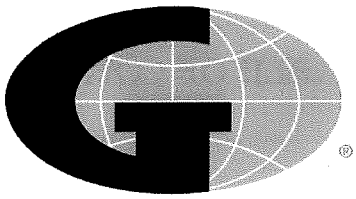

Arthur J. Gallagher & Co.

MASTER PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION OF ARTHUR J. GALLAGHER & CO. (ILLINOIS) EMPLOYEE'S SELF-FUNDED MEDICAL/DENTAL PLAN And INSURED BENEFITS (INCLUDING SEVERANCE PLAN, INSURED BASIC LIFE, AD&D, LONG TERM DISABILITY, BUSINESS TRAVEL ACCIDENT, VOLUNTARY AD&D, VOLUNTARY VISION, VOLUNTARY GROUP UNIVERSAL LIFE, GROUP LEGAL and EMPLOYEE ASSISTANCE PLAN)

Amended and Restated January 1, 2014

TABLE OF CONTENTS

I. INTRODUCTION

This document, when attached to the applicable benefit booklets, insurance certificates and group insurance contracts serves as the Master Plan Document and as the Summary Plan Description for this Plan required by ERISA §102 and §402. This document describes the conditions under which this Plan will pay for medical and/or dental care. There may be circumstances when a Participant and his provider determine that care that is not covered by this Plan is appropriate. All decisions regarding care are up to a Participant and his provider. This document describes the conditions of coverage for basic life, and accidental death and dismemberment, long term disability, business travel accident, employee assistance benefits, severance plan, voluntary vision insurance, voluntary accidental death and dismemberment, voluntary group universal life, and group legal.

Several factors affect the Participant's receipt of the benefits described in the booklets. The Participant must be properly enrolled and have coverage that is effective and which is not limited by an exclusion. The Participant's benefits are subject to coverage limits, claims limitations, satisfaction of Participant costs, and coordination of benefits provisions.

Arthur J. Gallagher & Co. (Illinois) ("Gallagher") maintains this health & welfare benefit plan for the exclusive benefit of eligible Employees (as defined) and their eligible Dependents (as defined). Some of these benefits are self-funded and some are insured. The Plan benefits are summarized in the self-funded benefit schedules and applicable certificates of insurance. Each benefit offered under the Plan is governed by a legal contract or benefit booklet, which serves as the final authority with respect to that benefit in the event of any discrepancies with the information in this summary. However, with regard to provisions governing basic eligibility for coverage, the provisions of this summary and the applicable legal contract or benefit booklet will be read together, and an individual must satisfy the requirements specified in both documents in order to be eligible for coverage. In the event of a direct conflict in such provisions, the more restrictive eligibility provision will apply. Gallagher reserves the right to change or end any of its benefits plans at any time and for any reason.

Participants should read this entire Plan document including all exhibits and/or attachments to ensure that all requirements and conditions of the Plan are fully understood.

Plan Document: The written plan document required by ERISA §402 consists of this document, together with self-funded benefits booklets and group insurance contracts.

II. SUMMARY OF PLAN BENEFITS

A. SELF-FUNDED BENEFITS

The Plan provides Eligible Employees and their Dependents, if applicable, with medical, dental, and prescription drug benefits. The Plan also provides Eligible Employees and their Spouses with certain wellness benefits. These health benefits are self-funded. A summary of the benefits provided under the Plan is set forth in the appropriate schedules of benefits, and benefit booklets.

This Plan shall provide benefits in accordance with the applicable requirements of Federal law.

This Plan will also provide benefits as required by any qualified medical child support order, as defined in ERISA §609(a). A copy of the procedures governing qualified medical child support orders (QMCSOs) may be obtained without charge from the Plan Administrator. This Plan will also provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of Dependent children who are biological children of Participants or Beneficiaries, in accordance with ERISA §609(c).

Under the federal law entitled Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers offering group insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours) or require that a provider obtain authorization from the plan or the insurance issuer from prescribing a length of stay not in excess of the above periods.

The federal law entitled the Women's Health and Cancer Rights Act requires coverage for reconstructive surgery following mastectomies. Accordingly, this Plan shall provide, in a case of a Participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction with such mastectomy, coverage for:

(a) reconstruction of the breast on which the mastectomy has been performed;

(b) surgery and reconstruction of the breast to produce a symmetrical appearance; and

(c) prostheses and physical complications for all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and benefit percentage provisions as may be deemed appropriate and as are consistent with those established for other benefits under the Plan.

B. INSURED BENEFITS

The plan provides Eligible Employees with basic life, AD&D, long term disability, business travel accident, voluntary AD&D, voluntary group universal life insurance, group legal, and voluntary vision. These fully insured benefits are provided under group insurance contracts entered into between Arthur J. Gallagher & Company and the insurance companies. Summaries of the insured benefits provided under the plan are stated in the certificates of insurance.

C. The plan provides Eligible employees with an employee assistance plan and a severance plan. Details of these plan provisions are stated on the Gallagher One Portal.

III. ELIGIBILITY AND ENROLLMENT

A. ELIGIBILITY

This section describes the Plan's eligibility provisions. You need to read it very carefully. By enrolling any person in the Plan, you state, represent, and agree to all of the following:

- You understand the Plan's eligibility requirements
- The person you enroll meets the Plan's eligibility requirements
- If the person ceases to meet the eligibility requirements you will immediately notify the Employer
- You understand that the Employer reserves the right to require you, as a condition of eligibility and at any time, to submit proof of eligibility of any person you enroll and you agree to provide the required proof within the time specified by the Employer
- You understand that meeting the eligibility requirements and providing required proof of eligibility are material conditions of enrollment and continued coverage under the Plan
- You understand that enrolling a person who does not meet the eligibility requirements, failing to notify the Employer immediately if a person ceases to meet the eligibility requirements, or refusing or failing to provide required proof of eligibility constitutes fraud or an intentional misrepresentation of material fact and is prohibited by the Plan
- If a person does not meet the eligibility requirements at the time of enrollment, the Employer will cancel that person's coverage as of the date of enrollment
- If a person ceases to meet the eligibility requirements at a time after enrollment, the Employer will cancel that person's coverage as of the date that person ceased to meet the eligibility requirements
- If you refuse or fail to provide required proof of eligibility for a person, the Employer will cancel that person's coverage as of the date of enrollment or such other date as the Employer determines, in its sole discretion, to be appropriate
- If you enroll a person who does not meet the eligibility requirements, or if you fail to notify the Employer immediately if a person ceases to meet the eligibility requirements, or refuse or fail to provide required proof of eligibility for a person, you may be financially and legally responsible for all health care expenses incurred during the period of ineligibility and you may be subject to disciplinary action and criminal charges

The following individuals are eligible:

1. EMPLOYEE

i) An Eligible Employee is:

- **Full-Time Employees**- An active Employee, who is directly employed in the regular business of and compensated for services by the Employer and who the Employer classifies as regularly expected to work 30 or more hours per week will be considered a Full-Time Employee and will be an Eligible Employee;
- **Non-Full-Time Employees-** Certain Employees who are directly employed in the regular business of and compensated for services by the Employer, but who are not classified by the

Employer as Full-Time Employees as described above, may become Eligible Employees for purposes of medical coverage only, as described below.

