered. The coverage determination is made using the descriptions of covered charges included in this section and the Claims Administrator's own internal guidelines. The decision to accept a service or obtain a goods or supplies is yours.

DEDUCTIBLE

The amount of out-of-pocket expenses you must pay for covered services before the plan pays any expenses.

DISABILITY

A physical or mental impairment that substantially limits one or more of an individual's major life activities.

ELIGIBLE FAMILY MEMBERS

Child/Dependent Child means:

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

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

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

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

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

ELIGIBLE RETIREE

An employee is eligible for coverage under this plan if he/she is a US regular employee of Marsh & McLennan Companies or any subsidiary or affiliate of Marsh & McLennan Companies (other MMA and any of its subsidiaries or Mercer PeoplePro) who terminates employment with five or more years of vesting service at age 55 or later, or at age 65 and eligible for active employee medical coverage at retirement or is a current retiree (under or over age 65) enrolled in retiree medical coverage.

When you or a covered family member reach age 65 or is deemed to be eligible for Medicare, the person who is age 65 or is eligible for Medicare is no longer eligible for coverage under the Pre-65 Retiree Medical Plan.

EVIDENCE OF INSURABILITY (EOI)

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

EXPLANATION OF BENEFITS (EOB)

A summary of benefits processed by the Claims Administrator.

GLOBAL BENEFITS DEPARTMENT

Refers to the Global Benefits Department, located at 121 River Street, Hoboken, NJ 07030.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

A Federal law, HIPAA imposes requirements on employer health plans including concerning the use and disclosure of individual health information.

HOSPICE

A hospice is an institution that provides counseling and medical services that could include room and board to terminally ill individuals. The hospice must have required state or governmental Certificate of Need approval and must provide 24 hour-a-day service under the direct supervision of a physician. The staff must include a registered nurse, a licensed social service worker and a full-time claims administrator. If state licensing exists, the hospice must be licensed.

IN-NETWORK PROVIDERS

Preferred health care providers who have agreed to charge reduced fees to members.

INPATIENT

Being treated and admitted at a covered facility for an overnight stay either by a physician or from the emergency room.

LIFE THREATENING ILLNESS OR INJURY– EMERGENCY ROOM COVERAGE

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson (including the parent of a minor child or the guardian of a disabled individual), who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

Some examples of emergencies include:

- Heart attack, suspected heart attack or stroke
- Suspected overdose of medication
- Poisoning
- Severe burns
- Severe shortness of breath
- High fever (103 degrees or higher), especially in infants
- Uncontrolled or severe bleeding
- Loss of consciousness
- Severe abdominal pain
- Persistent vomiting
- Severe allergic reactions.

The Plan covers emergency services necessary to screen and stabilize a member when:

- A primary care physician or specialist physician directs the member to the emergency room
- A plan representative (employee or contractor) directs the member to the emergency room
- The member acting as a prudent layperson and a reasonable person would reasonably have believed that an emergency condition existed.

MARSH & MCLENNAN COMPANIES MEDICAL PLANS AND MEDICARE PRESCRIPTION DRUG COVERAGE FOR DISABLED EMPLOYEES

Marsh & McLennan Companies newsletter that provides an overview of how Medicare Part D could affect your Marsh & McLennan Companies prescription drug coverage. It highlights issues you'll want to think about as you consider your prescription drug options.

The US Federal government's health insurance program, administered by the Social Security Administration, that pays certain hospital and medical expenses for those who qualify, primarily those who are over age 65 or under age 65 and are totally and permanently disabled. Medicare coverage is available regardless of income level. The program is government subsidized and operated.

MEDICALLY NECESSARY

Healthcare services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental Illness, substance use disorder, condition, disease or its symptoms, that are all of the following

as determined by the Claims Administrator or its designee, within the Claims Administrator's sole discretion. The services must be:

- in accordance with Generally Accepted Standards of Medical Practice;
- clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness, substance use disorder disease or its symptoms;
- not mainly for your convenience or that of your doctor or other health care provider; and
- not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your Sickness, Injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on Physician specialty society recommendations or professional standards of care may be considered. The Claims Administrator reserves the right to consult expert opinion in determining whether health care services are Medically Necessary. The decision to apply Physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Claims Administrator's sole discretion.

The Claims Administrator develops and maintains clinical policies that describe the Generally Accepted Standards of Medical Practice scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Claims Administrator and revised from time to time), are available to Covered Persons on [**www.myuhc.com**, or **mymedica.com**, residents in MA, ME, NH use **www.myharvardpilgrim.org** or by calling the number on your ID card, and to Physicians and other health care professionals on UnitedHealthcareOnline].

