Execution Version

RIMKUS CONSULTING GROUP, INC.

BENEFIT PLAN

(Amended and Restated Effective as of May 1, 2016)

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POLICY APPENDIX A-1

RIMKUS CONSULTING GROUP, INC. BENEFIT PLAN
(Amended and Restated Effective as of May 1, 2016)

Rimkus Consulting Group, Inc. (the "**Plan Sponsor**") maintains the Rimkus Consulting Group, Inc. Benefit Plan (the "**Plan**") for the benefit of the eligible Employees (and their eligible Dependents) of the Plan Sponsor and the other adopting Employers. The Plan Sponsor hereby amends and restates the Plan effective as of May 1, 2016.

The Plan is an "employee welfare benefit plan", as defined in the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**").

Terms of the Plan pertaining to eligibility, coverage, exclusions and limitations on coverage, and other rules pertaining to the benefits available under the Plan, are set forth in the Wrap-SPD (as defined herein) and the Welfare Program Documents (as defined herein) which are incorporated into the Wrap-SPD in their entirety by reference and, together with the Wrap-SPD, constitute the "**Summary Plan Description**" of the Plan. The Summary Plan Description and the Policies set forth in the Policy Appendix to this Wrap-Plan (as defined herein) are incorporated into this Wrap-Plan in their entirety by reference and, together with this Wrap-Plan, shall together form the complete Plan.

The capitalized terms used in this Wrap-Plan shall be defined as provided in Article I.

ARTICLE I.
DEFINITIONS AND INTERPRETATIONS

1.1 **Definitions**. As used in the Plan, any capitalized terms not defined herein shall have the meaning ascribed to them in the Wrap-SPD, and the following words and phrases shall have the meanings ascribed to them as follows, unless the context clearly requires a different meaning:

(a) **Affiliate**. A corporation or other entity which is controlled by the Plan Sponsor, or under common control with the Plan Sponsor, as determined by the Plan Sponsor after taking into consideration the common control rules under Section 3(40)(B) of ERISA (*i.e.*, for multiple employer welfare associations).

(b) **Affordable Care Act**. The federal Patient Protection and Affordable Care Act of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010 and subsequent amendments, and the authoritative guidance issued thereunder by the appropriate governmental entities.

(c) **Beneficiary**. A Beneficiary under the Plan as defined under the terms of the respective Welfare Program.

(d) **Board**. The Board of Directors of the Plan Sponsor.

(e) **Claims Administrator**. The third party administrator, insurance company or other person or entity, as set forth in Appendix D to the Wrap-SPD, as designated by the Plan Administrator to process claims and/or perform other administrative duties under the Plan or a Welfare Program.

(f) **Claims Fiduciary**. The person or entity that serves as the named claims fiduciary with respect to reviewing and making final decisions regarding claims under a Welfare Program. The "Claims Fiduciary" shall be the Plan Administrator unless otherwise set forth in Appendix D to the Wrap-SPD.

(g) **Code**. The Internal Revenue Code of 1986, as amended, and the implementing regulations and other authority issued thereunder by the appropriate governmental authority. References herein to any section of the Code shall also refer to any successor provision thereof.

(h) **Dependent**. An Employee's (a) legal Spouse, (b) Child under age 26, and (c) unmarried Child age 26 or over who is dependent on the Employee because of a mental or physical handicap rendering the Child medically incapacitated and unable to be self-supportive. For purposes of determining eligibility for Dependent coverage, the term "Child" means a (i) biological child of an Employee, (ii) legally adopted child or a child placed for adoption with the Employee or Spouse, (iii) stepchild of an Employee, (iv) child for whom health care coverage is required under the terms of a Qualified Medical Child Support Order, as described in Article XIII of the Wrap-SPD, or (v) child for whom the Employee or Spouse has a court appointed legal guardianship.

Notwithstanding the foregoing, if the applicable Welfare Program Document for a

Fully-Insured Program provides a definition of "Dependent" that is different than this definition, the definition in such Welfare Program Document will control for purposes of that Fully-Insured Program.

The Plan Administrator reserves the right to require evidence from an Employee of an individual's status as a "Dependent" under the Plan. If the Plan Administrator so requires, the Employee must provide such evidence to the Plan Administrator (or its delegate) in the form and manner, and within the timeframe, specified by the Plan Administrator (or its delegate). Such evidence may include, but is not limited to, certifications, affidavits or other written or electronic documentation. The Plan Administrator (or its delegate) shall determine, in its discretion, whether such evidence reasonably substantiates such individual's status as a "Dependent" under the Plan.

(i) **Disclosure Administrator**. The individual or entity, as designated in Article XIV of the Wrap-SPD, to whom the Plan Administrator has delegated the authority, duty and discretion to furnish, on its behalf, the disclosures that are required by Section 104(b)(4) of ERISA and which are requested in accordance with Section 2.5 of this Wrap-Plan.

(j) **Effective Date**. The effective date of this amendment and restatement of the Plan, *i.e.*, May 1, 2016.

(k) **Employee**. Any individual who is (i) considered to be in an employer-employee relationship as a "common law" employee with the Employer and (ii) on the U.S. payroll records of the Employer for purposes of federal income tax withholding, unless otherwise specified in a Welfare Program Document for a particular Welfare Program. Except as may otherwise be expressly stated in a Welfare Program Document for a particular Welfare Program, the term "Employee" shall not include any person during any period that such person was classified on the Employer's records as other than an Employee. For example, the term "Employee" shall not include anyone classified on the Employer's records as an independent contractor, agent, leased employee, contract employee or similar classification, regardless of whether any agency (governmental or otherwise) or court determines that any such person is or was a common law employee of an Employer, even if such determination has a retroactive effect. For purposes of this definition, (i) a "leased employee" means any person, regardless of whether or not he is a "leased employee" as defined in Code Section 414(n)(2), whose services are supplied by an employment, leasing, or temporary service agency and who is paid by or through an agency or third-party, (ii) an "independent contractor" means any person rendering service directly or indirectly to the Employer and whom the Employer treats as an independent contractor by reporting payments for the person's services on IRS Form 1099 (or its successor), and (iii) a "contract employee" means a person who is employed by a third-party entity which is retained by the Employer through a contract for services, pursuant to which such person indirectly renders services to, or for the benefit of, the Employer.

Furthermore, employees who (i) are non-resident aliens and (ii) receive no earned income (within the meaning of Code Section 911(d)(2)) from an Employer which constitutes income from sources within the United States (within the meaning of

Code Section 861(a)(3)) shall not be considered Employees who are eligible to participate in the Plan.

(l) **Employer**. The Plan Sponsor, or any of its Affiliates that have adopted the Plan with the consent of the Plan Sponsor. The adopting Employers of the Plan shall be listed in Appendix A to the Wrap-SPD, as such Appendix may be revised from time to time by the Plan Sponsor without the need for a formal amendment to the Plan.

(m) **ERISA**. The Employee Retirement Income Security Act of 1974, as amended.

(n) **Fully-Insured Program**. Each of the following Welfare Programs that are fully-insured:

- Rimkus Consulting Group, Inc. Cigna Dental PPO Insurance Plan;
- Rimkus Consulting Group, Inc. Cigna Vision Standard Comprehensive PPO Insurance Plan;
- Rimkus Consulting Group, Inc. Aetna Group Life and AD&D Ultra Benefits Insurance Program;
- Rimkus Consulting Group, Inc. Aetna Long-Term Disability Benefits Insurance Program; and
- Rimkus Consulting Group, Inc. Aetna Short-Term Disability Benefits Insurance Program.

(o) **Participant**. An Employee of the Employer who meets the requirements for eligibility as set forth in the Summary Plan Description and who properly enrolls for coverage under the Plan. The term "Participant" also includes any Dependent of a person specified in the previous sentence who is properly enrolled for coverage under the Plan. A person shall cease to be a Participant when he no longer meets the requirements for eligibility as set forth in applicable provisions of the Plan.

(p) **Participant Contribution**. The pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term "Participant Contribution" thus includes, but is not limited to, contributions used for the provision of benefits under a self-funded arrangement of the Plan Sponsor or an Employer as well as contributions used to purchase coverage under insurance contracts or policies.

(q) **Plan**. Rimkus Consulting Group, Inc. Benefit Plan (which consists of (i) this Wrap-Plan, (ii) the Policies set forth in the Policy Appendix and incorporated herein by reference, (iii) the Wrap-SPD as incorporated herein by reference, and (iv) each Welfare Program Document as incorporated hereunder by reference), as amended from time to time. The Wrap-Plan, Policies, Wrap-SPD and Welfare Program Documents each contain the terms of the Plan and together constitute the Plan.

(r) **Plan Administrator**. The person or entity which has the authority and responsibility to manage and direct the operation of the Plan in its discretion. However, the Plan Administrator may assign or delegate duties to third parties, such as the Claims Administrator or the Claims Fiduciary, under the terms of either the Plan or any Welfare Program, or by means of a separate written agreement. The

Plan Administrator is the "plan administrator" for purposes of Section 3(16)(A) of ERISA. The Plan Sponsor shall be the "Plan Administrator".

(s) **Plan Sponsor**. Rimkus Consulting Group, Inc., or its successor in interest.

(t) **Plan Year**. Each twelve (12) month calendar year commencing May 1st and ending on April 30th.

(u) **Spouse**. A person to whom an Employee is lawfully married, which marriage was solemnized, authenticated and recorded as required by the state or foreign jurisdiction in which the marriage took place, to the extent such marriage is legally recognized as valid for purposes of applicable federal law (including, but not limited to, the Code and ERISA), and any regulations promulgated under such applicable federal law, but will not include an individual separated from the Employee under a legal separation or divorce decree. The term "Spouse" shall also include a common law spouse if the Employee and spouse became common law married in a state which recognizes common law marriages and meet all the requirements for common law marriage in that state. The Employee must provide proof of a ceremonial or common law marriage acceptable to the Plan Administrator if requested, such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state.

(v) **Summary Plan Description**. The Summary Plan Description of the Plan, which consists of (i) the Wrap-SPD, including any appendices attached thereto, and (ii) each Welfare Program Document incorporated thereunder by reference, as all such documents may be amended from time to time (including, without limitation, by distribution of a summary of material modification), and all of which are incorporated into this Wrap-Plan by reference and contain certain terms of the Plan.