- **New-Hires.** Some Employees may not be classified as Full-Time Employees at time of hire. That may occur because the Employee is expected to work less than 30 hours per week, is hired into a position for which customary employment is six months or less (e.g., summer interns), or is hired into a position where Employer is not certain of the hours the employee will work (e.g., "casual hour" employees). These Employees may become eligible for medical coverage if, during the 11 month period beginning on their date of hire, they average 130 hours of service per month. This 11 month period is referred to as the Employee's "Initial Measurement Period." An Employee who averages 130 hours of service in his or her Initial Measurement Period will be considered an Eligible Employee for medical coverage during the 12 month period that begins on the first day of the second calendar month after the Employee's Initial Measurement Period ends (provided he or she remains employed during that period). This 12 month period is referred to as the Employee's "Initial Stability Period." For example, a Non-Full-Time Employee hired on June 15, 2015 would have an Initial Measurement Period that ended on May 14, 2016. If the Employee averaged 130 hours per month during that Initial Measurement Period, the Employee would become an Eligible Employee on July 1, 2016.

- **Ongoing Employees**. Hours of service are also measured during each 12 month period running from October 3rd through the following October 2nd. These 12 month periods are referred to as the "Standard Measurement Period." An Employee who averages 130 hours per month during a Standard Measurement Period will be considered an Eligible Employee for medical coverage for the following calendar year (provided he or she remains employed during that period). This 12 month period is referred to as the "Standard Stability Period." For example, a long-time Employee who has historically worked 15 hours per week will have his or her hours of service measured during the Standard Measurement period running from October 3, 2015 through October 2, 2016. If the employee averages 130 hours per month during that Standard Measurement Period, the Employee would become an Eligible Employee on January 1, 2017.

Hours of service for purposes of determining monthly averages during these Measurement Periods will be determined in accordance with IRS rules.

- **Retirees**- For purposes of medical benefits , "Eligible Employee" will include a retired Employee, who had attained age 55 and had 10 or more years of service with the Employer as of September 30, 1992, and who was covered under this Plan on the date immediately prior to retirement.

ii) The following Employees are not Eligible Employees:

- Employees who are members of a unit of employees covered by a collective bargaining agreement between employee representatives and the Employer if health care benefits were the subject of good faith bargaining between the Employer and such representatives, unless the collective bargaining agreement requires such employees to participant in the Plan.
- Except as described above for purposes of medical benefits, Employees of the Employer who are classified as seasonal or temporary employees on the books and records of the Employer.
- Individuals treated by the Employer as independent contractors, regardless of whether they may be classified as employees for purposes of any federal or state tax or employment law.

- Leased employees within the meaning of Code Section 414(n).
- Nonresident aliens with no U.S. source of income.

iii) Acquisitions and Other Business Transactions. An individual who becomes an Employee as a result of an acquisition of a business or portion of a business by the Employer shall be considered an Eligible Employee effective as of the date specified or determined under the governing transactional document(s).

- Individuals who became Employees as a result of the purchase by Gallagher Bassett Services, Inc. of MedInsights, Inc. and of the TPA business from GAB Robins North America, Inc. pursuant to the purchase agreement dated as of September 29, 2010 by and among GAB Robins North America, Inc., GAB Robins Risk Management Services, Inc., Gallagher Bassett Services, Inc. and Arthur J. Gallagher & Co became Eligible Employees effective as of January 1, 2011.
- In connection with an acquisition or other business transaction, Gallagher may amend the Plan to provide that individuals who become Eligible Employees as a result of the transaction: receive credit under the Plan for service performed with the employer from whom they were hired: receive credit for deductibles satisfied under their medical coverage at the employer from whom they were hired; are eligible for life insurance coverage in the same amount and/or calculated using earnings figures as in effect at the employer from whom they were hired; or receive other particular treatment with respect to benefits under the Plan. Gallagher is not required to amend the Plan to provide for any such special treatment. If Gallagher decides to amend the Plan to provide for special treatment for such Eligible Employees, it may make such amendment by distributing an explanation of the intended treatment to the affected Eligible Employees and need not make any formal amendment to this Plan document. Any such special treatment shall be applied consistently to similarly situated individuals who become Eligible Employees as a result of the same business transaction.

An Employee who is otherwise eligible to participate in this Plan except that he is a member of one of the ineligible classes described above, shall become an Eligible Employee upon ceasing to be a member of any such ineligible class.

2. DEPENDENTS

i) Spouse

The individual who is the Eligible Employee's spouse as determined under the law of the state or country in which the marriage was performed and who is not legally divorced from the Eligible Employee or whose marriage to the Eligible Employee has not been otherwise legally terminated.

ii) Children

a) For Medical, Dental and Vision Coverage-

An Eligible Employee's child (as defined below) until the date he attains age 26. Effective January 1, 2015, until the last day of the month in which the child reaches age 26.

An Eligible Employee's unmarried child who is already covered under a Plan and who is 26 years of age or older and who, from the date his coverage would otherwise terminate under the Plan, is both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) principally dependent upon the Eligible Employee for support and maintenance and qualifies as an exemption under the Internal Revenue Code. (Proof may be required.)

b) For Life Insurance, Voluntary AD&D Insurance and Voluntary Group Universal Life Insurance-

An Eligible Employee's unmarried child from birth until the date he attains age 19, provided the child is principally dependent on the Eligible Employee for his support and maintenance. (Proof may be required.) An Eligible Employee's unmarried child at least 19 years of age to the date he attains 25 years of age provided the child is a full-time student in an accredited school, is principally dependent on the Eligible Employee for his support and maintenance and qualifies as an exemption under the Internal Revenue Code. (Proof may be required.) An Eligible Employee's unmarried child who is already covered under a Plan and who is 19 years of age or older and who, from the date his coverage would otherwise terminate under the Plan, is both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) principally dependent upon the Employee for support and maintenance and qualifies as an exemption under the Internal Revenue Code. (Proof may be required.)

c) Group Legal-

An Eligible Employee's unmarried children up to age 21 who depend on the Eligible Employee for support.

d) EAP-

An Eligible Employee's children and any other family members who reside in the Eligible Employee's residence. An Eligible Employee's child will be considered to reside in the Eligible Employee's residence while the child is attending college.

e) Proof and Definition

The Employer will have the right to require due proof of the continuation of the mental retardation and/or physical handicap and will have the right and opportunity to examine the child whenever the Employer may reasonably require it during such continuation. After two years have elapsed from the date the child attained the limiting age, only one examination will be required per year.

A "Child" is:

- An Eligible Employee's biological child or legally adopted child. An adopted child shall be considered a "child" from the moment the child is placed in the custody of the parents for adoption; or
- An Eligible Employee's stepchild; or
- An Eligible Employee's foster child (a foster child is an individual who is placed with the Eligible Employee by an authorized placement agency or by judgment, decree or other order of any court of competent jurisdiction); or
- Any child for whom the Eligible Employee has been granted legal guardianship by a court of law; or
- Any child for whom the Eligible Employee is required to provide health care coverage under a Qualified Medical Child Support Order. Participants have the right to obtain applicable determination procedures free of charge from the Plan Administrator.