MEDICARE

The US Federal government's health insurance program, administered by the Social Security Administration, that pays certain hospital and medical expenses for those who qualify, primarily those who are over age 65 or under age 65 and are totally and permanently disabled. Medicare coverage is available regardless of income level. The program is government subsidized and operated.

NOTICE OF CREDITABLE COVERAGE

The Medicare Modernization Act requires all group health plan sponsors that offer prescription drug coverage to provide notices to covered employees, retirees, and their dependents who are eligible for Medicare's new prescription drug benefit (Part D).

OUT-OF-NETWORK PROVIDERS

Non-preferred health care providers who do not charge reduced fees to members.

OUT-OF-POCKET EXPENSES

Subject to the following, the maximum amount you have to pay (excluding your contributions to participate in the plan) toward the cost of your medical care in the course of one year. There are some services and charges that do not count towards the out-of-pocket maximum, such as amounts exceeding plan limits, amounts exceeding the network negotiated price for prescription drugs, amounts your physician or health care provider may charge above the reasonable and customary charge.

OUTPATIENT

Treatment/care received at a clinic, emergency room or health facility without being admitted as an overnight patient.

A review service that helps ensure you receive proper treatment and services and that these services are provided in the appropriate setting.

Preauthorization/Precertification/Utilization Review

You are responsible for preauthorizing out-of-network services only. Your in-network provider will preauthorize all other services.

PREDETERMINATION OF BENEFITS

This feature helps you estimate how much the Plan may pay (subject to your deductible and Plan maximum at the time the estimate is provided) before you begin treatment. It is intended to avoid any misunderstanding about coverage or reimbursement, and it is not intended to interfere with your course of treatment.

PRE-EXISTING CONDITION

A health problem you had and received treatment for before your current benefit elections took effect.

PRESCRIPTION DRUGS

- **Formulary/Brand Name (Preferred) Prescription Drugs.** A comprehensive list of preferred brand-name drug products that are covered under the plan. Preferred drugs are selected based on safety, effectiveness, and cost.
- **Generic Prescription Drugs.** Prescription drugs, whether identified by chemicals, proprietary or non-proprietary name, that are accepted by the FDA as therapeutically effective and interchangeable with drugs having an identical amount of the same active ingredient as its brand name equivalent.
- **Non-Formulary (Non-Preferred) Prescription Drugs.** Prescription drugs that do not appear on the formulary list are considered non-formulary or non-preferred; these drugs may either be excluded from coverage or may cost more.

PREVENTIVE/WELLNESS CARE

Annual examinations or routine care covered under the plan; care that prevents or slows the course of an illness or disease or care that maintains good health.

QUALIFIED FAMILY STATUS CHANGE (STATUS CHANGE, QUALIFIED CHANGE IN FAMILY STATUS, LIFE OR FAMILY CHANGE)

An event that changes your benefit eligibility. For example, getting married and having a child or your spouse or dependent lose other coverage. You can make certain changes to your before-tax benefit elections that are due to and consistent with the change in family status.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A court order, judgment or decree that (1) provides for child support relating to health benefits under a plan with respect to the child of a group health plan participant or requires health benefit coverage of such child in such plan and is ordered under state domestic relations law or (2) is made pursuant to a state medical child support law enacted under Section 1908 of the Social Security Act. A QMCSO is usually issued requiring you to cover your child under your health care plan when a parent receiving post-divorce custody of the child is not an employee.

QUALIFYING EVENT

A "qualifying event" under COBRA includes loss of coverage as a result of your leaving the Company (other than for gross misconduct); a reduction in hours, your death, divorce or legal separation; your eligibility for Medicare, or a dependent child's loss of dependent status; or, if you are a retiree, loss of coverage due to the Company filing for bankruptcy.

REASONABLE & CUSTOMARY (R&C) CHARGES/FEES

Charges/fees that do not exceed the prevailing charges for comparable services in your provider's area. The Claims Administrator determines these limits based on the complexity of the service, the range of services provided and the prevailing charge level in the geographic area where the provider is located. The plan's reasonable and customary guidelines include up to the 85th percentile of providers' charges in the area.

The plan does not cover amounts charged by providers in excess of the reasonable and customary charge for any service or supply. The Claims Administrator regularly reviews the reasonable and customary charge schedule. To confirm whether your provider's charges are within the reasonable and customary limit, obtain a Predetermination of Benefits.

WAITING PERIOD/ELIMINATION PERIOD

The amount of time you must wait before being able to participate in a plan.

Benefits Handbook Date September 1, 2016

Administrative Information

Marsh & McLennan Companies

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.