(w) **Welfare Program**. A program of benefits that is offered by the Plan Sponsor (and/or another Employer) under the Plan to provide certain employee group health and/or welfare benefits coverage to eligible individuals which would be an "employee welfare benefit plan" under Section 3(1) of ERISA if offered separately. The Welfare Programs are incorporated into Wrap-SPD, which is, in turn, incorporated into this Wrap-Plan. Each Welfare Program under the Plan is identified in Appendix B of the Wrap-SPD. The Plan Sponsor may add or delete a Welfare Program from the Plan by amending Appendix B of the Wrap-SPD.

(x) **Welfare Program Document**. A written arrangement, including (i) a benefits booklet, summary of coverage, plan document or summary plan description, including any amendments, riders or attachments thereto, (ii) an insurance contract between an Employer and an insurance company, health maintenance organization (HMO), administrative service organization (ASO) or other similar organization to provide certain employee group health and/or welfare benefits, including any amendments, endorsements or riders thereto, or (iii) a certificate of coverage, schedule of benefits, notice or other instrument under which a Welfare Program is established, operated or maintained. Each of the documents referenced in items (i), (ii) and (iii) (above) is attached to the Wrap-SPD as part of Appendix C thereto and incorporated, in its entirety, herein by reference. A Welfare Program Document (or any portion thereof) shall not, in and of itself, constitute either the written "Plan

document" or the "summary plan description" of the Plan, as required by ERISA, notwithstanding any references in any Welfare Program Document to the contrary; however, such Welfare Program Document does contain the terms of the Plan. Any reference to a Welfare Program Document also refers to any amendment, rider, exhibit or attachment thereto.

(y) **Wrap-Plan**. This wrap-around Plan document (including any appendices attached thereto), as may be amended from time to time, into which the Policies, the Wrap-SPD and the Welfare Program Documents are incorporated by reference to form the Plan.

(z) **Wrap-SPD**. The wrap-around summary plan description document (including the appendices attached hereto), as may be amended from time to time, into which the Welfare Program Documents are incorporated by reference to form the Summary Plan Description.

1.2 **Interpretation.** Notwithstanding any reference in a Welfare Program Document that such Welfare Program Document, in and of itself (or any portion thereof), constitutes a written "Plan document" as required by ERISA, the Plan shall consist of this Wrap-Plan, the Policies as set forth in the Policy Appendix hereto, the Wrap-SPD, including all appendices thereto, and the Welfare Program Documents for the Welfare Programs as identified in Appendix B of the Wrap-SPD. If a term or provision of this Wrap-Plan or the Wrap-SPD directly conflicts with a term or provision of a Welfare Program Document or Policy, the term or provision of the Welfare Program Document or Policy, as applicable, shall control unless specifically stated otherwise herein or in the Wrap-SPD. Further, if a term or provision of this Wrap-Plan directly conflicts with any term or provision of the Wrap-SPD, then the term or provision of the Wrap-SPD shall control.

Notwithstanding the foregoing, if there is a conflict between a term or provision of this Wrap-Plan, a Welfare Program Document, a Policy or the Wrap-SPD, and such conflict involves a term or provision required by ERISA, the Code or other controlling law, on the one hand, and a term or provision not so required on the other, the term or provision required by controlling law shall control. This determination shall be made by the Plan Administrator. The terms and provisions of this Wrap-Plan shall not enlarge the rights of a Participant, Dependent or Beneficiary to any benefit available under a Fully-Insured Program.

The terms and provisions of the Plan include the terms and provisions of this Wrap-Plan, the Policies listed in the Policy Appendix to this Wrap-Plan, the Wrap-SPD, and the Welfare Program Documents.

ARTICLE II.
ADMINISTRATION OF THE PLAN

2.1 **Controlling Provisions for Fully-Insured Programs.** The provisions of this Article II shall supersede any provisions of a Welfare Program Document for a Welfare Program that is not a Fully-Insured Program regarding the subject matter hereof and shall govern and control. With respect to a Fully-Insured Program, to the extent a provision of this Article II conflicts with, or is inconsistent with, a provision of the Welfare Program Document regarding the same subject matter, the provision of the Welfare Program Document will control, unless

such conflict involves a term or provision required by ERISA, the Code or other controlling law, in which case the term or provision required by controlling law will control. This determination will be made by the Plan Administrator.

2.2 **Allocation of Authority**. The Plan Administrator shall control and manage the operation and administration of the Plan, except to the extent such duties have been delegated to other persons or entities as provided in this Wrap-Plan or the Wrap-SPD. Any decisions made by the Plan Administrator or Claims Fiduciary (or any other person or entity delegated authority by the Plan Administrator or Claims Fiduciary to determine benefits in accordance with the Plan), as applicable, shall be final and conclusive on all Participants, Beneficiaries and all other persons and entities, subject only to the claims appeal provisions of the Plan. Neither the Plan Administrator nor any Employee shall receive any compensation from the Plan with respect to services provided under the Plan, except as an Employee may be entitled to benefits hereunder.

2.3 **Powers and Duties of Plan Administrator** The Plan Administrator (and the Claims Fiduciary, but only with respect to reviewing and making decisions regarding claims under a Welfare Program) shall each have such powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the following:

(a) to have final discretionary authority to (i) administer, enforce, construe, and construct the Plan, including the Welfare Program Documents, (ii) make decisions relating to all questions of eligibility to participate, and (iii) make a determination of benefits including, without limitation, reconciling any inconsistency, correcting any defect, supplying any omission, and making all findings of fact;

(b) to prescribe procedures to be followed by Participants filing application for benefits;

(c) to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, any information that explains the Plan and benefits thereunder;

(d) to receive from the Employer and from Participants such information as necessary for the proper administration of the Plan;

(e) to furnish the Employer and the Participants such annual reports with respect to the administration of the Plan as necessary;

(f) to receive, review and keep on file (as it deems necessary) reports of benefit payments by the Employer and reports of disbursements for expenses;

(g) to exercise such authority and responsibility as it deems appropriate in order to comply with the terms of the Plan relating to the records of Participants, including an examination at the Employer's expense of the records of the Plan to be made by such attorneys, accountants, auditors or other agents as it may select, in its discretion, for that purpose; and

(h) to appoint persons or entities to assist in the administration as it deems advisable; and the Plan Administrator may delegate thereto any power or duty imposed upon or granted to it under the Plan.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision will be considered ambiguous and will be interpreted by the Plan Administrator (or the Claims Fiduciary) in a fashion consistent with its intent, as determined by the Plan Administrator (or the Claims Fiduciary). The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The Plan Administrator (or Claims Fiduciary) may rely upon the direction or information from a Participant relating to such Participant's entitlement to benefits hereunder as being proper under the Plan, and will not be responsible for any act or failure to act. Neither the Plan Administrator nor the Employer makes any guarantee to any Employee in any manner for any loss that may result because of the Employee's participation in the Plan.

All decisions, interpretations, determinations and actions in the exercise of the powers and duties described in this Section will be final and conclusive on all persons and entities subject only to the claims appeal provisions of the Plan. Benefits under the Plan will be paid only if the Plan Administrator (or Claims Fiduciary) determines in its discretion that the Participant is entitled to them. There will be no *de novo* review of any such decision, interpretation, determination or action by any court. Any review of any such decision, interpretation, determination or action will be limited to determining whether the decision, interpretation, determination or action in question was so arbitrary and capricious as to be an abuse of discretion under ERISA standards.

2.4 **Delegation by the Plan Administrator** The Plan Administrator may delegate to other persons or entities any of the administrative functions relating to the Plan, together with all powers necessary to enable its designee(s) to properly carry out such duties hereunder, including, without limitation, delegation to the Claims Administrator, the Claims Fiduciary and the Disclosure Administrator. The Plan Administrator may employ such counsel, accountants, Claims Administrators, Claims Fiduciaries, consultants, actuaries and such other persons or entities as it deems advisable in its discretion. The Plan Administrator, as well as any person to whom any duty or power in connection with the operation of the Plan is delegated, may rely upon all valuations, reports, and opinions furnished by any accountant, consultant, third-party administration service provider, legal counsel, or other specialist. Moreover, the Plan Administrator or such delegate who is also an Employee shall be fully protected in respect to any action taken or permitted in good faith in reliance on such information.

2.5 **Disclosure Responsibility**.

(a) *General.* The Disclosure Administrator shall, in response to a written request by a Participant or Beneficiary, furnish a copy of the documents and instruments specified in Section 104(b)(4) of ERISA ("**Plan Disclosures**") as required by ERISA. A Participant's or Beneficiary's request for Plan Disclosures must be submitted to the Disclosure Administrator in writing, at the address listed in Article XIV of the Wrap-SPD, and must identify the particular Plan Disclosures that are being requested. The Disclosure Administrator may, in its discretion, impose a reasonable charge to cover the cost of copying and furnishing the requested Plan Disclosures to the extent permitted by ERISA.

(b) *Claim-Related Requests by an Authorized Representative*. To the extent that a request for Plan Disclosures is related to a Participant's or Beneficiary's claim for benefits under the Plan, the request may be submitted to the Disclosure Administrator by an authorized representative of the Participant or Beneficiary, provided that (i) the authorization of such representative is designated in writing by the Participant or Beneficiary in a manner that is sufficiently clear and conspicuous, as determined by the Disclosure Administrator in its discretion, to enable the Disclosure Administrator to reasonably verify the status of the authorized representative and the scope of such authorization, and (ii) a copy of the signed authorization is submitted to the Disclosure Administrator with the request for Plan Disclosures. The Disclosure Administrator will not make any Plan Disclosures to a person or entity claiming to be an authorized representative prior to receipt of an authorization that meets the criteria in clauses (i) and (ii), as determined by the Disclosure Administrator.

(c) *Examination of Records*. Participants and Beneficiaries shall have the right to examine such records, documents and other data as required by ERISA at reasonable times during regular business hours. Nothing contained in the Plan shall give any Participant the right to examine any data or records with respect to any other Participant except as required by applicable law which cannot be waived.