An Eligible Employee may be required to provide proof of an individual's status as a Child at any time. A Participant cannot be covered simultaneously as an Employee and a Dependent. If both parents of a child are covered for benefits, either but not both may cover the child as a Dependent.

3. DOMESTIC PARTNERS

i. DEFINITION OF DOMESTIC PARTNER

a) "Registered domestic partners" are defined as two people who have a domestic partnership that is currently registered with a governmental body pursuant to state or local law authorizing such registration.

b) "Non-registered domestic partners," whether of the same or opposite sex, are defined as two people who *do not* have a domestic partnership that is currently registered with a governmental body pursuant to state or local law authorizing such registration, but who otherwise meet the following criteria:

1. Are living together in a committed exclusive relationship of mutual caring and support and have shared a common household for a period of at least one continuous year;
2. Intend for the domestic partnership to be permanent;
3. Are financially interdependent such that they are jointly responsible for the common welfare and financial obligations of the household, or the non-employee domestic partner is chiefly dependent upon the employee for care and financial assistance;
4. Are neither legally married to any other individual, and if previously married, a legal divorce or annulment has been obtained or the former spouse is deceased;
5. Are mentally competent to enter into a contract according to the laws of the state in which they reside;
6. Are at least 18 years of age and are old enough to enter into marriage according to the laws of the state in which they reside;
7. Do not have a blood relationship that would bar marriage under applicable laws of the state in which they reside if they otherwise satisfy all other applicable state marriage requirements; and
8. Are not in a relationship solely for the purpose of obtaining benefits; and
9. Have filed an Affidavit of Domestic Partnership, as set forth in Section iii below.

c) "Domestic Partner," as used throughout this document, refers to both registered domestic partners and non-registered domestic partners.

ii. ELIGIBILITY

All Eligible Employees are eligible to enroll for Domestic Partner benefits.

Eligible Employees may enroll for Domestic Partner benefits on behalf of registered domestic partners and non-registered domestic partners. A child of an Eligible Employee's Domestic Partner also is eligible for enrollment to the same extent that a child of an Eligible Employee's spouse is eligible for enrollment. A child of an employee's domestic partner meets the definition of "stepchild" as set forth in the Arthur J. Gallagher & Co. Self-Funded Medical/Dental Plan, and is eligible for enrollment in medical, dental and vision coverage to the same extent that a stepchild is eligible under the Plan. To be eligible for life insurance and AD&D coverage, the child must: (i) reside in the employee's household in a regular parent-child relationship and (ii) be the eligible dependent of the employee (i.e., the child is principally dependent on the employee for support and maintenance and qualifies as an exemption under Internal Revenue Code Section 152).

iii. CERTIFICATION

Employees engaged in a domestic partnership with a non-registered domestic partner must submit a signed and notarized ***Affidavit of Domestic Partnership*** certifying the domestic partnership to begin the enrollment process.

The Affidavit of Domestic Partnership can be found on the Gallagher One Portal and at www.connect2mybenefits.com/ajg.

iv. PAYING FOR DOMESTIC PARTNER BENEFITS

Gallagher pays a portion of the cost to provide certain benefits for employees, spouses, and eligible dependent children. The company's contribution for benefits will be the same whether you choose to cover a spouse or a Domestic Partner. The value of Gallagher's contribution toward coverage for you and your children is tax-free. However, because of IRS requirements, the full cost of Gallagher's share of your Domestic Partner's (and his or her child's) coverage must be added to your income and taxed for any applicable federal, FICA, state, local, or other payroll taxes. This tax effect will not apply if your Domestic Partner (and/or his or her child) qualifies as a tax dependent under IRC Section 152, as modified by IRC Section 105(b). (Proof may be required.)

The total contribution that you pay for medical and/or dental coverage will depend on your coverage tier and earnings level. You will pay the same amount for Domestic Partner coverage as a similarly situated employee will pay for spouse coverage. Premiums for Voluntary Vision, Voluntary AD&D and Group Universal Life coverage for Domestic Partners are determined by the same factors used to calculate premiums for spouses. See Section V below for more information about specific benefit coverages available to Domestic Partners.

Contributions and/or premiums for coverage for yourself and your children will continue to be taken on a pre-tax basis, where applicable. Contributions and/or premiums for coverage of a child of an employee's Domestic Partner will be made on a pre-tax basis to the extent permitted by applicable law. Federal regulations currently require that your contributions and/or premiums for Domestic Partner coverage be made on an after-tax basis unless you certify that your Domestic Partner qualifies as a tax dependent under IRC Section 152, as modified by IRC Section 105(b).

v. BENEFIT PLANS AND DOMESTIC PARTNER COVERAGE

BENEFIT PLAN	DOMESTIC PARTNER ELIGIBILITY
Medical Plan	Domestic partners are eligible for all benefits available through the Medical Plan, including COBRA. A child of an Eligible Employee's Domestic Partner is eligible for enrollment to the same extent that a child of an Eligible Employee's spouse qualifies for enrollment (see Section II above).
Dental Plan	Domestic partners are eligible for all benefits available through the Dental Plan, including COBRA. A child of an Eligible Employee's Domestic Partner is eligible for enrollment to the same extent that a child of an Eligible Employee's spouse qualifies for enrollment (see Section II above).

Voluntary Vision Plan	Domestic partners are eligible for all benefits available through the Medical/Dental Plan, including COBRA. A child of an Eligible Employee's Domestic Partner is eligible for enrollment to the same extent that a child of an Eligible Employee's spouse qualifies for enrollment (see Section II above).
Basic Life/AD&D Plan	Domestic partners are eligible for the same coverage amount provided to spouses. This $5,000 coverage amount is automatic and paid in full by Gallagher; no enrollment is required. A child of an Eligible Employee's Domestic Partner is eligible for enrollment to the same extent that a child of an Eligible Employee's spouse qualifies for enrollment (see Section II above). Each eligible dependent child over the age of 6 months is eligible for $2,500 in company provided Basic Life/AD&D insurance.
Voluntary Group Universal Life (GUL) Plan	Domestic partners are eligible for a coverage amount up to $250,000. Coverage is elected in multiples of $10,000 A child of an Eligible Employee's Domestic Partner is eligible for enrollment to the same extent that a child of an Eligible Employee's spouse qualifies for enrollment (see Section II above). Coverage options are $5,000 or $10,000 for each eligible child.
Voluntary AD&D Plan	Domestic Partners are eligible for coverage under the Family (Domestic) coverage level. A child of an Eligible Employee's Domestic Partner is eligible for enrollment to the same extent that a child of an Eligible Employee's spouse qualifies for enrollment (see Section II above). Eligible children of a Domestic Partner may be covered under the Family (Domestic) coverage option.
Flexible Spending Accounts	Employees may use flexible spending account contributions to reimburse health care or dependent day care expenses of a Domestic Partner and his/her children to the extent permitted by current IRS regulations.
Business Travel Accident Plan	Like spouses, Domestic Partners are eligible for $25,000 of coverage as a class 2 participant under the plan.
WorkLife Program	Domestic partners are covered dependents under the WorkLife program with full access to counseling sessions, informational resource, and assistance.
Group Legal Plan	Benefits for legal services for a wide variety of legal matters are available under the plan to Domestic Partners. An unmarried child of an Eligible Employee's Domestic Partner is also covered to the same extent that an unmarried child of an Eligible Employee's spouse qualifies for coverage (see Section II above).
Leaves of Absence and FMLA	Time off from work, as needed, for birth or adoption of a child, a serious health condition, death, etc., as it applies to members of your household, includes your Domestic Partner.