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

In This Section

See Page

How the Benefits Handbook Is Used

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

The Claims Administrator (or Account Administrator or Plan Administrator, as applicable) for each plan described in the Benefits Handbook uses the description of the applicable plan in the Benefits Handbook to make determinations on claims for benefits under the plan 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 compete 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 are administrative facts 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 Marsh & McLennan Companies, Inc. 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 $350, $800, $1,500 and $2,850 Deductible Plans

Administered by Aetna, Anthem BlueCross BlueShield (Anthem BCBS), UnitedHealthcare (UHC) - all States or insured by Kaiser - CA, CO, GA, MD, VA, Washington and DC.

Medical Plans Available Under Each Carrier

- The Marsh & McLennan Companies $350 Deductible Medical Plan
- The Marsh & McLennan Companies $800 Deductible Medical Plan
- The Marsh & McLennan Companies $1,500 Deductible Medical Plan
- The Marsh & McLennan Companies $2,850 Deductible Medical Plan

The sixteen plans each form 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 Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Plan Administrator

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

Plan Administrator – Deductible Medical Plans
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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

Group Contract Number

Aetna - The group contract number is 868802.

Anthem BCBS - The group contract number is 003330152.

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

- Southern CA: 232189
- Northern CA: 604494
- CO: 35660
- GA: 10165
- OR/WA: 19847
- VA/MD/DC: 23042

UHC - The group contract number is 098400.

Source of Benefits Funding and Trustee

For Aetna, Anthem BCBS and UHC:

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:

Mellon Trust
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 Companies Employer Funded Welfare Benefit Trust by the trustee:

Mellon Trust
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:

Express Scripts.
P.O. Box 14711
Lexington, KY 40512
Phone: +1 800 282 2881
Website: www.express-scripts.com
Group #: MMCRX05

For filing a mail-order prescription drug claim:

Express Scripts
P.O. Box 30493
Tampa, FL 33630-3493
Phone: +1 800 282 2881
Web site: www.express-scripts.com
Group #: MMCRX05

For appealing a medical claim:

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

For appealing a prescription drug claim:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063-000
Attn: Coverage Appeals
Claims Appeal Phone: +1 800 282 2881
Clinical Appeal Phone: +1 800 753 2851

For COBRA coverage:

Trion
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:

Express Scripts
P.O. Box 14711
Lexington, KY 40512
Phone: +1 800 282 2881
Website: www.express-scripts.com
Group #: MMCRX05

For filing a mail-order prescription drug claim:

Express Scripts
P.O. Box 30493
Tampa, FL 33630-3493
Phone: +1 800 282 2881
Web site: www.express-scripts.com
Group #: MMCRX05

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:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063-000
Attn: Coverage Appeals
Claims Appeal Phone: +1 800 282 2881
Clinical Appeal Phone: +1 800 753 2851

For COBRA coverage:

Trion
Phone: +1 866 324 4087

For Kaiser:

Kaiser Customer Service Phone Numbers:

Region	*Toll Free*	*TTY/TTD*
Georgia	+1 888 865 5813	+1 800 255 0056
Northern California	+1 800 464 4000	+1 800 777 1370
Southern California	+1 800 464 4000	+1 800 777 1370
Oregon/Washington	+1 800 813 2000	OR Relay Service - +1 800 735 2900, WA Relay Service -+1 800 833 6384
Colorado	+1 800 632 9700	+1 800 521 4874
Virginia/Maryland/Washington, DC	+1 800 777 7902	+1 866 513 0008

Claims Processing and 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 – NW (Oregon/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

For UHC:

For filing a medical claim:

UnitedHealthcare
P.O. Box 740800
Atlanta, GA 30374-0800
Phone: +1 866 540 5954

For precertification:

UnitedHealthcare
Phone: +1 866 540 5954

For filing a retail prescription drug claim:

Express Scripts
P.O. Box 14711
Lexington, KY 40512
Phone: +1 800 282 2881
Website: www.express-scripts.com
Group #: MMCRX05

For filing a mail-order prescription drug claim:

Express Scripts
P.O. Box 30493
Tampa, FL 33630-3493
Phone: +1 800 282 2881
Web site: www.express-scripts.com
Group #: MMCRX05

For appealing a medical claim:

UnitedHealthcare
P.O. Box 3041
Salt Lake City, UT 84130-0432
Phone: +1 866 540 5954

For appealing a prescription drug claim:

Express Scripts
8111 Royal Ridge Parkway
Irving, TX 75063-000
Attn: Coverage Appeals
Claims Appeal Phone: +1 800 282 2881
Clinical Appeal Phone: +1 800 753 2851

For COBRA coverage:

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

Plan Administrator

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

Plan Administrator – Basic Life Insurance
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

The Plan Administrator is responsible only for determining claims with respect to 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:

Mellon Trust
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 Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Plan Administrator

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

Plan Administrator – Basic Long Term Disability
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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 342134G. The group insurance policy number is GLT-204034.