2.6 **Rules and Decisions**. The Plan Administrator may adopt such rules and procedures, as it deems necessary or appropriate for the proper administration of the Plan. The Plan Administrator will be entitled to rely upon information furnished to it which appears proper without the necessity of any independent verification or investigation.

2.7 **Facility of Payment for Incapacitated Participant**. Whenever, in the Claims Fiduciary's opinion, a Participant is entitled to receive any payment of a benefit hereunder and is under a legal disability or is incapacitated in any way so as to be unable to manage his own financial affairs (including physical and mental incompetence or status as a minor), the Claims Fiduciary may direct payments to such person or to the person's legal representative (such as a guardian or conservator, upon proper proof of appointment furnished to the Claims Fiduciary), Dependent, or relative of such person for such person's benefit, or the Claims Fiduciary may direct payment for the benefit of such person in such manner as the Claims Fiduciary considers advisable in its discretion. Any payment of a benefit, to the full extent thereof, in accordance with the provisions of this Section 2.7 will be a complete discharge of any liability for the making of such payment under the Plan.

2.8 **Reporting Responsibilities.** The Plan Administrator shall be responsible for filing all reports, returns and notices required by ERISA or the Code.

2.9 **Fiduciaries**. The Plan Administrator and the Claims Fiduciary are named fiduciaries. Any person or group of persons may serve in more than one fiduciary capacity with respect to the Plan. The Plan Administrator may designate persons or agents (including third party administrators) to carry out fiduciary responsibilities under the Plan.

2.10 **Complete and Separate Allocation of Fiduciary Responsibilities.** It is intended that this Article II shall allocate to each named fiduciary the individual responsibility for the prudent execution of the actions assigned to each named fiduciary. The performance of such responsibilities shall be deemed a several assignment and not a joint assignment. None of such responsibilities, nor any other responsibility, is intended to be shared by two or more of such fiduciaries unless such sharing is provided by a specific provision of this Wrap-Plan,

the Wrap-SPD or any Welfare Program Document. Whenever one named fiduciary is required by the Plan to follow the directions of another, the two shall not be deemed to have been assigned a shared responsibility, but the responsibility of the one giving the direction shall be deemed the named fiduciary with regard to said responsibility to be its sole responsibility, and the responsibility of the one receiving such direction shall be to follow it insofar as such direction is on its face proper under the Plan and applicable law.

2.11 **Disclaimer of Liability.** Except as otherwise required by Sections 404 through 409 of ERISA, neither any Employer nor the Plan Administrator shall be liable for any act, or failure to act, which is made in good faith pursuant to the provisions of the Plan.

2.12 **Indemnification.** To the full extent permitted by law, the Plan Sponsor and each other Employer (collectively, in this Section 2.12, the "**Employer**") jointly and severally shall indemnify each past, present and future Employee who acts in the capacity of an agent, delegate or representative of the Plan Administrator (including any benefits committee) or the Plan Sponsor, under the Plan (collectively, each such Employee shall be referred to in this Section 2.12 as a "**Plan Administration Employee**") against, and each Plan Administration Employee shall be entitled without further act on his part to indemnity from the Employer for, any and all losses, liabilities, costs and expenses (including the amount of judgments, court costs, attorneys' fees and the amount of approved settlements made with a view to the curtailment of costs of litigation, other than amounts paid to an Employer) incurred by the Plan Administration Employee in connection with or arising out of any pending, threatened or anticipated possible action, suit, or other proceeding, including any investigation that might lead to such a proceeding, in which he is or may be involved by reason of, or in connection with, his being or having been a Plan Administration Employee. **This indemnity obligation is intended to indemnify the Plan Administration Employee against the consequences of his active, passive, concurrent or partial negligence; provided, however, such indemnity shall not include any and all losses, liabilities, costs and expenses incurred by any such Plan Administration Employee (a) with respect to any matters as to which he is finally adjudged in any such action, suit or proceeding to have been guilty of gross negligence or willful misconduct in the performance of his duties as a Plan Administration Employee, or (b) with respect to any matter to the extent that a settlement thereof is effected in an amount in excess of the amount approved by the Plan Sponsor (which approval shall not be unreasonably withheld).**

No right of indemnification hereunder shall be available to, or enforceable by, any such Plan Administration Employee unless, within twenty (20) days after his actual receipt of service of process in any such action, suit or other proceeding (or such longer period as may be accepted by the Plan Sponsor), he shall have offered the Plan Sponsor, in writing, the opportunity to handle and defend same at its sole expense, and the decision by the Plan Sponsor to handle the proceeding shall conclusively determine that the Plan Administration Employee is entitled to the indemnity provided herein unless he then expressly agrees otherwise.

Until and unless a final judicial determination has been made that indemnity is not applicable, all the costs and expenses of the Plan Administration Employee shall be promptly and fully paid or reimbursed by the Employer upon demand.

The foregoing right of indemnification shall inure to the benefit of the heirs, executors,

administrators and personal representatives of each Plan Administration Employee, and shall be in addition to all other rights to which he may be entitled as a matter of law, contract, or otherwise.

ARTICLE III.
BENEFITS

The actual terms and conditions of eligibility, coverage, exclusions and limitations on coverage, and the additional rules pertaining to the benefits of Participants under the Plan, are set forth in the Welfare Program Documents and the Wrap-SPD. The deductibles, copayments, out-of-pocket maximum amounts, and the reimbursement percentages for eligible charges under the Plan, are contained in the Welfare Program Documents. The Welfare Program Documents, as then currently in effect, are incorporated in their entirety by reference into the Wrap-SPD which, in turn, is incorporated by reference into this Wrap-Plan.

Notwithstanding anything to the contrary contained herein, with respect to the Fully-Insured Programs, benefits will be paid solely in the form and amount specified in the relevant Welfare Program Document for each Fully-Insured Program, and pursuant to the terms and conditions of such Fully-Insured Program, except as otherwise required by ERISA, the Code or other applicable law, regulation, or other authority issued by a governmental entity.

ARTICLE IV.
ADOPTION OF THE PLAN BY OTHER ENTITIES

4.1 **Adoption Procedure.** With the approval of the Plan Sponsor, any Affiliate of the Plan Sponsor may adopt and become an Employer under the Plan by executing and delivering to the Plan Sponsor an adoption instrument stating that the Affiliate intends to adopt the Plan and to be bound as an Employer by all the terms and conditions of the Plan with respect to its eligible Employees and their Dependents. The adoption instrument shall specify the effective date of such adoption of the Plan and shall become, as to such Affiliate and its Employees, a part of the Plan.

4.2 **Administration.** Any Affiliate which adopts the Plan shall designate the Plan Sponsor as its agent to act for it in all transactions affecting the administration of the Plan, and shall designate the Plan Administrator to act for such Affiliate and its Participants in the same manner in which the Plan Administrator may act for the Plan Sponsor and its Participants hereunder.

4.3 **Termination of Participation.** Any Employer may cease to participate in the Plan with respect to its Employees, provided the Employer is authorized to do so by the Plan Administrator. The Plan Sponsor may amend Appendix A to the Wrap-SPD, as needed, to reflect an Employer's withdrawal of the Plan, without regard to the formal amendment provisions of the Plan.

ARTICLE V.
FUNDING

Notwithstanding anything to the contrary contained herein or in a Welfare Program Document, participation in the Plan by a Participant and the payment of Plan benefits will be conditioned on such Participant Contributions towards the cost of coverage under the Plan at such

time and in such amounts as the Plan Administrator will establish from time to time. The Plan Administrator shall designate the applicable method by which the Participant must make any Participant Contributions, and the Participant must consent in writing (including electronically, as applicable), or as otherwise required under the Plan Administrator's procedures, to such payment method to remain covered under the Plan. Nothing herein requires an Employer or the Plan Administrator to contribute to or under the Plan, or to maintain any fund or segregate any amount for the benefit of any Participant, Dependent or Beneficiary, except to the extent specifically required under the terms of a Welfare Program. No Participant, Employee, Dependent or Beneficiary will have any right to, or interest in, the assets of any Employer as the result of coverage under the Plan until actually paid.

Benefits or premiums for the Plan will be provided through a trust, insurance contracts or through the general assets of the Employer in accordance with the terms of the relevant Welfare Program. An Employer will have no obligation, but will have the right, to insure or reinsure or to purchase stop loss coverage, where applicable, with respect to any Welfare Program under the Plan. To the extent that the Plan is provided through an Employer's purchase of insurance, payment of any benefits under such Welfare Program will be the sole responsibility of the insurer, and the Employer will have no responsibility for such payment.

ARTICLE VI.
CLAIMS PROCEDURES

6.1 General.

(a) Except as provided in subsection (b) (below), a claim for benefits under a Welfare Program will be submitted in accordance with, and to the party designated under, the terms of such Welfare Program. Notwithstanding the foregoing, unless a Welfare Program specifically provides otherwise, a claim for benefits must be submitted not later than twelve (12) months after the date that the claim arises (for example, the date a medical service is provided and the charge is incurred). If a Welfare Program does provide otherwise, then the limitation under the Welfare Program will control. In the event that a claim, as originally submitted, is not complete, the Claimant will be notified and the Claimant will then have the responsibility for providing the missing information within the timeframe stated in such notification.

A Participant or Beneficiary may designate an authorized representative to act as "claimant" on his or her behalf with respect to the Plan's claims procedures, as permitted by ERISA. The Claims Fiduciary for the applicable Welfare Program may require that any such designation be made in writing (including electronically) using a form prescribed by the Claims Fiduciary as consistent with ERISA and in accordance with the Claims Fiduciary's procedures for such purpose in a manner that is sufficiently clear and conspicuous to enable the Claims Fiduciary to reasonably verify the status of the authorized representative and the scope of such authorization. Whether any such designation of an authorized representation meets such requirements shall be determined by the Plan Administrator or Claims Fiduciary, as applicable, in its discretion. The Plan Administrator or the Claims Fiduciary, as applicable, may disregard any designation of an authorized representative that it deems to be defective or otherwise improper or invalid hereunder. In particular, and without limitation, such entities reserve the right and discretion to refuse to honor a Participant's or Beneficiary's designation of an authorized representative if the Plan

Administrator or Claims Fiduciary, as applicable, determines that such designation is fraudulent; such as, for example, when the Plan Administrator or Claims Fiduciary, as applicable, determines that the signature of approval on the designation does not belong to the Participant or Beneficiary.