	Gallagher's Family and Medical Leave of Absence (FMLA) policy is available on the Gallagher One Portal.

vi. DOMESTIC PARTNERSHIP ENROLLMENT

Enrollment for Domestic Partner benefits can occur during Annual Enrollment or, as explained in Section vii below, within 31 days after you either (i) obtain a certification of domestic partnership from a state or local government or (ii) file an Affidavit of Domestic Partnership with Human Resources.

vii. LIFE EVENTS AND DOMESTIC PARTNERSHIPS

Benefits elections that you make during Annual Enrollment are generally effective throughout the following calendar year – January 1 through December 31.

You can change certain benefits elections immediately during the year only if you experience a qualified life event. With regard to your domestic partnership, the following will be considered qualified life events:

- Obtaining a state or local government certification of domestic partnership;
- Filing and approval of an Affidavit of Domestic Partnership;
- Filing and approval of an Affidavit of Termination of Domestic Partnership (which can be found on the Gallagher One Portal and at www.connect2mybenefits.com/ajg);
- Birth, adoption, or placement of a child with you for adoption or foster care, if that child meets the eligibility requirements stated in section 3 ii above;
- Loss of eligible child status;
- Change in your Domestic Partner's employment status and/or benefit eligibility; and
- Death of a dependent, including your Domestic Partner.

Any benefit change(s) must be made through Employee Self Service within 31 days of the date of your qualified life event. Your change(s) must be consistent with the life event. For example, if you acquire a new dependent, adding medical coverage for that dependent would be consistent, but it would not be a reason to drop medical coverage for your family.

viii. Questions about processing life event transactions through Employee Self Service should be sent to HRSupport@ajg.com

ix. BENEFITS COVERAGE DURING A SHORT-TERM DISABILITY

If you are unable to work for an extended period because of illness or injury, you may qualify for short-term disability (STD) benefits. If you are on STD, you may continue your benefit coverage for yourself, your Domestic Partner, and your eligible dependent children by paying the applicable contribution and premium amounts.

x. CONTINUATION OF BENEFITS – COBRA COVERAGE

The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a law that allows you and your eligible dependents to continue group health care coverage after your employment ends if you pay the full cost of coverage.

Although federal law does not require that COBRA apply to your Domestic Partner, Gallagher is offering the option to continue group health care coverage for your Domestic Partner to the same extent as a spouse would be entitled to continued coverage under COBRA.

xi. ADDITIONAL INFORMATION

If you have any questions about your benefits or coverage for domestic partners, please email HRSupport@ajg.com

4. SCREENING PROGRAM ELIGIBILITY

The Plan also offers health screening services as described in information provided by Gallagher. In addition to Eligible Employees and their Spouses and eligible Domestic Partners who are enrolled in the Plan, screening services are available to all Employees and their Spouses and eligible Domestic Partners, whether or not they are enrolled in medical coverage under the Plan. For an individual who is not enrolled in medical coverage under the Plan (whether because the individual is not eligible or because the individual has not been enrolled), participation in medical coverage under the Plan is limited to the screening program and the individual who participates in the screening program is considered a participant in medical coverage under the Plan only on the day on which the individual actually participates in the screening program.

B. NEW HIRE ENROLLMENT

An Eligible Employee hired as a Full-Time Employee (as described in section III.A.1.) on or after the effective date of this Plan becomes eligible for benefits on the first day of active employment. Coverage for benefits becomes effective on the date the Employee is eligible for coverage provided the Employee has enrolled and authorized any required contributions within 31 days of the date eligible. An Employee hired as a Non-Full-Time Employee (as described in section III.A.1), may become an Eligible Employee for purposes of medical benefits as described in section III.A.1 and will be eligible for medical benefits at the time described in that section.

Each Eligible Employee becomes eligible to cover his Dependents for benefits on the later of the following dates:

- the date he is eligible for benefits, if he then has a Dependent;
- the date he acquires an eligible Dependent through marriage, birth, adoption, placement for adoption, grant of legal guardianship, authorized foster child placement or pursuant to a valid Qualified Medical Child Support Order. When an Employee enrolls his Dependents and authorizes any required contributions for Dependent benefits, Dependent benefits will become effective as follows:

  • If an Employee has eligible Dependents on the effective date of his coverage and he has enrolled and authorized contributions for Dependent benefits on or prior to the Employee's effective date, then coverage for those Dependents will be effective on the date the Employee's coverage begins.

  • If an Employee does not have eligible Dependents on the effective date of his coverage and later acquires an eligible Dependent(s), and if he enrolls and authorizes any required contributions for Dependent benefits within 31 days of the date of acquisition, then coverage for the Dependent(s) will be effective on the date of acquisition.

If the Employee is already enrolled for Dependent benefits, any newly acquired dependents, including newborns, must be enrolled within 31 days of acquisition. Coverage will be effective on the date of acquisition. Benefits will not become effective for the Dependents of an Employee unless the Employee is covered, or simultaneously becomes covered, for benefits. Under no circumstances will coverage for an Employee's Dependents occur prior to coverage for the Employee. If an Employee does not enroll himself or himself and his Dependents within 31 days of the date eligible, he will not be eligible to enroll in the Plan until one of the following occurs:

C. SPECIAL ENROLLMENT

If an Eligible Employee experiences a loss of other medical, dental or vision coverage, including COBRA Continuation Coverage, the existence of which was the reason for declining coverage under this Plan when previously eligible to enroll, then the Employee may enroll for health coverage within 31 days of the loss of such coverage. Loss of coverage means that COBRA Continuation Coverage has been exhausted or that coverage which was not under a COBRA Continuation provision has been terminated as a result of a loss of eligibility for the coverage or termination of employer contributions towards such coverage. Coverage will be effective on the date coverage was lost.

If an Eligible Employee declined coverage for his Dependents under this Plan when previously eligible to enroll because his Dependents had other health coverage, including COBRA Continuation Coverage, and they experience a loss of the other health coverage as described above, the Employee may enroll for Dependent health benefits within 31 days of the occurrence. Coverage will be effective on the date coverage was lost.

If an Eligible Employee acquires a Dependent through marriage, he may enroll for coverage within 31 days of the marriage. Coverage will be effective on the date of the marriage. If an Eligible Employee acquires a Dependent through birth, adoption or placement for adoption, the Employee may enroll for coverage within 31 days of the birth, adoption or placement for adoption. Coverage will be effective on the date of the acquisition.

If the Eligible Employee is already enrolled for Dependent benefits, any newly acquired Dependents, including newborns, must be enrolled within 31 days of acquisition. Coverage will be effective on the date of acquisition.

Effective April 1, 2009 if an Eligible Employee or a Dependent is covered under a Medicaid or a CHIP plan and coverage is terminated as a result of the loss of eligibility for Medicaid or CHIP coverage, they may be able to enroll. However the request to enroll must be made within 60 days after the date eligibility is lost. If an Eligible Employee or a Dependent becomes eligible for premium assistance under an applicable State Medicaid or CHIP plan to purchase coverage under the group health plan, they may be able to enroll if requested within 60 days. Please note that premium assistance is not available in all states and this special enrollment rule is not available in connection with State programs that are not either a Medicaid plan under Title XIX of the Social Security Act or the State children's health insurance program under Title XXI of the Social Security Act.