Source of Benefits Funding and Trustee

The Basic Long Term Disability Plan is partially self-insured by the Company and partially insured by 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 Companies Employer Funded Welfare Benefit Trust by the trustee:

Mellon Trust
135 Santilli Highway
Everett, MA 02149

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

The Company has engaged the services of 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 946710
Maitland, FL 32794-6710
Phone: +1 800 303 9744
Fax: +1 407 919 6329

For filing a claim:

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

For regular mail:
The Hartford
P.O. Box 14306
Lexington, KY 40512-4306

For overnight mail:
The Hartford – Maitland Disability
2432 Fortune Drive
Lexington, KY 40509

For appealing a claim:

The Hartford
P.O. Box 14087
Lexington, KY 40512-4087
Fax: +1 855 339 7249

Best Doctors Program

Plan Name

The Best Doctors Program

The Best Doctors 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 Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Plan Administrator

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

Marsh & McLennan Companies, Inc. – Best Doctors
c/o Global Benefits, 6th Floor
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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

Group Contract Number

N/A

Source of Benefits Funding

The Best Doctors 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:

Best Doctors
1 Boston Place, 32nd Floor
Boston, MA 02108
Phone: +1 866 904 0910

For appealing a claim:

Best Doctors
1 Boston Place, 32nd Floor
Boston, MA 02108
Phone: +1 866 904 0910

For COBRA coverage:

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

Plan Administrator

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

Plan Administrator – Business Travel Accident Insurance
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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

Group Contract Number

The active group contract number is GTP 9129189-A.

Source of Benefits Funding

The Business Travel Accident Insurance Plan is insured through a contract with the National Union Fire Insurance Company of Pittsburgh, a division of American International Group (AIG), and is solely responsible for paying benefits. 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

For filing a claim:

National Union Fire Insurance Company of Pittsburgh, PA a division of American International Group (AIG)
AIG Claims
P.O. Box 25897
Shawnee Mission, KS 66225
Phone: +1 800 551 0824

For appealing a claim:

National Union Fire Insurance Company of Pittsburgh, PA a division of American International Group (AIG)
AIG Claims
P.O. Box 25897
Shawnee Mission, KS 66225
Phone: +1 800 551 0824

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

Plan Administrator

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

Plan Administrator – Dental Plan
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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 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:

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, 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:

Trion
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 forms part of the Marsh & McLennan Companies Health & Welfare Benefits Program, but 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 Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Plan Administrator

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

Plan Administrator – DCFSA
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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 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 trustees:

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

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

Claims Administrator

For sending a claim:

Trion Spending Account Service Center
2300 Renaissance Boulevard
King of Prussia, PA 19406
Phone: +1 866 324 4087
Fax: +1 888 788 1928

For appealing a claim:

Trion Spending Account Service Center
2300 Renaissance Boulevard
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 Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Plan Administrator

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

Marsh & McLennan Companies, Inc. – Employee Assistance Program
c/o Global Benefits, 6th Floor
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

The Plan Administrator is responsible only for determining claims with respect to 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 Companies 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:

Trion
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:

- Best Doctors Program
- The Business Travel Accident Insurance Plan
- The Employee Assistance Program (EAP)
- The Healthyroads Program
- 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 Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Plan Administrator

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

Marsh & McLennan Companies, Inc.
c/o Global Benefits, 6th Floor
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

The Plan Administrator is responsible only for determining claims with respect to 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 Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

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, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794

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

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:

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

Plan Administrator

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

Plan Administrator – HMSA HMO
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

The Plan Administrator is responsible only for determining claims with respect to 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 trustees:

Mellon Trust
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:

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

Plan Administrator

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

Plan Administrator – HMSA PPP
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

The Plan Administrator is responsible only for determining claims with respect to 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 trustees:

Mellon Trust
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:

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

Plan Administrator

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

Plan Administrator – HCFSA
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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 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 trustees:

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

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

Claims Administrator

For sending a claim:

Trion Spending Account Service Center
2300 Renaissance Boulevard
King of Prussia, PA 19406
Phone: +1 866 324 4087
Fax: +1 888 788 1928

For appealing a claim:

Trion Spending Account Service Center
2300 Renaissance Boulevard
King of Prussia, PA 19406
Phone +1 866 324 4087
Fax: +1 888 788 1928

For COBRA coverage:

Trion
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 held at Trion, the HSA custodian. 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 are:

Mellon Trust
135 Santilli Highway
Everett, MA 02149

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

Claims Administrator

The Claims Administrator processes HSA reimbursement claims for Trion.