(b) To the extent that a Welfare Program does not prescribe a claims procedure for benefits that satisfies the requirements of Section 503 of ERISA and the regulations promulgated thereunder, as determined by the Plan Administrator, the claims procedures set out below in Sections 6.2 through 6.9 will apply to a claim for benefits under a Welfare Program. To the extent that a particular Welfare Program is not subject to the Affordable Care Act, then the provisions of this Article VI that apply only to plans subject to the Affordable Care Act shall not apply to such Welfare Program.

(c) The claims procedures applicable to claims made for benefits under the Plan do not include casual or general inquiries regarding eligibility or particular Welfare Program benefits that may be provided under the Plan. In order for an "inquiry" to constitute a claim for benefits or an appeal of an Adverse Benefit Determination, a Participant or Beneficiary must follow the claim procedures under the applicable Welfare Program, or, if such procedures are not contained in such Welfare Program, then according to the claims procedures set forth in this Article VI.

(d) To the extent required by the Affordable Care Act, the Plan will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

6.2 Definitions.

(a) *Adverse Benefit Determination* means any of the following: (i) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit under the Plan, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's eligibility to participate in the Plan; (ii) a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit under the Plan, resulting from the application of precertification procedures or other utilization review procedures; (iii) a failure to cover an item or service for which benefits under the Plan are otherwise provided because it is determined to be experimental and/or investigational or not medically necessary or because another exclusion applies under the Plan; and (iv) a rescission of coverage, which is a cancellation or discontinuance of coverage that has a retroactive effect, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at that time.

(b) *Adverse Benefit Determination on Review* means the upholding or affirmation of an appealed Adverse Benefit Determination.

(c) *Affordable Care Act Program* or *ACA Program* means each of the following (together, the "*ACA Programs*"), to the extent such program does not constitute an "excepted benefit" under the Affordable Care Act:

- Rimkus Consulting Group, Inc. Choice Plus Base Plan; and
- Rimkus Consulting Group, Inc. Choice Plus Premium Plan.

(d) *Benefit Determination* means a determination by the Claims Administrator on a claim for benefits under the Plan, whether or not an Adverse Benefit Determination.

(e) *Benefit Determination on Review* means a determination by the Claims Fiduciary (or if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) on an appeal of an Adverse Benefit Determination, whether or not an Adverse Benefit Determination on Review.

(f) *Claimant* means a Participant or Beneficiary under the Plan, or his authorized representative or health care provider, who is designated by the Participant or Beneficiary to act on his behalf. In the case of an Urgent Care Claim, a Health Care Professional with knowledge of the medical condition of the Participant to whom the Urgent Care Claim applies will be permitted to act as the authorized representative of such Participant.

(g) *Concurrent Care Decision* means, with respect to an ongoing course of treatment previously approved by the Plan which is to be provided over a period of time or number of treatments: (i) any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments; or (ii) any request by a Claimant to extend the ongoing course of treatment beyond the period of time or number of treatments. A Concurrent Care Decision described in clause (i) will constitute an Adverse Benefit Determination.

(h) *Disability Claim* means a claim for benefits that is conditioned upon a showing of "disability" by the Claimant.

(i) *External Review* means a review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to the external review process described in Section 6.9.

(j) *Final Internal Adverse Benefit Determination* means an Adverse Benefit Determination on Review that has been upheld by the Plan at the completion of the internal appeals process described in Sections 6.5 and 6.6 (or an Adverse Benefit Determination with respect to which the internal appeals process has been exhausted under the deemed exhaustion rules of Section 6.10).

(k) *Final External Review Decision* means a determination by an Independent Review Organization at the conclusion of an External Review.

(l) *Health Care Claim* means a Pre-Service Claim, a Post-Service Claim, a Concurrent Care Decision or an Urgent Care Claim.

(m) *Health Care Professional* means a physician or other health care service provider who is licensed, accredited, or certified to perform the specified health services consistent with state law.

(n) *Independent Review Organization or IRO* means an entity that conducts independent

External Reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit Determinations pursuant to Section 6.9.

(o) *Other Claim* means a claim other than (i) a Disability Claim or (ii) a Health Care Claim.

(p) *Pre-Service Claim* means a claim for a benefit under a group health plan that, under the terms of the applicable plan, conditions the receipt of the benefit, in whole or in part, on pre-approval of the benefit in advance of obtaining medical care.

(q) *Post-Service Claim* means a claim for a benefit under a group health plan for reimbursement or consideration of payment for the cost of medical care that has already been rendered. A Post-Service Claim is a claim that is neither a Pre-Service Claim nor an Urgent Care Claim.

(r) *Urgent Care Claim* means a claim for medical care or treatment that, if not received, (i) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or (ii) in the opinion of a health care provider with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim. If a health care provider with knowledge of the Claimant's medical condition deems the medical care or treatment urgent, then the claim is an Urgent Care Claim.

6.3 Initial Claim Procedure and Time Limits.

(a) *Initial Claim Process.*

A claim and all required documentation will be filed in writing with the applicable Claims Administrator and decided within the applicable timeframe under federal law, regardless of whether all information required to perfect the claim is included. The timeframe for decision begins upon receipt by the Claims Administrator of a claim submitted by the Claimant in accordance with the Plan's claims procedures, and is contingent upon the type of claim that is submitted, whether the claim submitted is a complete claim or incomplete claim, whether additional information is required and whether an extension is required to make a decision on the claim.

(b) *Urgent Care Claim:*

(i) If an Urgent Care Claim is submitted, the Claims Administrator will render a Benefit Determination and provide notice to the Claimant of such Benefit Determination as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after the Urgent Care Claim is received, subject to subsection (b)(ii).

(ii) If an Urgent Care Claim as submitted is incomplete, the Claims Administrator will notify the Claimant as soon as possible, but not later than twenty-four (24) hours after receiving the incomplete claim. Such notice will request the additional information required to render a decision on the claim and explain why such information is necessary. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the requested information. Regardless of whether the Claimant provides the Claims Administrator with the requested information, the Claims Administrator

will render a Benefit Determination on the claim and provide notice to the Claimant of such Benefit Determination as soon as possible, but not later than forty-eight (48) hours after the earlier of (A) receipt of the requested information or (B) the end of the period afforded the Claimant to provide the requested information.

(iii) In the event that the Claimant fails to follow the Plan's procedures for filing an Urgent Care Claim, the Claimant will be notified of such failure and of the proper procedures to be followed in filing such a Claim. The notification will be provided to the Claimant as soon as possible, but not later than twenty-four (24) hours following the failure. Notification may be oral, unless written notification is requested by the Claimant. For the purposes of this Section 6.3(b)(iii), a failure to follow the Plan's procedures for filing will mean only such a failure that is (A) a communication by Claimant that is received by a person or organizational unit customarily responsible for handling benefit matters under the Plan; and (B) a communication that names a specific Claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

(iv) Notification of any Adverse Benefit Determination with respect to an Urgent Care Claim will be made in accordance with Section 6.4.

(c) *Concurrent Care Decisions.*

(i) As to a Concurrent Care Decision which is an Adverse Benefit Determination, the Claims Administrator will notify the Claimant, in accordance with Section 6.4, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a Benefit Determination on Review of that Adverse Benefit Determination before the benefit is reduced or terminated.

(ii) In the event of a Concurrent Care Decision which is a request by a Claimant to extend the course of treatment beyond the period of time or number of treatments and is an Urgent Care Claim, such Concurrent Care Decision will be decided as soon as possible, taking into account the medical exigencies. The Claims Administrator will notify the Claimant of the Benefit Determination, whether or not adverse, within twenty-four (24) hours after receipt of the Claim by the Plan, provided that any such Claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any Adverse Benefit Determination concerning a request to extend the course of treatment, whether or not involving an Urgent Care Claim, will be made in accordance with Section 6.4, and appeal of the same will be governed by Sections 6.6(a)(i), (ii) or (iii), as appropriate.

(d) *Other Health Care Claims.* In the case of a Health Care Claim that is neither an Urgent Care Claim nor a claim involving a Concurrent Care Decision as described in subsection (c), the Claims Administrator will notify the Claimant of the Plan's Benefit Determination, as follows:

(i) Pre-Service Claim:

(A) The Claims Administrator will render a Benefit

Determination and provide notice to the Claimant of such Benefit Determination (whether or not adverse) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the Pre-Service Claim by the Plan. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least forty-five (45) days from the receipt of the notice within which to provide the specified information.

(B) In the event that the Claimant fails to follow the Plan's procedures for filing a Pre-Service Claim, the Claimant will be notified of such failure and of the proper procedures to be followed in filing such a claim. The notification will be provided to the Claimant as soon as possible, but not later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the Claimant. For the purposes of this Section 6.3(d)(i)(B), a failure to follow the Plan's procedures for filing will mean only such a failure that is (i) a communication by Claimant that is received by a person or organizational unit customarily responsible for handling benefit matters under the Plan; and (ii) a communication that names a specific Claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

(C) Notification of an Adverse Benefit Determination made hereunder will be made in accordance with Section 6.4.

(ii) Post-Service Claim:

(A) The Claims Administrator will render a Benefit Determination and provide notice to the Claimant of any such Adverse Benefit Determination within a reasonable period of time, but not later than thirty (30) days after receipt of the Post-Service Claim. This period may be extended one time by the Plan for up to fifteen (15) days, provided that the Claims Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Post-Service Claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

(B) Notification of an Adverse Benefit Determination made hereunder will be made in accordance with Section 6.4.

(e) *Disability Claims.*

(i) If a Disability Claim is submitted, the Claims Administrator will render a Benefit Determination and provide notice to the Claimant of any such Adverse Benefit Determination within a reasonable period of time, but not later than forty-five (45) days after receipt of the Disability Claim (the "**Initial Period**"). The Initial Period may be extended by the Plan for up to thirty (30) days (the "**First Extension**"), provided that the Claims Administrator both (A) determines that such an extension is necessary due to matters beyond the control of the Plan, and (B) notifies the Claimant, prior to the expiration of the Initial Period, of the circumstances requiring the First Extension and the date by which the Plan expects to render a decision.