D. ANNUAL ENROLLMENT

If the Eligible Employee enrolls during the annual enrollment period which occurs each Calendar Year, coverage will be effective on the subsequent January 1st.

E. CREDITABLE COVERAGE FOR HEALTH COVERAGE

Creditable Coverage includes coverage under most individual and group health insurance plans (including Medicare, Medicaid, governmental and church plans) whether or not a fully insured plan or a self-insured plan. Creditable coverage does not include liability, dental, vision, specified diseases and/or other supplemental type plans which are defined as excepted benefits by HIPAA.

Prior to January 1, 2015, the Plan shall issue a Certificate of Creditable Coverage, automatically and without charge, under the following circumstances:

1. For an individual who loses coverage under the Plan, but is not entitled to COBRA coverage, the Certificate of Creditable coverage shall be issued as soon as reasonably possible after coverage ceases.

2. For an individual who is a Qualified Beneficiary entitled to elect COBRA coverage, the Certificate of Creditable Coverage shall be issued with the COBRA notice sent after the Qualifying Event.

3. For an individual who is a Qualified Beneficiary and has elected COBRA coverage, the Certificate of Creditable Coverage shall be issued within a reasonable time after the cessation of COBRA coverage or, if applicable, after the expiration of any grace period for the payment of COBRA premiums.

The Plan shall also issue a Certificate of Creditable Coverage at any time within twenty-four (24) months after coverage ceases, provided that the Plan receives a written request for the Certificate of Creditable Coverage by the former Plan Participant or beneficiary (or by another person authorized by the former Plan Participant or beneficiary). Written requests for a Certificate of Creditable Coverage must be directed to Blue Cross and Blue Shield of Illinois, 300 East Randolph Street, Chicago, IL 60601. The Certificate of Creditable coverage shall be in the form required by HIPAA. Also upon written request, the Plan shall provide a copy of the Plan Document and other information as outlined in the model form established by HIPAA to provide additional information on categories of benefits for plans that use the Alternative Method of counting Creditable Coverage. The Plan shall charge the requesting entity or individual a fee to cover the reasonable cost of providing this information. This provisions cease to be applicable January 1, 2015.

IV. EXTENSIONS OF COVERAGE

A. FMLA QUALIFIED LEAVE OF ABSENCE

If the Covered Employee takes a qualified leave of absence as recognized by the Family Medical Leave Act of 1993 or similar state law, coverage for the Employee and any covered Eligible Dependents may be continued for the duration of the qualified leave up to twelve weeks under the Family Medical Leave Act. The Employee will be responsible for making any required contributions to the Plan according to the Family and Medical Leave of Absence policy stated in the AJG Human Resource Administrative and Policy Guide.

B. SICKNESS OR INJURY EXTENSION OF COVERAGE

If a Covered Employee is absent from work because of Sickness or Injury, coverage for the Employee and any covered Eligible Dependents will be continued for a maximum of 6 months from the start of the absence if the Covered Employee qualifies for Short Term Disability benefits, to run

concurrently with the Family Medical Leave Act of 1993 extension of coverage, if applicable. The Employee will be responsible for making any required contributions to the Plan.

C. RETIREMENT EXTENSION OF COVERAGE

If a Covered Employee is absent from work because of retirement, and is an eligible retired Employee (as defined below) his coverage may be considered to continue until terminated by the Employer, provided the Participant makes any required contributions. An Eligible Retired Employee is defined as a retired employee who has attained age 55 and had 10 years or more years of service with the Employer as of September 30, 1992 and was covered under this Plan on the date immediately prior to retirement.

If a retired Employee dies, coverage for the surviving Eligible Dependents covered under this Plan on the date of the retiree's death will continue until the earliest of the following:

- the end of the period for which any required contributions have been paid; or
- when the surviving spouse remarries; or
- with respect to a surviving child only, when the child ceases to meet the definition of a Dependent or becomes eligible for other health coverage.

D. MILITARY EXTENSION OF COVERAGE

If a Covered Employee is absent from work because of being called to active duty in the Armed Forces of any country, his coverage may be continued according to the Military Leave policy stated in the AJG Human Resource Administrative and Policy Guide.

E. COBRA CONTINUATION COVERAGE

Federal Legislation known as the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended (COBRA) requires that an Employee and/or Dependent may elect to continue health, dental, vision and employee assistance plan coverages as specified in the benefit booklet attached to this document.

Note: All Plan Participants must notify the Plan in writing within sixty (60) days of

(a) Divorce or legal separation

(b) Covered Dependent child ceasing to qualify as a Dependent

(c) Acceptance of Medicare or coverage under another employer's group health plan (whether or not as an Employee), if that plan does not limit coverage for a preexisting condition of the individual

(d) Second qualifying event

(e) Qualified Beneficiary's disability or cessation of disability

(f) Death of the Employee

Written notice must be provided to the Claims Administrator or the designated COBRA Claims Administrator, if applicable. The notice must include the name of the Employee with identification number, Plan Name and Number, date and type of the qualifying event and name(s) of the applicable Dependent(s). Written notices should be sent to: Arthur J. Gallagher & Co. (Illinois), The Gallagher Centre, Two Pierce Place, Itasca, IL 60143.

FAILURE TO NOTIFY THE PLAN IN A TIMELY MANNER WILL RESULT IN LOSS OF ELIGIBILITY FOR COBRA CONTINUATION COVERAGE.

V. TERMINATION AND REINSTATEMENT OF COVERAGE

A. TERMINATION OF EMPLOYEE COVERAGE

The coverage of any Employee covered under this Plan will cease on the earliest of the following dates except as provided under Continuation of Benefits (if applicable):

- The date this Plan terminates.
- The date ending the period for which any required contributions have been paid.
- The date he is no longer eligible for coverage under this Plan.
- The date he begins active duty in the Armed Forces of any country for longer than one month (continuation coverage rights may apply under the Military Leave policy).
- The date of his death.
- The date his employment terminates.
- The date he elects in writing that termination of coverage occurs.

This Plan will provide a Certificate of Creditable Coverage after the Employee's coverage terminates under the Plan.

B. TERMINATION OF DEPENDENT COVERAGE

Coverage with respect to each Dependent covered under this Plan Document will cease on the earliest of the following dates:

- The date benefits cease for the Employee.
- The date such individual ceases to be a Dependent as defined in this Plan Document;
- The date the Dependent begins active duty in the Armed Forces of any country for longer than one month.
- The date for which written election of termination is received.
- The date ending the period for which any required contributions have been paid.
- With respect to a physically or mentally handicapped child age 26 or older, the date the child becomes eligible for other medical coverage through his own employer.

The Plan will provide a Certificate of Creditable Coverage after the Dependent's coverage terminates under the Plan. Certificates will not be provided after December 31, 2014.

C. REINSTATEMENT OF PARTICIPANT'S COVERAGE

1. COBRA PARTICIPANTS

A Qualified Beneficiary who has elected COBRA continuation coverage will be considered to have had no lapse of coverage, provided the coverage is in effect on the day before the Employee returns to eligible employment.