For sending a completed claim:

Trion Spending Account Service Center
2300 Renaissance Boulevard
King of Prussia, PA 19406
Phone: +1 866 324 4087
Fax: +1 888 788 1928

For appealing a claim:

Trion Spending Account Service Center
2300 Renaissance Boulevard
King of Prussia, PA 19406
Phone: +1 866 324 4087
Fax: +1 888 788 1928

The Healthyroads Program

Plan Name

The Healthyroads Program

This program includes the Healthyroads Lifestyle Coaching Program, Healthyroads Connected! Program, Healthyroads Biometric Screenings Program and the Active&Fit Program and forms part of the Marsh & McLennan Companies Group Benefits Plan.

Plan Number

503

Plan Type

This is a wellness plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

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

Plan Administrator

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

Marsh & McLennan Companies, Inc. – Healthyroads Program
c/o Global Benefits, 6th Floor
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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

Source of Benefits Funding

The Healthyroads Program is provided through a contract with Healthyroads. Healthyroads is the Claims Administrator, that administers claims for this program, except with respect to claims for eligibility to participate, and is solely responsible for providing benefits.

Claims Administrator

For filing a claim:

Healthyroads
Attn: Appeals and Grievance Department
P.O. Box 509040
San Diego, CA 92150-9040
Phone: +1 877 330 2746
Email: service@healthyroads.com

For appealing a claim:

Healthyroads
Attn: Appeals and Grievance Department
P.O. Box 509040
San Diego, CA 92150-9040
Phone: +1 877 330 2746
Email: service@healthyroads.com

For COBRA coverage:

Trion
Phone: +1 866 324 4087

The HelloWallet Program

Plan Name

The HelloWallet Program

The HelloWallet Program is an online financial planning tool available to employees. The HelloWallet Program is not a plan subject to ERISA.

Plan Sponsor

N/A

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

Plan Administrator

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

Plan Administrator – Legal Assistance Plan
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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 130.

Source of Benefits Funding

The Legal Assistance Plan is provided through a contract with Hyatt Legal Plans, Inc. Hyatt Legacy Plans, Inc. 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 Hyatt Legal Plans, Inc.

Claims Administrator

For filing a claim:

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

For appealing a claim:

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

For converting your coverage:

Hyatt Legal Plans, Inc.
Phone: +1 800 821 6400
Website: legalplans.com

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

Plan Name

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

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

Plan Administrator

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

Plan Administrator – Limited Purpose HCFSA
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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 36-2668272.

Source of Benefits Funding and Trustee

The Limited Purpose 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 trustees:

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

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

Claims Administrator

For sending a claim:

Trion Spending Account Service Center
2300 Renaissance Boulevard
King of Prussia, PA 19406
Phone: +1 866 324 4087
Fax: +1 888 788 1928

For appealing a claim:

Trion Spending Account Service Center
2300 Renaissance Boulevard
King of Prussia, PA 19406
Phone: +1 866 324 4087
Fax: +1 888 788 1928

For COBRA coverage:

Trion
Phone: +1 866 324 4087

Long Term Care Insurance Plan

Plan Name

Marsh & McLennan Companies Long Term Care Insurance Plan

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

Plan Number

501

Plan Type

This is a long term care plan.

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

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

Plan Administrator

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

Plan Administrator – Long Term Care Insurance
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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

Group Policy Number

The group policy numbers are 11034 and 11035.

Source of Benefits Funding

The Long Term Care Insurance Plan is insured through contracts with Genworth Life Insurance Company – Group LTC, 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 benefits.

Contributions are intended to be made solely by participating employees.

Claims Administrator

For filing a claim:

Genworth Life Insurance Company
Group Processing Center – Marsh & McLennan Companies
P.O. Box 64010
St. Paul, MN 55164-0010

For appealing a claim:

Genworth Life Insurance Company
Group Processing Center – Marsh & McLennan Companies
P.O. Box 64010
St. Paul, MN 55164-0010

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

Plan Administrator

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

Plan Administrator – Long Term Disability Bonus Income Plan
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

The Plan Administrator is responsible only for determining claims with respect to 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.

Contributions 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

For filing a claim:

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

For regular mail:
The Hartford
P.O. Box 14306
Lexington, KY 40512-4306

For overnight mail:
The Hartford – Maitland Disability
2432 Fortune Drive
Lexington, KY 40509

For appealing a claim:

The Hartford

P. O. Box 14087
Lexington, KY 40512-4087
Fax: +1 855 339 7249

The Marsh & McLennan Companies Health & Welfare Benefits Program

Plan Name

Marsh & McLennan Companies Health & Welfare Benefits Program

The plan provides health, dependent care, long-term 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 $350, $800, $1,500 and $2,850 Deductible Plans
- The Basic Life Insurance Plan
- The Basic Long Term Disability Plan
- Dental Plan
- The Dependent Care Flexible Spending Account Plan (DCFSA)
- 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)
- Long Term Care Insurance Plan
- 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 Companies, Inc.
Waterfront Corporate Center
121 River Street - Sixth Floor
Hoboken, NJ 07030-5794

Plan Administrator

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

Marsh & McLennan Companies, Inc.
c/o Global Benefits, 6th Floor
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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.