(ii) If, prior to the end of the First Extension, the Claims Administrator determines that, due to matters beyond the control of the Plan, a decision cannot be rendered within the First Extension, the period for making the determination may be extended for up to an additional thirty (30) days (the "**Second Extension**"), provided that the Claims Administrator notifies the Claimant, prior to the expiration of the First Extension, of the circumstances requiring the Second Extension and the date as of which the Plan expects to render a decision.

(iii) In the case of any extension under this subsection (e), the notice of extension will specifically explain (A) the standards on which entitlement to a benefit is based, (B) the unresolved issues that prevent a decision on the claim, and (C) the additional information needed to resolve those issues, and the Claimant will be afforded at least forty-five (45) days within which to provide the specified information.

(iv) Notification of any Adverse Benefit Determination with respect to a Disability Claim will be made in accordance with Section 6.4.

(f) *Other Claims.*

(i) If an Other Claim is submitted, the Claims Administrator will render a Benefit Determination and provide notice to the Claimant of any denial, in whole or in part, of such Other Claim within a reasonable period of time, but not later than ninety (90) days after receipt of the Other Claim, unless the Claims Administrator determines that special circumstances require an extension of time for processing the Other Claim. If the Claims Administrator determines that an extension of time for processing is required, written notice of the extension will be furnished to the Claimant prior to the termination of the initial ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of such initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination.

(ii) Notification of any Adverse Benefit Determination with respect to an Other Claim will be made in accordance with Section 6.4 (below).

6.4 Notification of Benefit Determination.

(a) Except as provided in Section 6.4(b), the Claims Administrator will provide a Claimant with written or electronic notification of any Adverse Benefit Determination. The notification will set forth in a manner calculated to be understood by the Claimant:

(i) The specific reason or reasons for the Adverse Benefit Determination;

(ii) Reference to the specific Plan provisions upon which the determination is based;

(iii) A description of additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;

(iv) A description of the Plan's appeal procedures and time limits applicable to such procedures, including, in the case of an Urgent Care Claim, a description of the expedited review process applicable to such claims, along with a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on Review (or, if a Welfare Program requires two levels of appeal, following an Adverse Benefit Determination on Review with respect to the second appeal);

(v) In the case of an Adverse Benefit Determination under a Welfare Program regarding a Disability Claim or a Health Care Claim, if the Adverse Benefit Determination is based upon:

(A) an internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the Claimant upon request; or

(B) a medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

(vi) With respect to Health Care Claims under an ACA Program:

(A) information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable));

(B) the reason or reasons for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the ACA Program's standard, if any, that was used in denying the claim;

(C) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(D) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and External Review processes; and

(E) a statement describing availability upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

(b) In the case of an Adverse Benefit Determination involving an Urgent Care Claim, the information described in Section 6.4(a) may be provided to the Claimant orally within the time frame prescribed in Section 6.3(b), provided that a written or electronic notification is furnished to the Claimant not later than three (3) days after the oral notification.

6.5 Appeal Procedures.

(a) Each Claimant will have a reasonable opportunity to appeal an Adverse Benefit Determination to the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, to the Claims Administrator with respect to the first level appeal) as set forth hereafter. The Claimant must complete all of the administrative review steps available through the Claims Administrator before an appeal to the Claims Fiduciary, if any, is permitted under the Plan.

(b) Each Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the claim appealed. With respect to a Health Care Claim under an ACA Program, a Claimant is allowed to review the claim file and to present evidence and testimony as part of the internal claims and appeals process.

(c) Each Claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits under the Plan. Whether a document, record, or other information is "relevant" to a claim for benefits under the Plan will be determined by reference to Section 6.8.

(d) The appeal will take into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial Benefit Determination.

(e) The Claimant will have one-hundred eighty (180) days (sixty (60) days with respect to an Other Claim) following receipt of notification of an Adverse Benefit Determination within which to appeal said Determination. If the applicable Welfare Program requires two levels of appeal, the Claimant will have sixty (60) days following receipt of notification of an Adverse Benefit Determination on review of the first appeal within which to file a second appeal of the Adverse Benefit Determination.

Except with respect to an Other Claim:

(f) The appeal will not afford deference to the initial Adverse Benefit Determination and will be conducted by a decision maker who is neither the individual who made the Adverse Benefit Determination that is on appeal, nor the subordinate of such decision maker.

(g) In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part on a medical judgment, the decision maker will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involving the medical judgment.

(h) All medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination on appeal will be identified without regard to whether the advice was relied upon in making the Adverse Benefit Determination.

(i) All Health Care Professionals engaged for purposes of consultation under Section 6.5(g) will be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is on appeal, nor the subordinate of such individual.

(j) In the case of an Urgent Care Claim, a request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Claimant, and all necessary information, including the Plan's Benefit Determination on Review, will be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

(k) A Claimant will not be required to file more than two appeals of an Adverse Benefit Determination prior to bringing a civil action under Section 502(a) of ERISA. To the extent that the claims procedures set forth in any Welfare Program provide for more than two levels of appeal of an Adverse Benefit Determination, any level of appeal beyond the second level of appeal will be "voluntary".

(l) To the extent that any Welfare Program offers a voluntary level of appeal ("**Voluntary Appeal**") (except to the extent the Plan is required to do so by State law), including voluntary arbitration or any other form of dispute resolution, and notwithstanding anything in such Welfare Program to the contrary:

(i) The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies because the Claimant did not elect to submit a benefit dispute to a Voluntary Appeal;

(ii) Any statute of limitations or other defense based on timeliness is tolled during the time that a Voluntary Appeal is pending;

(iii) A Claimant may elect to submit a benefit dispute to a Voluntary Appeal only after exhaustion of the appeals permitted by the Welfare Program under which the benefit dispute arose, subject to Section 6.5(k);

(iv) A Claimant will be provided, upon request, sufficient information relating to the Voluntary Appeal to enable the Claimant to make an informed judgment about whether to submit a benefit dispute to Voluntary Appeal, including a statement that the decision of a Claimant as to whether or not to submit a benefit dispute to Voluntary Appeal will have no effect on the Claimant's rights to any other benefits under the Plan, and information about the applicable rules, the Claimant's right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past or present relationship with any party to

the review process; and

(v) No fees or costs will be imposed on the Claimant as part of the Voluntary Appeal.

(m) Notwithstanding anything in a Welfare Program to the contrary, a Claimant will not be subject to mandatory arbitration of an Adverse Benefit Determination, except to the extent that:

(i) The arbitration is counted as one of the two appeals described in Section 6.5(k) and is conducted in accordance with the requirements applicable to such appeals; and

(ii) The Claimant is not precluded from challenging the decision resulting from such arbitration under section 502(a) of ERISA or other applicable law.

With respect to a Health Care Claim under an ACA Program:

(n) Each Claimant will be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the ACA Program (or at the direction of the ACA Program) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided under Section 6.6 to give the Claimant a reasonable opportunity to respond prior to that date; and

(o) Before the ACA Program can issue a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant will be provided, free of charge, with the rationale; the rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided under Section 6.6 to give the Claimant a reasonable opportunity to respond prior to that date.

6.6 **Benefit Determination on Review**.

(a) *Timing of Notification.*

(i) *Urgent Care Claim*. In the case of an Urgent Care Claim, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant in accordance with Section 6.6(b) of the Plan's Benefit Determination on Review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the Claimant's appeal of an Adverse Benefit Determination by the Plan; provided that the Claims Fiduciary (or Claims Administrator) defers to the attending health care provider with respect to the decision as to whether a claim constitutes "urgent care."

(ii) *Pre-service Claims*. In the case of a Pre-Service Claim, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant, in accordance with Section 6.6(b), of the Plan's Benefit Determination on Review within a reasonable period of time appropriate to the medical circumstances. Such notification will be provided not later than thirty (30) days after receipt by the Plan of the Claimant's

appeal of an Adverse Benefit Determination, unless the applicable Welfare Program requires two appeals of an Adverse Benefit Determination, in which case such notification will be provided not later than fifteen (15) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination.

(iii) *Post-Service Claims*. In the case of a Post-Service Claim, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant, in accordance with Section 6.6(b), of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than sixty (60) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the applicable Welfare Program requires two appeals of an Adverse Benefit Determination, in which case such notification will be provided not later than thirty (30) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination.

(iv) *Disability Claims*. In the case of a Disability Claim, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will notify the Claimant, in accordance with Section 6.6(b), of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than forty-five (45) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the Claims Fiduciary (or Claims Administrator) determines that special circumstances require an extension of time for processing the claim. If the Claims Fiduciary (or Claims Administrator) determines that an extension of time for processing is required, written notice of the extension will be furnished to the Claimant prior to the termination of the initial forty-five (45) day period. In no event will such extension exceed a period of forty-five (45) days from the end of the initial period. The extension notice will indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination on Review.

(v) *Other Claims.* In the case of an Other Claim, the Claims Fiduciary (or if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) shall notify the Claimant in accordance with Section 6.6(b) of the Plan's Benefit Determination on Review within a reasonable period of time, but not later than sixty (60) days after receipt by the Plan of the Claimant's appeal of an Adverse Benefit Determination, unless the Claims Fiduciary (or Claims Administrator) determines that special circumstances require an extension of time for processing the claim. If the Claims Fiduciary (or Claims Administrator) determines that an extension of time for processing is required, written notice of the extension shall be furnished to the Claimant prior to the termination of the initial sixty (60) day period. In no event shall such extension exceed a period of sixty (60) days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the Plan expects to render the Benefit Determination on Review.

(vi) In the case of an Adverse Benefit Determination on Review, the Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will provide access to, and

copies of, documents, records, and other information described in Sections 6.6(b)(iii), (iv) and (vi), as appropriate.