2. REINSTATEMENT OF COVERAGE FOLLOWING A MILITARY LEAVE

Upon return from a military leave of absence, provided the Employee qualifies under the Veteran's Reemployment Rights Statute and provided that an enrollment form is submitted, coverage for the Employee and Eligible Dependents will be reinstated on the return-to-work date.

3. REINSTATEMENT OF COVERAGE AFTER VOLUNTARY TERMINATION OF EMPLOYMENT

If an Employee terminates his employment with the Plan Sponsor and is subsequently rehired by the Plan Sponsor, the Employee will be treated as a newly hired Employee at the date of such reemployment.

If any of the above reinstatements of coverage take place in the same Calendar Year, any deductible and/or out-of-pocket maximums will be credited.

VI. CLAIM PROCEDURES

A. CLAIMS FOR SELF-FUNDED BENEFITS:

For the purposes of determining the amount of, and entitlement to, benefits under the self-funded component benefit programs, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement. The Plan Administrator may delegate this power to the Claims Administrator.

To obtain benefits from a self-funded arrangement, you may be required to complete, execute and submit to the Claims Administrator a written claim form. The Claims Administrator has the right to secure evidence as it deems necessary to decide your claim.

The Claims Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. If your claim is denied, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Claims Administrator for a review of the denied claim. The Claims Administrator and/or the Plan Administrator will decide your appeal in accordance with reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

See the applicable benefits booklet for more information about how to file a claim and for details regarding the claims procedures applicable to your claim.

B. CLAIMS FOR FULLY INSURED BENEFITS

For purposes of the determination of the amount of, and entitlement to, benefits of the component benefit programs provided under insurance contracts, the respective insurer is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The insurance company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company denies your claim, in whole or part, you will receive a written notification explaining the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

See the certificate of insurance for more information about how to file a claim and for details regarding the claims procedures of the applicable insurance company.

C. CLAIMS FOR OTHER BENEFITS

For the purposes of determination of the amount of and entitlement to severance plan and employee assistance plan benefits see the provisions of the plans stated on the Gallagher One portal. The Plan Administrator is the named Fiduciary under the plan with the full power to make factual determinations and to interpret and apply the terms of the plan as they relate to the benefits.

D. ADMINISTRATIVE CLAIMS

Claims that are not a claim for a specific benefit under the Plan are called "administrative claims." For example, if you believe that your child should be considered an eligible child for purposes of coverage under the Plan and you haven't been permitted to enroll your child, your claim would be an administrative claim. The Plan Administrator has full discretionary authority to decide administrative claims. You must submit an administrative claim to the Plan Administrator within 60 days after the date you know or should have known that there is an issue, dispute or other claim relating to the Plan. This does not include issues submitted to HR Support; only formal written administrative claims submitted to the Plan Administrator at the address specified below are covered by this procedure. If a claim involves a change or amendment to the Plan, you are considered to know about your claim when the change or amendment to the Plan is first communicated to Employees or participants and beneficiaries in the Plan, and the 60 day period for filing a claim begins on the date the change is first communicated, whether or not the change or amendment has become effective by that date. If you do not file an administrative claim by the applicable deadline, your claim will expire and you will not be able to proceed with a lawsuit based on that claim.

For administrative claims, the Plan Administrator will respond to your claim within 60 days and may take one 60 day extension if circumstances warrant. If your administrative claim is denied, the Plan Administrator will provide you with a written explanation of why your claim was denied, including the specific reason for the denial, reference to the pertinent Plan provisions on which the denial is based, a description of any additional material or information you may need to perfect your claim and an explanation of why that material or information is necessary and a description of the Plan's review procedures and applicable time limits. If your administrative claim is denied, you have the right to file a written appeal with the Plan Administrator. Your written appeal must be filed within 60 days after your initial claim was denied. The Plan Administrator will decide your appeal within 60 days after receipt and may take one 60 day extension if circumstances warrant. If your claim is denied on appeal, the Plan Administrator will provide you with a written explanation of why your appeal was denied, including the specific reason for the denial, reference to the pertinent provisions on which the denial is based, a statement that you may receive, free of charge upon request, reasonable access to and copies of all documents, records and other information relevant to your claim, as well as a statement of your right to bring suit under ERISA.

Administrative claims that relate to retroactive terminations of medical coverage may be subject to a different procedure. The Plan Administrator will determine when a different procedure must be applied to such a claim and will process the claim accordingly [note: We added this section in our 2011 revised draft.].

VII. SUMMARY AND PROTECTED HEALTH INFORMATION

(This section shall apply only to benefits subject to HIPAA)

A. DISCLOSURE OF SUMMARY HEALTH INFORMATION

This Plan shall disclose to the Plan Sponsor summary health information (information that does not and could not be used to identify an individual) if the Plan Sponsor requests such information for the purpose of:

- obtaining premium bids from health plans for providing health insurance coverage under this Plan; or
- modifying, amending, or terminating this Plan.

B. DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

The Plan will disclose PHI (information that identifies or could identify an individual) to the Plan Sponsor only in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy laws. The Plan will use PHI to the extent and in accordance with the uses and disclosures permitted by (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to plan administration, as defined under 45 CFR §164.504(a).

The Plan Sponsor hereby acknowledges and agrees to the following provisions in this document:

1. Not to use or further disclose PHI other than as permitted or required by the plan document or as required by law; and to ensure that the separation between the Plan and Plan Sponsor required under the privacy rules is supported by reasonable and appropriate security measures;

2. To ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI; and to implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

3. Not to use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;

4. To report to the Plan any security incident or any PHI use or disclosure that it becomes aware is inconsistent with the uses or disclosures for which provision is made;

5. To make available PHI in accordance with 45 CFR §164.524;

6. To make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526;

7. To make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528;

8. To make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services upon request;

9. If feasible, to return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Employer will limit further its uses and disclosures of the PHI to those purposes that make the return or destruction of the information infeasible; and

10. To ensure that adequate separation between the Plan and the Employer, as required by 45 CFR §164.504(f), is established and maintained.

11. To implement policies and procedures to ensure that its creation, receipt, maintenance or transmission of electronic PHI (ePHI) on behalf of the Plan complies with applicable administrative, physical and technical safeguards required to protect the confidentiality and integrity of ePHI under the Security Standards 45 CFR § 164.

12. To ensure that agents or subcontractors agree to implement the applicable administrative, physical and technical safeguards required to protect the confidentiality and integrity of ePHI under the Security standards 45 CFR § 164.

13. To report to the Plan any security incidents as defined at 45 CFR § 164.304 as soon as practicable, but not later than 10 days from the date Plan Sponsor becomes aware of the incident.

C. LIMITATIONS OF PHI ACCESS AND COMPLIANCE

Access to PHI information may be given only to the Plan Sponsor and staff of the Plan Sponsor who receive PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business in carrying out Plan administration functions that the Plan Sponsor performs for the Plan. The access and use of PHI by the Plan Sponsor and staff described

above is limited to purposes of the administration functions that the Plan Sponsor performs for the Plan. If the Plan Sponsor and said staff do not comply with this Plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

VIII. PLAN ADMINISTRATION

A. PLAN ADMINISTRATOR

Any duly authorized delegate of the Plan Administrator may exercise any authority or responsibility allocated or reserved to the Plan Administrator under this Plan.