The Marsh & McLennan Companies Retirement Plan A

Plan Name

Marsh & McLennan Companies Retirement Plan A

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

Information regarding eligibility to participate in the Marsh & McLennan Companies Retirement Plan A can be found in the *Marsh & McLennan Companies Retirement Plan A* 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 A
c/o Global Benefits Department, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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 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 Chief Executive Officer of the Company or the Board to manage and supervise Plan Investments.

Claims Administrator

For filing a claim:

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

For appealing a claim:

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

The Marsh & McLennan Companies Retirement Plan B

Plan Name

Marsh & McLennan Companies Retirement Plan B

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

Information regarding eligibility to participate in the Marsh & McLennan Companies Retirement Plan B can be found in the *Marsh & McLennan Companies Retirement Plan B* 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 B
c/o Global Benefits Department, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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 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 Chief Executive Officer of the Company or the Board to manage and supervise Plan Investments.

Claims Administrator

For filing a claim:

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

For appealing a claim:

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

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

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, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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 342135G. The group insurance policy number is GLT-204034.

Source of Benefits Funding and Trustee

The Optional Long Term Disability Plan is partially self-insured by the Company and partially insured by 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:

Mellon Trust
135 Santilli Highway
Everett, MA 02149

The Company pays the premiums for the insured portion of the plan directly to 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 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 946710
Maitland, FL 32794-6710
Phone: +1 800 303 9744
Fax: +1 407 919 6329

For filing a claim:

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

For regular mail:
The Hartford
P.O. Box 14306
Lexington, KY 40512-4306

For overnight mail:
The Hartford – Maitland Disability
2432 Fortune Drive
Lexington, KY 40509

For appealing a claim:

The Hartford
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 Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030

Plan Administrator

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

Plan Administrator – Voluntary AD&D
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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

Group Contract Number

The group insurance contract number for active employees is PAI 9131403.

The group insurance contract number for retired employees is PAI 8062289.

Source of Benefits Funding

The Voluntary AD&D Plan is fully insured through contracts with National Union Fire Insurance Company, a Chartis Company. Chartis 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 is solely responsible for paying benefits.

Contributions are made solely by participating employees and retirees.

Claims Administrator

National Union Fire Insurance Company, an AIG Company
32 Old Slip, 22nd floor
New York, NY 10005
Phone: +1 800 551 0824

For filing a claim:

National Union Fire Insurance Company, an AIG Company
A&H Claims Division
P.O. Box 25987
Shawnee Mission, KS 66225
Phone: +1 800 551 0824

For appealing a claim:

National Union Fire Insurance Company, an AIG Company
A&H Claims Division
P.O. Box 25987
Shawnee Mission, KS 66225
Phone: +1 800 551 0824

For converting your coverage:

National Union Fire Insurance Company, an AIG Company
c/o Reuben Warner Associates
1655 Richmond Avenue
Staten Island, New York 10312
Phone: +1 718 477 3700

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

Plan Administrator

The Plan Administrator can be reached at:

Plan Administrator – RRA
c/o Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

The Plan Administrator is responsible only for determining claims with respect to 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:

Mellon Trust
135 Santilli Highway
Everett, MA 02149

Benefits are payable solely from the trust.

The Company has engaged the services of the Claims Administrator, who is responsible for processing claims for this self-insured plan, 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 both a stock bonus 401(k) savings plan and an employee stock ownership 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 Companies, Inc.
1166 Avenue of the Americas
New York, NY 10036-2774

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
c/o Global Benefits Department, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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://colleagueconnect.mmc.com. 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
c/o Global Benefits Department, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794

For appealing a claim:

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

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 Companies
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, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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://colleagueconnect.mmc.com. 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
c/o Global Benefits Department, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794

For appealing a claim:

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

The Short Term Disability Benefits Policy

Plan Name

Marsh & McLennan Companies Short Term Disability Benefits Policy

Plan Type

N/A

Plan Year

The plan year is January 1 - December 31.