(b) *Manner and Content of Notification of Benefit Determination on Review.*

The Claims Fiduciary (or, if the applicable Welfare Program requires two levels of appeal, the Claims Administrator with respect to the first level appeal) will provide a Claimant with written or electronic notification of the Plan's Benefit Determination on Review. In the case of an Adverse Benefit Determination on Review, the notification will set forth in a manner calculated to be understood by the Claimant:

(i) The specific reason or reasons for the Adverse Benefit Determination on Review;

(ii) Reference to the specific Plan provisions upon which the Adverse Benefit Determination on Review is based;

(iii) A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits under the Plan. Whether a document, record, or other information is relevant to a claim for benefits will be determined by reference to Section 6.8;

(iv) A statement describing any Voluntary Appeal procedures offered by the Plan and the Claimant's right to obtain the information about such procedures described in Section 6.5(l)(iv);

(v) A statement of the Claimant's right to bring an action under Section 502(a) of ERISA (or, if a Welfare Program requires two levels of appeal, the Claimant's right to bring an action under Section 502(a) of ERISA following an Adverse Benefit Determination on Review with respect to the second appeal);

(vi) Except with respect to an Other Claim, if the Adverse Benefit Determination on Review is based upon:

(A) an internal rule, guideline, protocol, or other similar criterion, either the specific rule, guideline, protocol, or other similar criterion, or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination on Review and that a copy of the rule, guideline, protocol, or other similar criterion will be provided, free of charge, to the Claimant upon request; or

(B) a medical necessity or experimental and/or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided, free of charge, upon request;

(vii) The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office and your state

insurance regulatory agency;"

(viii) With respect to Health Care Claims under an ACA Program:

(A) information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount (if applicable));

(B) the reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the ACA Program's standard, if any, that was used in denying the claim. In the case of a notice of Final Internal Adverse Benefit Determination, this description must include a discussion of the decision;

(C) a description of available internal appeals and external review processes, including information regarding how to initiate an appeal;

(D) the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and External Review processes; and

(E) a statement describing availability upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

6.7 Calculating Time Periods.

For the purposes of Sections 6.3 and 6.6(a), the period of time within which a Benefit Determination or a Benefit Determination on Review is required to be made, will begin at the time a claim or appeal, as the case may be, is filed in accordance with the procedures of the Plan, without regard to whether all information necessary to make a Benefit Determination or a Benefit Determination on Review, as the case may be, accompanies the filing. In the event that a period of time is extended as permitted under Section 6.3 or 6.6(a) due to a Claimant's failure to submit information necessary to decide a claim or the appeal, the period for making the Benefit Determination or the Benefit Determination on Review will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

6.8 Relevance to Claim.

For the purposes of Sections 6.5(c) and 6.6(b)(iii), a document, record, or other information will be considered "relevant" to a Claimant's claim if such document, record, or other information:

(a) Was relied upon in making the Benefit Determination;

(b) Was submitted, considered, or generated in the course of making the Benefit Determination, without regard to whether such document, record, or other information was relied upon in making the Benefit Determination;

(c) Demonstrates compliance with any administrative processes and safeguards in making the Benefit Determination; or

(d) Except with respect to an Other Claim, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the Benefit Determination.

6.9 External Review.

The Plan will comply with the External Review requirements of the Affordable Care Act with respect to the ACA Programs. External Review will only be available with respect to claims under an ACA Program.

An ACA Program will comply with the safe harbor for non-grandfathered self-funded group health plans not subject to a State external review process, and therefore subject to the Federal external review process in accordance with U.S. Department of Labor Technical Release 2010-01, U.S Department of Labor Technical Release 2011-02, and subsequent guidance ("**Federal External Review**"), as described in this Section 6.9 below, until superseded by future guidance.

The remainder of this Section 6.9 explains the Federal External Review process, which may be applicable in accordance with the foregoing paragraphs of this Section 6.9.

A denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant fails to meet eligibility requirements under the Plan is not eligible for External Review. In addition, until the issuance of official guidance to the contrary, External Review only applies to (1) an Adverse Benefit Determination that involves medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigational), as determined by the external reviewer; and (2) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

(a) *Request for Standard External Review*. A Claimant shall have four (4) months from the receipt of the notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination to submit a written request for an External Review to the Plan Administrator.

(b) *Preliminary Determination*. Within five (5) business days of receipt of a request for an External Review, the Plan Administrator shall complete a preliminary review of the request to determine whether:

(i) The Claimant is or was covered by the ACA Program at the time the health care item or service in question was requested, or, for retroactive reviews, whether the Claimant was covered by the ACA Program at the time the health care item or service was provided;

(ii) The Final Internal Adverse Benefit Determination does not relate to whether the Claimant satisfied the eligibility requirements of the ACA Program;

(iii) The Claimant has exhausted the Plan's internal appeal process applicable to the ACA

Program, unless the Claimant is not required to exhaust the internal appeal process under 29 CFR § 2590.715-2719; and

(iv) The Claimant has provided all the information and forms required to process an External Review.

(c) *Preliminary Notice*. If a request is not eligible for External Review, the Plan Administrator must issue a written notice to the Claimant within one (1) business day after the Plan Administrator completes the preliminary review, which must include the reasons the requested appeal is not eligible for External Review and contact information for the Employee Benefit Security Administration. If a request is not eligible for External Review because it is incomplete, the notice must include a description of the information necessary to complete the request and permit the Claimant to submit such information by the later of 48 hours after the Claimant receives the notice or by the end of the four (4) month period during which the External Review must be requested.

(d) *Standard External Review*. If a claim is eligible for External Review, the Plan will assign the claim to an Independent Review Organization. The external IRO will conduct a full review of the file, applicable Plan provisions and any material submitted as required by applicable guidance and in compliance with the IRO's contract with the Plan. The IRO will conduct this review on a de novo basis without deference to the Plan's decision.

Within five business (5) days after the Plan has assigned an IRO to review the claim, the Plan shall provide the documents and information considered by the Plan in making its Final Internal Adverse Benefit Determination. If the IRO receives any new evidence or information, it shall provide such information to the Plan and the Plan may reconsider its decision. If the Plan changes its decision upon reconsideration, it must notify the Plan participant and the IRO of its new decision within one (1) business day of making such decision. The IRO must then terminate its review.

The IRO shall provide the Claimant and the Plan with a written notice of its decision within 45 days of the date on which the IRO received the request for External Review. Such notice shall include all information required by applicable guidance.

Upon receipt of the IRO's final determination reversing the Plan's determination, the Plan shall immediately provide coverage or payment for the claim.

(e) *Expedited External Review*. An expedited External Review shall be provided:

(i) If the Claimant received an Adverse Benefit Determination that involves a medical condition of the Claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal;

(ii) If the Claimant received a Final Internal Adverse Benefit Determination and the Claimant has a medical condition where the timeframe for completion of a standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function; or

(iii) If the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services, but has not been discharged since receiving such emergency services.

Upon receipt of a request for an expedited External Review, the Plan shall determine if the request satisfies the requirements to be eligible for a standard External Review. The Plan must immediately send the Claimant a notice of such preliminary determination of eligibility.

If a claim is eligible for expedited External Review, the Plan shall assign the claim to an IRO. The IRO shall provide the Claimant and the Plan with a written notice of its decision as soon as possible, but in no event more than 72 hours after the IRO received the request for an expedited External Review. If the notice is not in writing, within 48 hours of the date the notice is provided, the IRO must provide a written confirmation of its decision to the Claimant and the Plan.

6.10 Exhaustion of Administrative Remedies.

Notwithstanding anything to the contrary in a Welfare Program, no action at law or in equity may be brought to recover under the Plan until all administrative remedies have been exhausted (including two appeals of an Adverse Benefit Determination if required by the applicable Welfare Program). If a Claimant fails to file a timely claim, or if the Claimant fails to request a review in accordance with the Plan's claim procedures outlined herein, such Claimant will have no right of review and will have no right to bring any action in any court. The denial of the claim will become final and binding on all persons for all purposes.

If the Plan fails to strictly adhere to all the requirements of Sections 6.3 through 6.8 with respect to a Health Care Claim under an ACA Program, the Claimant is deemed to have exhausted the internal claims and appeals process of Sections 6.3 through 6.8. In such case, the Claimant may initiate an External Review under Section 6.9 and is also entitled to pursue any available remedies under Section 502(a) of ERISA or under State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a Claimant chooses to pursue remedies under Section 502(a) of ERISA under such circumstances, the claim or appeal is deemed denied on review without the exercise of discretion by an appropriate fiduciary.

Notwithstanding the prior paragraph, the internal claims and appeals process with respect to a Health Care Claim under an ACA Program will not be deemed exhausted based on *de minimis* violations that do not cause, and are not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant. The Claimant may request a written explanation of the violation from the Plan, and the Plan must provide such explanation within 10 days, including a specific description of its basis, if any, for asserting that the violation should not cause the internal claims and appeals process of this section to be deemed exhausted. If an external reviewer or a court rejects the Claimant's request for immediate review on the basis that the Plan met the standards for the exception, the Claimant has the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the external reviewer or court rejects the claim for immediate review (not to exceed 10 days), the Plan shall provide the Claimant with notice

of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon Claimant's receipt of such notice.

6.11 Action for Recovery.

Unless otherwise expressly stated in a Welfare Program, and subject to Section 6.10, any action at law or in equity with respect to any and all claims relating to the Plan must be brought for recovery within one year from the earlier of (1) the date of a Final Internal Adverse Benefit Determination, if applicable, or (2) the accrual of any claim under or relating to the Plan that does not result in a Final Internal Adverse Benefit Determination. If the particular Welfare Program expressly states a limitations period for bringing an action thereunder, then the Welfare Program will control.

6.12 Participant's Responsibilities.

Each Participant will be responsible for providing the Claims Administrator, the Claims Fiduciary, the Plan Administrator and/or the Employer with the Participant's and each Beneficiary's current U.S. mailing address and electronic address, as specified in the Welfare Programs. Accordingly, any notices required or permitted to be given by the Claims Administrator, Claims Fiduciary, Plan Administrator or Employer hereunder will be deemed given if directed to such address furnished by the Participant and mailed by regular United States mail, delivered by messenger or other professional delivery service, or provided by electronic means as specified in Section 2520.104b-l(c) of ERISA. The Claims Administrator, Claims Fiduciary, Plan Administrator and the Employer will not have any obligation or duty to locate a Participant, Dependent or Beneficiary. In the event that a Participant, Dependent or Beneficiary becomes entitled to a payment under the Plan and such payment is delayed or cannot be made:

(a) because the current address according to the Claims Fiduciary's records is incorrect;

(b) because the Participant, Dependent or Beneficiary fails to respond to the notice sent to the current address according to the Claims Fiduciary's records,

(c) because of conflicting claims to such payments; or

(d) for any other reason;

the amount of such payment, if and when made, will be determined under the provisions of the Plan without payment of any interest or earnings.