The Plan Administrator shall have the right to hire all persons providing services to the Plan and to appoint a Claims Administrator to receive, initially review and process claims for benefits and to make final binding decisions on appeals of denied benefits.

The Plan Administrator shall have the authority and responsibility to call and attend the meetings at which this Plan's funding policy and method are reestablished and reviewed.

The Plan Administrator shall have the discretionary authority and responsibility to construe and interpret terms of this Plan; to make factual determinations, including all questions of eligibility; to establish the policies, interpretations, practices, and procedures of this Plan; to adopt and implement procedures, including Care Management, in its sole discretion; to decide whether care or treatment is Medically Necessary and whether a charge meets Reasonable and Customary criteria; and to render final decisions on review of claims as described in this Plan Document. All interpretations under the Plan, and all determinations of fact made in good faith by the Plan Administrator or its delegate will be final and binding on the Participants and beneficiaries and all other interested parties. The Plan Administrator shall also have the right to appoint an appeals committee or other such entity or to delegate to a Claims Administrator the authority and responsibility for exercising the above rights and responsibilities.

Furthermore, the Plan Administrator shall have the right to change contribution rates for Participants at any time and from time to time.

The insured benefits provided under the Plan are provided under group insurance contracts entered into between Arthur J. Gallagher & Co. and the applicable insurance companies. Claims for the fully insured benefits are to be sent to the appropriate insurance company. That insurance company is responsible for paying claims and exercises discretionary authority in determining the benefits payable under the insurance contract. Neither the Employer nor the Plan Administrator exercises any authority with respect to the benefits payable under an insurance contract and the Employer and Plan Administrator do not guarantee the payment of any benefit under an insurance contract. You must look solely to the insurance carrier for the payment of benefits.

The applicable insurance company or claims administration firm is responsible for:

(a) Determining eligibility for and the amount of any benefits payable under the Plan.

(b) Prescribing claims procedures to be followed and the claim forms to be used by Participants pursuant to the Plan.

Those entities also have the authority to require Participants to furnish them with such information deemed necessary for the proper administration of the Plan. If you have questions concerning eligibility for and/or the amount of any benefits payable under the Plan, please contact the applicable insurance company or claims administration firm.

The Plan Administrator has a duty to maintain records and to file reports required by law. This duty shall include complying with applicable reporting or disclosure requirements.

The Plan Administrator shall forward applications to the Claims Administrator and notify the Claims Administrator in writing of changes with respect to Participants and other facts necessary for determining Plan coverages and for processing claims for Plan benefits.

The Plan Administrator, appeals committee or any duly authorized representative of the Plan Administrator will have the right to examine any claim for benefits under this Plan. The Plan Administrator will, at the Plan's expense, have the right to have the person whose Sickness or Injury is the basis for a claim examined as often as reasonably required during the time a claim is pending under the Plan. The Plan Administrator will not discriminate in treatment of individuals in similar situations, and the Claims Administrator is not obligated to inquire into the circumstances.

For purposes of determining the applicability of the coordination of benefits and subrogation provisions of this Plan or any provision with a similar purpose that is in another plan and for purposes of implementing those provisions, the Plan Administrator or Claims Administrator may release necessary information to, or obtain necessary information from, any other organization or individual.

The Plan Sponsor shall have the unlimited right to amend this Plan in any and all respects at any time, and from time to time, without prior notice to any Participant or Eligible Dependent. Any such amendment shall be by a written resolution of the majority of the Board of Directors and shall become effective as of the date specified in the enabling resolution. Any such amendment shall be binding upon all Participants (including those Participants on continuation coverage). However, the responsibilities of the named fiduciaries and their delegates shall not be increased or changed by amendment without their written consent.

An amendment to the Plan may be retroactively effective but shall not adversely affect the rights of a Participant under this Plan for covered medical expenses provided after the effective date of the amendment but before the amendment is adopted.

The Plan shall furnish a summary of a material reduction in covered medical services or benefits to Participants within 60 days after the change has been adopted by the Plan, or at such earlier date as may be required by law.

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, the Plan Sponsor reserves the unlimited right to terminate or merge the Plan at any time without prior written notice to any Participant. Such termination shall be evidenced by a resolution of the majority of the Board of Directors. The date of the merger or termination will be the date specified in the enabling resolution. Termination of the Plan shall apply to all Participants (including those on

continuation coverage). Additionally, the Plan Administrator reserves the right to determine from time to time the level of contribution required from Participants for Plan coverage.

The Plan Administrator shall perform all other responsibilities allocated to the Plan Administrator in the instrument appointing the Plan Administrator.

B. CLAIMS ADMINISTRATOR

The Claims Administrator shall have the authority and responsibility to administer the Plan's claims procedures with respect to the particular benefit(s) for which the Claims Administrator serves, to process claims for benefits in accordance with Plan provisions, and to file claims with the insurance companies, if any, who issue stop loss insurance policies with respect to such benefits.

The Plan Administrator must furnish the Claims Administrator all information the Claims Administrator reasonably requires as to matters pertaining to this Plan. All material which may have a bearing on coverage or contributions will be open for inspection by the Claims Administrator at all reasonable times during the continuance of this Plan and until the final determination of all rights and obligations under this Plan.

C. PARTICIPANT

A Participant of this Plan is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information about Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

The Employee and qualified beneficiaries may continue health care coverage if there is a loss of coverage under the Plan as a result of a qualifying event. COBRA participants may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prior Creditable Coverage can be provided for a reduction or elimination of exclusionary periods of coverage for preexisting conditions under a group health plan, if there is creditable coverage from another plan. Participants should be provided a certificate of creditable coverage, free of charge, from their group health plan or health insurance issuer when they lose coverage under the plan, when they become entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if requested before losing coverage, or if requested up to 24 months after losing coverage. Without evidence of creditable coverage, Participants may be subject to a preexisting condition exclusion for 12 months after the enrollment date for coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Employee and other Plan Participants and beneficiaries. No one, including the Employer, a union, or other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforcement of Rights

If a claim for a welfare benefit is denied or ignored, in whole or in part, Participants have a right to know why this was done, 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 steps that may be taken to enforce the above rights. For instance, if a copy of plan documents or the latest annual report from the Plan is requested and not received within 30 days, a suit may be filed in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If there is a claim for benefits which is denied or ignored, in whole or in part, a suit may be filed in a state or Federal court, after you have satisfied the Plan's appeal procedures. In addition, if there is disagreement with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, a suit may be filed in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If the suit is successful, the court may order the person sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance with Your Questions

If there are any questions about this Plan, contact the Plan Administrator. If there are any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance

and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The Participants in this Plan have the sole right to select their own providers of health care. The Plan will not choose a provider for any Participant, or have any liability for any acts, omissions, or conduct of any provider. The Plan's only obligation is to make payments according to the terms of this Plan Document. The payments that the Plan makes are not an attempt to fix the value of any services or supplies provided to a Participant.

A Participant will have no right to assign the payment of any benefits for which he is eligible under this Plan, except to the extent that assignment is specifically permitted under the terms of the benefit booklet/description document for that benefit.