Plan Sponsor

The Plan Sponsor is:

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

Plan Administrator

The Plan Administrator can be reached at:

Plan Administrator – Short Term Disability
Global Benefits, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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

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

Claims Administrator

For filing a claim:

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

For filing an appeal:

The Hartford-Comprehensive Employee Benefit Services Company
Maitland Claim Appeal Unit
P.O. Box 946710
Maitland, FL 32794
Phone: +1 800 303 9744

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

Plan Administrator

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

Plan Administrator – Vision Care Plan
c/o Global Benefits Department, 6th Floor
Marsh & McLennan Companies, Inc.
Waterfront Corporate Center
121 River Street
Hoboken, NJ 07030-5794
Telephone: +1 201 284 4000

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 30052197.

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 997100
Sacramento, CA 95899

For appealing a claim:

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

For COBRA coverage:

Trion
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 Companies, Inc.
1166 Avenue of the Americas
New York, NY 10036

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

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 $350, $800, $1,500 and $2,850 Deductible Plans
- The Basic Life Insurance Plan
- The Basic Long Term Disability Plan
- The Best Doctors 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 Healthyroads Program
- The Legal Assistance Plan
- The Limited Purpose Health Care Flexible Spending Account Plan (LPHCFSA)

- The Long Term Care Insurance Plan
- The Long Term Disability Bonus Income Plan
- The Optional 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 A
- The Marsh & McLennan Companies Retirement Plan B
- 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 64.

- 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 A/B (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. Currently, updated monthly statements are available on Total Rewards accessible via Colleague Connect (**https://colleagueconnect.mmc.com**).

- For applicable plans, continue health care coverage for yourself, spouse, or covered family members if there is a loss of coverage under the plan as a result of a qualifying event. You or your covered family members 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 59, are required to provide Summary Plan Descriptions (SPDs) for those plans. This Benefits Handbook serves as the Summary Plan Description for the following plans:

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.

Health & Welfare Plans

- The $350, $800, $1,500 and $2,850 Deductible Plans
- The Basic Life Insurance Plan
- The Basic Long Term Disability Plan
- The Best Doctors 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 Healthyroads Program
- The Health Care Flexible Spending Account Plan (HCFSA)
- The Legal Assistance Plan
- The Limited Purpose Health Care Flexible Spending Account Plan (LPHCFSA)
- The Long Term Care Insurance Plan
- The Long Term Disability Bonus Income Plan
- The Optional 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 A

- The Marsh & McLennan Companies Retirement Plan B
- 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 A/B SAR has been replaced with a Marsh & McLennan Companies Retirement Plan A/B 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.

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	▪ Marsh & McLennan Companies 401(k) Savings and Investment Plan
Marsh & McLennan Agency 401(k) Savings and Investment Plan		2014	▪ Marsh & McLennan Agency 401(k) Savings and Investment Plan
Marsh & McLennan Companies, Inc. Health & Welfare Benefits Program		2014	▪ 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 ▪ Long Term Care Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Group Benefits Plans		2014	▪ 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		2014	▪ Mercer HR Services Retirement Plan
The Comprehensive Medical Plan		2014	▪ 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	▪ 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	▪ Marsh & McLennan Agency 401(k) Savings and Investment Plan
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	▪ 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 ▪ Long-Term Care Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
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	▪ 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/handbook.connect.mmc.com/Prod/CURR/004-Mercer-HR-Services-Retirement-Plan-2013-Summary-Anuual-Report.pdf	2013	▪ 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	▪ 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	▪ 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	▪ Marsh & McLennan Agency 401(k) Savings and Investment Plan
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	▪ 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 ▪ Long-Term Care Plan

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
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	▪ 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/004- Mercer HR Services Retirement Plan-2012 Summary Annual Report.pdf	2012	▪ 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	▪ 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	▪ 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	▪ 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	▪ Optional Long-Term Disability Plan ▪ Optional Life Insurance Plan ▪ Long-Term Care Plan
Marsh & McLennan Companies, Inc. Employer Funded Welfare Benefit Trust	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/MMC-Employer-Funded-Welfare-Benefit-Plan-2011-SAR.pdf	2011	▪ 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)

Annual Funding Notice/ SAR	PDF Link	Covering Year(s)	Reporting on Plan(s)
Marsh & McLennan Companies, Inc. Group Benefits	http://mmcbenefits-handbook.connect.mmc.com/Prod/CURR/MMC-Group-Benefits-Plans-2011-SAR.pdf	2011	▪ 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	▪ 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	▪ 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 HelloWallet Program
- Identity Protection Benefit Program
- The Personal Life Insurance Plan

- The Pet Insurance Program
- The Short Term Disability Benefits 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 $350, $800, $1,500 and $2,850 Deductible Plans (through Aetna, Anthem BCBS and UHC)
- The Basic Life Insurance Plan
- The Basic Long Term Disability Plan
- The Best Doctors Program
- The Business Travel Accident Insurance Plan
- The Dental Plan
- The Dependent Care Flexible Spending Account Plan (DCFSA)
- 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 Healthyroads Program
- The Legal Assistance Plan
- The Limited Purpose Health Care Flexible Spending Account Plan (LPHCFSA)
- The Long Term Care Insurance Plan
- The Long Term Disability Bonus Income Plan
- The Optional 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 Companies, Inc.'s General Counsel. A copy of any of these documents will be furnished to a plan participant or beneficiary (or an authorized representative) upon request at a reasonable charge of up to 25 cents per page to cover reproduction and handling. 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 Companies, Inc.'s internal employee communication channels, and, where applicable, the plan's Guide to Benefits.