To the extent that the entitlement of a Participant, Dependent, Beneficiary or other individual to a benefit under the Plan is the subject of an interpleader action in a court of competent jurisdiction, the Plan Administrator, Plan Sponsor and any other Plan fiduciary may act in reliance upon any order issued by such court regarding any individual's entitlement to benefits under the Plan, which action shall satisfy its fiduciary and other duties under the Plan.

6.13 Unclaimed Benefits.

If, within twelve (12) months after any amount becomes payable hereunder to a Participant or Beneficiary, and the same will not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care will have been exercised in attempting to make such payments,

the amount thereof will be forfeited and will cease to be a liability of the Plan.

ARTICLE VII.
RIGHT OF SUBROGATION AND REIMBURSEMENT

The provisions of this Article VII will govern and control the Plan's rights to subrogation and reimbursement, and will supersede any subrogation and reimbursement provisions set forth in any Welfare Program Document (other than a Welfare Program Document for a Fully-Insured Program) to the extent that such other provisions are more restrictive or limited regarding the rights of the Plan than are these provisions. The Plan reserves all its subrogation and reimbursement rights, at law and in equity, to the full extent not contrary to applicable law as determined by the Plan Administrator.

The Plan Administrator may, in its discretion, designate a third party service provider or other person or entity to exercise the rights described in this Article VII on behalf of the Plan. In addition, the Plan Administrator may, in its discretion and on a case-by-case basis, waive or limit any of the subrogation and reimbursement rights set forth in this Article VII on behalf of the Plan to the extent deemed appropriate. Any such waiver or limitation in a particular case will not limit or diminish in any way the Plan's rights in any other instance or at any other time.

7.1 Benefits Subject to this Provision.

This Article VII will apply to all health benefits provided under the Plan, except for those provided under a Fully-Insured Program. For purposes of this Article, certain terms are defined as follows:

(a) "**Recovery**" means any and all monies and property paid by a Third Party to (i) the Participant, (ii) the Participant's attorney, assign, legal representative, or Beneficiary, (iii) a trust of which the Participant is a beneficiary, or (iv) any other person or entity on behalf of the Participant, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault is made as to the Third Party) to compensate for any losses or damages caused by, resulting from, or in connection with, the injury or illness.

(b) "**Reimbursement**" means repayment to the Plan for medical or other benefits that it has paid to or on behalf of the Participant toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this amount, including the Plan's equitable rights to recovery.

(c) "**Subrogation**" means the Plan's right to pursue the Participant's claims against a Third Party for any or all medical or other benefits or charges paid by the Plan.

(d) "**Third Party**" means any individual or entity, other than the Plan, who is or may be liable, or legally or equitably responsible, to pay expenses, compensation or damages in connection with a Participant's injury or illness.

The term "Third Party" will include the party or parties who caused the injury or illness; the insurer, guarantor or other indemnifier or indemnitor of the party or parties who caused the injury or illness; a Participant's own insurer, such as an uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers'

compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the injury or illness.

7.2 **<u>When this Provision Applies</u>.**

A Participant may incur medical or other charges related to any injury or illness caused by the act or omission of a Third Party. Consequently, such Third Party may be liable, or legally or equitably responsible, for payment of charges incurred in connection with the injury or illness. If so, the Participant may have a claim against that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be Subrogated to all rights the Participant may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to 100% of the amount of benefits paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this <u>Article VII</u> (including, without limitation, attorneys' fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the Participant has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Participant receives the Recovery or (b) the Participant's attorney, a trust of which the Participant is a beneficiary, or other person or entity receives the Recovery on behalf of the Participant. This right of Reimbursement enforceable by an equitable lien is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA, and will be construed accordingly.

As a condition to receiving benefits under the Plan, the Participant hereby agrees to immediately notify the Plan Administrator, in writing, of whatever benefits are payable under the Plan that arise out of any injury or illness that provides, or may provide, the Plan with Subrogation and/or Reimbursement rights under this <u>Article VII</u>.

The Plan's equitable lien supersedes any right that the Participant may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Participant procures, or may be entitled to procure, regardless of whether the Participant has received compensation for any or all of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first and primary Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for a Participant's legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. As a condition to coverage and receiving benefits under the Plan, the Participant agrees that acceptance of benefits, as well as participation in the Plan, is constructive notice of the provisions of this <u>Article VII</u>, and Participant hereby automatically grants an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described above.

In addition to the foregoing, the Participant:

(a) Authorizes the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of medical or other benefits paid for the injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Participant's rights to Recovery when the provisions of this <u>Article VII</u> apply;

(b) Must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

(c) Must cooperate fully with the Plan in its exercise of its rights under this Article VII, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder.

Furthermore, the Plan Administrator reserves the absolute right and discretion to require a Participant who may have a claim against a Third Party for payment of medical or other charges that were paid, or are payable, by the Plan to execute and deliver a Subrogation and Reimbursement agreement acceptable to the Plan Administrator (including execution and delivery of a Subrogation and Reimbursement agreement by any parent or guardian on behalf of a covered Dependent, even if such Dependent is of majority age) and, subject to Section 7.5, that acknowledges and affirms: (i) the conditional nature of medical or other benefits payments which are subject to Reimbursement and (ii) the Plan's rights of full Subrogation and Reimbursement, as provided in this Article VII ("**S&R Agreement**").

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other illnesses or injuries), the Participant will execute and deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injury or illness. The Plan may file a copy of an S&R Agreement signed by the Participant and his attorney (and if applicable, signed by the parent or guardian on behalf of the covered Dependent) with such other entities, or the Plan may notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Participant (and his attorney, as applicable), a Participant's claim for any medical or other benefits for any injury or illness will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the timeframe applicable to the particular type of benefits claimed by the Participant, as specified in the Plan's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Plan's claims procedures will constitute the basis for denial of the Participant's claim for benefits for the injury or illness, and will be subject to the Plan's claims appeal procedures.

The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the injury or illness before an S&R Agreement and other papers are signed and actions taken (for example, to obtain a prompt payment discount); however, in that event, any payment by the Plan of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Plan precludes operation of the "made whole" and "common fund" doctrines. A Participant who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VII, including attorneys' fees and costs of suit, regardless of

an action's outcome) to the Plan under the terms of this Article VII. A Participant who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold such Recovery in constructive trust for the Plan because the Participant is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Plan, or receiving benefits under the Plan, the Participant automatically agrees, without further notice, to all the terms and conditions of this Article VII and any S&R Agreement.

The Plan Administrator has maximum discretion to interpret the terms of this Article VII and to make changes in its interpretation as it deems necessary or appropriate.

7.3 Amount Subject to Subrogation or Reimbursement.

Any amounts Recovered will be subject to Subrogation or Reimbursement, even if the payment the Participant receives is for, or is described as being for, damages other than medical expenses or other benefits paid, provided or covered by the Plan. This means that any Recovery will be automatically deemed to first cover the Reimbursement, and will not be allocated to or designated as reimbursement for any other costs or damages the Participant may have incurred, until the Plan is reimbursed in full and otherwise made whole. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Participant does not receive full compensation for all of his charges and expenses.

7.4 When Recovery Includes the Cost of Past or Future Expenses.

In certain circumstances, a Participant may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or injury that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. Participation in the Plan also precludes operation of the "made-whole" and "common-fund" doctrines in applying the provisions of this Article VII.

It is the responsibility of the Participant to inform the Plan Administrator when expenses incurred are related to an illness or injury for which a Recovery has been made. Acceptance of benefits under the Plan for which the Participant has already received a Recovery will be considered fraud, and the Participant will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Participant is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

7.5 When a Participant Retains an Attorney.

If the Participant retains an attorney, the Plan will not pay any portion of the Participant's attorneys' fees and costs associated with the Recovery, nor will it reduce its Reimbursement pro-rata for the payment of the Participant's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator reserves the absolute right and discretion to require the

Participant's attorney to sign an S&R Agreement as a condition to any payment of benefits under the Plan and as a condition to any payment of future Plan benefits for the same or other illnesses or injuries. Additionally, pursuant to such S&R Agreement, the Participant's attorney must acknowledge and consent to the fact that the "made-whole" and "common fund" doctrines are inoperable under the Plan, and the attorney must agree not to assert either doctrine in his pursuit of Recovery.

Any Recovery paid to the Participant's attorney will be subject to the Plan's equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VII, including attorneys' fees and costs of suit regardless of an action's outcome) to the Plan under the terms of this Article VII. A Participant's attorney who receives any such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Participant nor his attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

7.6 When the Participant is a Minor, is Deceased, is a COBRA Qualified Beneficiary or is a Dependent.

The provisions of this Article VII apply to the parents, trustee, guardian or other representatives of a minor Participant and to the heirs or personal representatives of the estate of a deceased Participant, regardless of applicable law and whether or not the representative has access to or control of the Recovery. For purposes of this Article VII, the term "Participant" will also include a COBRA Qualified Beneficiary (as defined in Section 11.11 of the Wrap-SPD) who has elected COBRA Continuation Coverage under the Plan. If a covered Dependent is the Participant whose benefits under the Plan are subject to the Plan's Subrogation and Reimbursement rights, the covered Employee who enrolled such Dependent under the Plan will also be required to execute the S&R Agreement, upon request, even if the Dependent is not a minor, and, in such event, the Employee will be liable for any breach of this Article VII by the Employee or such Dependent.

7.7 When a Participant Does Not Comply.

When a Participant does not comply with the provisions of this Article VII, the Plan Administrator will have the power and authority, in its sole discretion, to (i) deny payment of any claims for benefits by or on behalf of the Participant and (ii) deny or reduce future benefits payable (including payment of future benefits for the same or other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Participant to enforce the provisions of this Article VII, the Participant will be obligated to pay the Plan's attorneys' fees and costs regardless of the action's outcome.

ARTICLE VIII.
AMENDMENT OR TERMINATION

The provisions of this Article VIII will govern and control amendment and termination of the Plan, and will supersede any conflicting or inconsistent provisions set forth in a Welfare Program Document.