IX. GENERAL PROVISIONS

A. LEGAL COMPLIANCE/CONFORMITY

This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws of the Employer's principal place of business to the extent such laws are not preempted by federal law. If any provision of the Plan Document or Employer's Plan is contrary to any law to which it is subject, the provision is hereby automatically changed to meet the law's minimum requirement.

B. EFFECT OF PRIOR COVERAGE

Coverage for any Participant under this Plan Document replaces any prior coverage in effect for that Participant provided by the Employer under any immediately prior plan document or policy.

C. SEVERABILITY

In the event that any provision of this Plan shall be held to be illegal or invalid for any reason by a court of competent jurisdiction, such illegality or invalidity shall not affect the remaining provisions of the Plan and the Plan shall be construed and enforced as if such illegal or invalid provision had never been contained in the Plan.

D. STATUS OF EMPLOYMENT RELATIONS

The adoption and maintenance of this Plan shall not be deemed to constitute a contract between the Employer and the Employees or to be consideration for, or an inducement or condition of, the employment of an Employee. Nothing in this Plan shall be deemed to affect the right of the Employer to discipline or discharge any Employee at any time or the right of the Employee to terminate his employment at any time. Nor shall anything in this Plan be deemed to give the Employer the right to require any Employee to remain in its employ or give the right to any Employee to be retained in the employ of the Employer.

E. HEADINGS

Headings are for reference and not for interpretation or construction.

F. WORD USAGE

Whenever words are used in this document in the singular or masculine form, they shall where appropriate be construed so as to include the plural, feminine, or neuter form.

G. TITLES FOR REFERENCE

The titles used within this document are for reference purposes only. In the event of a discrepancy between a title and the content of a section, the content of a section shall control.

H. CLERICAL ERROR

No clerical errors made by the Employer, Plan Administrator, or the Claims Administrator in keeping records pertaining to this coverage or delays in making entries in such records will invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any benefits paid will be made.

I. MISSTATEMENTS

If any relevant fact as to an individual to whom the coverage relates is found to have been misstated, an equitable adjustment of contributions will be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is in force under this Plan and its amount.

J. REFUND OF OVERPAYMENTS

If the Plan pays benefits for expenses incurred on account of a Covered Participant, that Covered Participant, or any other person or organization that was paid, must provide a refund to the Plan if either of the following apply:

- All or some of the expenses were not paid by the Covered Participant or did not legally have to be paid by the Covered Participant.
- All or some of the payment the Plan made exceeded the benefits under the Plan.

The refund shall equal the amount the Plan paid in excess of the amount it should have paid under the terms of the Plan. If the refund is due from another person or organization, the Covered Participant agrees to help the Plan obtain the refund when requested.

If the Covered Participant, or any other person or organization that was paid, does not promptly refund the full amount, the Plan may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Plan may have other rights in addition to the right to reduce future benefits.

X. IDENTIFICATION OF PLAN

PLAN NAME: Arthur J. Gallagher & Co. (Illinois)
Employee's Self-Funded Medical/Dental Plan and Insured Benefits

EMPLOYERS: Arthur J. Gallagher & Co. Service Company, its Affiliates and Companies under common control.

PLAN SPONSOR:

Arthur J. Gallagher & Co. (Illinois)
The Gallagher Centre
Two Pierce Place
Itasca, Illinois 60143-3141

PLAN SPONSOR TAX ID NO.: 36-2481781

PLAN NO.: 503

TYPE OF BENEFITS PROVIDED: Welfare Benefits Plan

TYPE OF PLAN ADMINISTRATION: Self-Funded Third Party.

Health and dental benefits are self-funded by Company contributions and employee pre-tax or after tax deductions as elected by the Employee or as mandated by law. The Company shares responsibility with the applicable third party claims administration firm for administering these self-funded benefits, as set forth in this Plan document. Insured benefits are provided under the applicable group insurance contracts entered into between Arthur J. Gallagher & Co. and the insurance companies identified in this document. Claims for insured benefits are to be sent to the appropriate insurance company. That insurance company is responsible for paying claims. Note that the insurance companies and the Company share responsibility for administering the plan. The Severance Pay Plan is self-funded and administered by Arthur J. Gallagher & Co. The employee assistance plan is administered under a contract with a service provider that provides the services directly to eligible employees.

PLAN ADMINISTRATOR/NAMED FIDUCIARY:

Arthur J. Gallagher & Co. (Illinois)
Employee's Self-Funded Medical/Dental Plan and Insured Benefits Committee
Arthur J. Gallagher & Co. (Illinois)
The Gallagher Centre
Two Pierce Place
Itasca, Illinois 60143-3141

AGENT FOR SERVICE OF LEGAL PROCESS

General Counsel
Arthur J. Gallagher & Co. (Illinois)
The Gallagher Centre
Two Pierce Place
Itasca, Illinois 60143-3141

Legal process may also be served on the Plan Administrator

CONTRIBUTIONS TO PLAN:
Contributions for the Plan are provided partially by contributions of the Plan Sponsor and partially by contributions of Covered Employees

FISCAL YEAR END: December 31st.

Medical Claims Administrator:	Blue Cross and Blue Shield of Illinois 300 East Randolph Street Chicago, IL 60601
Prescription Drug Claims Administrator:	Claims incurred prior to January 1, 2015: Express Scripts P.O. Box 14711 Lexington, KY 40512 Claims incurred on or after January 1, 2015: Prime Therapeutics 300 East Randolph Street Chicago, IL 60601
Dental Claims Administrator:	Delta Dental of Illinois 111 Shuman Boulevard Naperville, IL 60563
Basic Life and AD&D Insurance Company:	Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192
Long Term Disability Insurance Company:	Reliance Standard Life Insurance Company 2001 Market St. Suite 1500 Philadelphia, PA 19103
Voluntary Vision Insurance Plan:	Eyemed Vision Care (866) 939-3633 4000 Luxottica Place Mason, OH 45040
Voluntary AD&D Insurance Company:	AIG P. O. Box 667 Wilmington, DE 19884
Voluntary Group Universal Life Insurance Company:	CIGNA P.O.Box 14577 Des Moines, IA 50306
Group Legal:	Hyatt Legal Plans 1100 Superior Ave. Suite 800

	Cleveland,OH 44114
Business Travel Accident Insurance Company:	Chubb Group of Companies Federal Insurance Company 15 Mountain View Road Warren, NJ 07059
WorkLife Program (Employees Assistance Program):	ComPsych NBC Tower 455 N. Cityfront Plaza Dr. 13th Floor Chicago, IL 60611 Telephone: (800)272-7255
Severance Plan	Plan Administrator: V.P. & Chief Human Resource Officer Arthur J. Gallagher & Co. 2 Pierce Place Itasca, IL 60143
Wellness Program Administrator:	Prior to January 1, 2015: Healthways 701 Cool Springs Blvd Franklin, TN 37067 On and after January 1, 2015: Viverae 10670 N. Central Express Parkway, Suite 700 Dallas, TX 75231

Important Disclaimer: The fully insured benefits hereunder are provided pursuant to Insurance Contracts between the Plan Sponsor and the applicable insurance companies. If the terms of this document conflict with terms of the applicable Insurance Contract, the terms of the Insurance Contracts will control, unless superseded by applicable law.