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 Companies, Inc. 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 Companies, Inc.'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 Companies intends to continue the retirement and savings plans described in the Benefits Handbook indefinitely, Marsh & McLennan Companies 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 Companies periodically evaluates its benefits programs.

However, if Marsh & McLennan Companies 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 Companies' 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 A/B 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 A/B, 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 A/B 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.

For the 2015 plan year, 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 March 15th and submitted no later than May 31st of the year following the Plan Year to which the expense was attributable (including any grace periods).

For plan years beginning on or after January 1, 2015, 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 May 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 A/B, 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.

Fully Insured Medical Plans

Refer to the 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, Best Doctors, RRA, EAP, and Healthyroads Benefit Determinations

This section applies to the following health care plans:

- $350, $800, $1,500 and $2,850 Deductible Plans (unless insured by Kaiser)
- 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
- Best Doctors Program
- Marsh & McLennan Companies RRA
- Marsh & McLennan Companies Employee Assistance Program
- Healthyroads 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.

Claims Concerning Eligibility and Enrollment

If your claim concerns whether or not you or a family member is eligible for coverage under the plan or whether you or a family member has properly enrolled in the plan, you may file a claim with the Plan Administrator for coverage. The claim should be in writing

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

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 $350, $800, $1,500, and $2,850 Deductible Plans only)
- include the denial code and corresponding meaning (for $350, $800, $1,500, and $2, 850 Deductible Plans 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 $350, $800, $1,500, and $2, 850 Deductible Plans only)
- describe the Claims Administrator's or Insurer's standard, if any, used in denying the claim (for $350, $800, $1,500, and $2,850 Deductible Plans only)
- describe the external review process, if applicable (for $350, $800, $1,500, and $2,850 Deductible Plans 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 $350, $800, $1,500, and $2,850 Deductible Plans only)

External Appeals Review

Only with respect to the $350, $800, $1,500, and $2,850 Deductible Plans, 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

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 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 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 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)
- 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)
- describe any voluntary appeal procedures offered by the plan and your right to obtain information about such procedures (appeal only)

Life Insurance, Accident Insurance, Legal Assistance, and Long Term Care 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
- Marsh & McLennan Companies Long Term Care Insurance 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

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 effect 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 provides 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 approved spouse or domestic partner in the event of your death) must contact the Claims Administrator and pay the required contribution within 31 days of the date you lose coverage.

Long Term Care Plan

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

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.

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

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 Companies, Inc.

If a Mistake Occurs

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

Right of Recovery

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 with 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.

JS 44 (Rev. 07/16)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

B.S., by and through her parents and guardians, To.S. and Ti.S., individually on behalf of similarly situated individuals, and derivatively on behalf of the MARSH & MCLENNAN COMPANIES, HEALTH & WELFARE BENEFITS PROGRAM

(b) County of Residence of First Listed Plaintiff Kitsap
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, Email and Telephone Number)*
David Tykulsker & Associates
161 Walnut St.,
Montclair, NJ 07042 (973) 509-9292; david@dtesq.com

DEFENDANTS

MARSH & MCLENNAN COMPANIES, INC. BENEFITS ADMINISTRATION COMMITTEE, THE MARSH & MCLENNAN COMPANIES HEALTH & WELFARE BENEFITS PROGRAM, MARSH & MCLENNAN COMPANIES, INC., AND AETNA LIFE INSURANCE COMPANY

County of Residence of First Listed Defendant Hudson
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*
(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☒ 4
Citizen of Another State	☒ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

CIVIL RIGHTS
- ☐ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☒ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 840 Trademark

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing *(Do not cite jurisdictional statutes unless diversity)*:
29 U.S.C. §§ 1132, 1185a, 1185d; 42 U.S.C. § 300gg- 5(a)

Brief description of cause:
Action to redress defendants' use of a hidden and illegal exclusion of mental health benefits

VII. REQUESTED IN COMPLAINT:

☒ CHECK IF THIS IS A CLASS ACTION UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☐ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions):
JUDGE _____ DOCKET NUMBER _____

DATE 5-11-17

SIGNATURE OF ATTORNEY OF RECORD David Tykulsker

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____