8.1 Right to Amend.

The Board (or a committee of the Board) and the Vice President, Human Resources shall each have the right, authority and power to make, at any time, and from time to time, any amendment to the Plan; provided, however, no amendment shall prejudice any claim under the Plan that was incurred but not paid prior to the effective date of the amendment, unless the person or entity responsible for the amendment, as applicable, determines that such amendment is necessary or desirable to comply with applicable law or is required under the terms of a particular Welfare Program. Moreover, if the Plan is amended, a Participant's right to receive coverage for expenses incurred for supplies or services that were actually received or actually rendered on his behalf before the effective date of such amendment shall not be reduced or eliminated. However, an amendment may reduce or eliminate a Participant's right to receive coverage for expenses that are or will be incurred for supplies or services that are received or rendered on or after the effective date of the amendment, even if such supplies or services were approved or are part of a series of treatments or services that began prior to such effective date.

8.2 Right to Terminate.

The Board (or a committee of the Board) and the Vice President, Human Resources shall each have the right, authority, power and discretion to terminate the Plan at any time, in whole or in part, without prior notice, to the extent deemed advisable in its or his discretion; provided, however, such termination shall not prejudice any claim under the Plan that was incurred but not paid prior to the termination date unless the person or entity responsible for the termination, as applicable, determines it is necessary or desirable to comply with applicable law.

The Board (or a committee of the Board) and the Vice President, Human Resources may, in its or his discretion, terminate the participation of any Employer, with respect to its Employees only, in the Plan, effective as of any date such party deems advisable. The Plan Sponsor may revise Appendix A of the Wrap-SPD, as needed, to reflect the termination of an Employer from participation in the Plan, without regard to the formal amendment provisions of the Plan.

ARTICLE IX.
MISCELLANEOUS PROVISIONS

9.1 Controlling Law. The Plan shall be construed, regulated and administered under the laws of the State of Texas without regard to its conflicts of law principles, except as preempted by ERISA or other controlling federal law, or as expressly provided in the applicable Welfare Program.

9.2 Invalidity of Particular Provision. If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, and the Plan shall be construed and enforced as if the invalid or illegal provision had not been inserted herein.

9.3 Acceptance of Terms and Conditions of the Plan by Participants. Each Participant, by making application to become a Participant under the Plan or by the execution of any form authorized under the terms of the Plan for himself or his legal representatives, approves and agrees to be bound by the terms and provisions of the Plan (including the incorporated Wrap-SPD and Welfare Programs) and by the actions of the Plan Administrator and the Claims Fiduciary taken in accordance with the Plan.

9.4 **<u>Construction</u>.** Words used in the Plan in the singular shall include the plural and vice-versa. The gender of words used herein shall be construed to include whichever may be appropriate under particular circumstances of the masculine, feminine or neuter genders. Headings of articles and sections used herein are inserted for convenience of reference and shall not create any inference or presumption concerning the construction of the Plan.

9.5 **<u>Non-Alienation of Benefits</u>.** No benefit, right or interest of any Participant under the Plan shall be subject to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, seizure, attachment or legal, equitable or other process, or be liable for, or subject to, the debts, liabilities or other obligations of such person, except as otherwise required by law. The Employer shall not be in any manner liable for or subject to the debts, contracts, liabilities, engagements or torts of any Participant entitled to benefits hereunder.

9.6 **<u>Limitation of Rights</u>.** Neither the establishment nor the existence of the Plan, nor any modification thereof, shall operate or be construed so as to:

(a) give any person any legal or equitable right against the Plan (including any assets of the Plan), the Plan Sponsor, an Employer or the Plan Administrator, except as required by controlling law which cannot be waived; or

(b) create a contract of employment with any Employee, obligate an Employer to continue the service of any Employee, or affect or modify the terms of an Employee's employment in any way, including the right of the Employer to discharge any Employee, with or without cause, at any time.

9.7 **<u>Costs and Expenses</u>.** Any costs and expenses incurred in the administration of the Plan shall be paid by the Plan, the Plan Sponsor and/or one or more Employers, as determined by the Plan Sponsor.

9.8 **<u>Assignment and Payment of Benefits</u>**. The provisions of this <u>Section 9.8</u> shall supersede any provisions of a Welfare Program Document (other than the Welfare Program Document(s) of a Fully-Insured Program) regarding the subject matter hereof and shall govern and control.

Except as otherwise expressly provided under the terms of a written agreement with a provider of healthcare services or supplies to which the Plan Administrator, the Claims Fiduciary, or other delegate of the Plan Administrator is a named party (a "**Plan Agreement**"), no rights, causes of action and benefits under the Plan can be assigned or transferred to any person or entity, including, but not limited to, an out-of-network healthcare provider (or any representative or agent with respect to such provider), either before or after healthcare services or supplies are provided to or on behalf of a Participant. For purposes of clarification and not limitation, such rights and causes of action shall include any administrative, statutory, or legal right or cause of action that a Participant or other individual may have under ERISA, including, but not limited to, any right to (a) make a claim for Plan benefits, (b) request the Plan or other documents related to the Plan or a claim for benefits, (c) file an appeal of a denied claim for Plan benefits, or (d) file a lawsuit under ERISA or other applicable law.

In the absence of a Plan Agreement which specifically provides for assignment of the Participant's benefits and/or rights under the Plan (i.e., is not merely an agreement between

the Participant and the provider or its representative or agent), the Plan Administrator and Claims Fiduciary, as applicable, each reserve the unilateral right and discretion to elect to make any benefit payment under the Plan directly to the provider, the Participant, or to another designated person or entity, with or without the Participant's authorization, with each such payment being made on behalf of the Participant, and not to such payment recipient in its, his or her own right. Moreover, if the Plan Administrator or Claims Fiduciary, as applicable, elects to make any such direct payment, it shall not constitute a waiver by the Plan Administrator or Claims Fiduciary of the anti-assignment provisions of this Section 9.8. In addition, any payment made under the Plan to any such person or entity discharges the Plan's responsibility to the Participant for benefits under the Plan to the full extent of such payment.

Disclosures of information about the Participant can only be made to a Participant or a Participant's authorized representative in accordance with applicable law and the terms of the Plan.

9.9 **Overpayments.** If, for any reason, any benefit, premium or fee under the Plan is erroneously paid or reimbursed by the Plan Administrator, Claims Fiduciary or other person or entity to a Participant or to an insurance company, a healthcare or other services provider (including an assignee of the Participant as described in Section 9.8), or other person or entity for the benefit of a Participant (collectively, a "Third-Party Payee"), such erroneously-paid amount shall constitute an "**Overpayment**" under the Plan, with respect to which the Plan shall have a right of first and primary reimbursement from such Participant or Third-Party Payee that is enforceable by an equitable lien equal to 100% of the Overpayment amount ("**Overpayment Reimbursement**"). Without limitation, the Plan's right to Overpayment Reimbursement is intended to entitle the Plan to equitable relief under Section 502(a)(3) of ERISA and shall be construed accordingly.

If such Overpayment is not refunded to the Plan within a reasonable time period as determined by the Plan Administrator or Claims Fiduciary, the Overpayment shall be (a) charged directly to the Participant (including, without limitation, to a covered Employee on behalf of any of his or her Dependents or Beneficiaries) or to a Third-Party Payee as a reduction of the amount of future benefits otherwise payable on behalf of the Participant, or (b) recouped by any other method which the Plan Administrator or Claims Fiduciary, as applicable, deems to be appropriate in its discretion. For example, the selected repayment method may include, without limitation, offsetting other payments made by the Plan to the Participant, or to the same Third-Party Payee on the Participant's behalf (in which case, such payment offset to a Third-Party Payee shall not constitute an adverse benefit determination that is subject the ERISA claims and appeals procedures of the Plan). For purposes of clarity and not limitation, in the event of the application of any Overpayment Reimbursement to a Third-Party Payee pursuant to the foregoing provisions of this Section 9.9, the offset of the overpayment hereunder is simply an adjustment to the amount owed to the Third-Party Payee to reflect the Overpayment and shall not be considered to be the denial or partial denial of any benefit claim under the Plan.

Notwithstanding the foregoing, if the relevant Welfare Program Document for a Fully-Insured Program contains provisions regarding the subject matter of this Section 9.9 which conflict with the provisions herein, the provisions of such Welfare Program Document will control with respect to that Fully-Insured Program.

9.10 **Entire Plan.** The Wrap-Plan, Policies, Wrap-SPD, Welfare Program Documents, and any appendices or exhibits attached thereto, together set forth the entire Plan, and fully supersede any and all prior plans, summary plan description documents, agreements, representations, promises or understandings, written or oral, pertaining to the subject matter hereof. Any amendment to the Plan must be in writing and in accordance with the applicable requirements of the Plan.

[Signature page follows.]

IN WITNESS WHEREOF, the undersigned, being duly authorized to act on behalf of the Plan Sponsor, has approved, adopted and executed this amended and restated Plan on this _____ day of _______________________, 2017, to be effective as of May 1, 2016.

ATTEST:	**RIMKUS CONSULTING GROUP, INC.**
By: ______________________________	By: ______________________________
Name: ____________________________	Name: ____________________________
Title: _____________________________	Title: _____________________________

RIMKUS CONSULTING GROUP, INC. BENEFIT PLAN
(Amended and Restated Effective as of May 1, 2016)

POLICY APPENDIX

As of May 1, 2016, the following group insurance policies (or contracts) issued by the insurance carrier (or service provider) to the Plan Sponsor (or other Employer), pursuant to which certain employee health and welfare benefits under the Plan are provided to Participants, including any amendments, endorsements or riders thereto (each individually a "**Policy**" and collectively, the "**Policies**"), are attached hereto and incorporated, in their entirety, into this Wrap-Plan by reference:

- Dental Insurance Policy between Rimkus Consulting Group, Inc. and Connecticut General Life Insurance Company;

- Vision Insurance Policy between Rimkus Consulting Group, Inc. and Connecticut General Life Insurance Company;

- Life, Accidental Death and Dismemberment, and Disability Insurance between Rimkus Consulting Group, Inc. and Aetna Life Insurance Company, Group Policy #473667.