Summary Plan Description
Participating Medical Plan
Accenture United States Group Health Plan

(Effective January 1, 2018) v3
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INTRODUCTION
This summary explains the main features of the Participating Medical Plan under the Accenture United States Group Health Plan (Plan) as amended effective January 1, 2018. The Plan was established by Accenture LLP (Accenture), effective July 1, 1999, to provide medical benefits for eligible employees and dependents of Accenture and its subsidiaries that have adopted the Plan (adopting employers).

The terms of the Plan are complicated. This summary is intended to explain the principal terms of the Plan in non-technical language. The complete terms and conditions of the Plan are described in a complex legal document. This summary is not intended to cover every circumstance covered in the Plan document. Should there be any inconsistency between the Plan document and this summary or an oral representation, the terms of the Plan document will govern. No benefits shall be paid based on the terms of this summary, unless such benefits are provided for under the terms of the Plan document. You may examine the complete Plan document on which this summary is based. It is available from Accenture.

The term “you” as used in this summary plan description refers to an employee of Accenture or other adopting employer who otherwise meets all the applicable eligibility and participation requirements under the Plan. Receipt of the summary plan description does not guarantee that the recipient is in fact a participant under the Plan or otherwise eligible for benefits under the Plan.

ADMINISTRATION
The Plan is administered by Accenture or its designated representative. Accenture is responsible for formulating and carrying out all rules and regulations necessary to administer the Plan and has the discretionary authority to make factual determinations and decisions regarding eligibility of employees and participants in the Plan. Accenture has delegated to one or more Claims Administrators the discretionary authority to make decisions regarding the interpretation or application of Plan provisions, and the discretionary authority to determine all questions, including factual determinations, as to the rights and benefits of employees and participants under the Plan. Benefits under the Plan will be paid only if the Plan Administrator (or its delegate) and/or Claims Administrator decides in its discretion that the claimant is entitled to them. Any decision made by Accenture or a Claims Administrator in good faith is final and binding on all persons. The Claims Administrators for the Plan are identified in the General Information Summary.

ELIGIBILITY
Employee Eligibility
You are eligible to participate in the Plan if you are regularly employed on a full-time or part-time basis, including temporary employees and interns, by Accenture or an adopting employer (other than Accenture Flex LLC (“Accenture Flex”) formerly Agility Services LLC) in the United States or Puerto Rico*, you are on the regular payroll of your employer, and you are treated or classified as an employee by your employer for purposes of withholding federal employment and income taxes. If you are employed by Accenture Flex, you are eligible to participate in the Plan and the coverage options for Accenture Flex employees if you satisfy the requirements for participation specified in Appendix A to this summary. Employees who are not employed by Accenture Flex are not eligible to participate in the coverage options for Accenture Flex employees. You are not eligible to participate in the Wellness Program if you are employed by Accenture Flex.

Generally, in all cases, you are not eligible to participate in the Plan if you are a leased employee, an independent contractor, or an employee whose employment is subject to the terms of a collective bargaining agreement. If you do not satisfy the applicable eligibility requirements described above, any subsequent determination by your employer, a government agency, a court, or other third party that you are an eligible employee will not have a retroactive effect for purposes of your eligibility to participate in the Plan, even if the determination is applicable to prior years.

*If you are employed by Accenture Puerto Rico LLC or any other adopting employer and your principal place of employment is in Puerto Rico, different rules apply to enrollment, medical plan options and your eligibility for participation under the Participating Flexible Benefits Plan is limited to paying for certain premiums on a pre-tax basis (federal only) through the Pretax Premium Option. For more information, please contact the Accenture Benefits Center at 1-877-332-2242.
Dependent Eligibility
If you are eligible to participate in the Plan, your dependents may also be eligible to participate in the Plan. Your eligible dependents are:

- Your spouse to whom you are legally married (not divorced or legally separated).
- Your same or opposite-sex domestic partner; provided all of the following criteria are met:
  - Your partner is 18 years or older.
  - Neither of you is married or in a domestic partner relationship with anyone else.
  - You are not related to each other by a degree of closeness that would prohibit legal marriage in the state in which you both reside.
  - You live together.
  - You are in an exclusive, committed relationship that is intended to be permanent, and you have agreed to be mutually responsible for each other’s common welfare (as demonstrated by partnership registration or license, or legal or financial interdependence).
- Any of the following children who are under age twenty-six (26):
  - Your natural child or legally adopted child (including a child placed with you for adoption). A legal adoption shall be deemed to have occurred on the date you assume a legal obligation for total or partial support of the child in anticipation of the adoption.
  - A stepchild or child for whom you are the legal guardian.
  - A foster child.
  - A child of your domestic partner.
  - A child who is the subject of a Qualified Medical Support Order (QMCSO) issued under ERISA Section 609, as determined by Accenture. You may request copies of the Accenture QMCSO policies and procedures by contacting the Accenture Benefits Center.
- An unmarried child of any age who receives at least one-half his or her support from you and who is mentally or physically incapable of self-sustaining employment as of the date the child otherwise attains any applicable maximum age under the Plan, provided they were covered under the Participating Medical Plan when they attained the limiting age under the Participating Medical Plan. However, if you were part of a transition from another employer, certain exceptions may apply.

A child will be treated as a tax code dependent of an employee who is not a natural parent only if no natural parent claims the child as a dependent on his or her tax return and the non-parent has a higher adjusted gross income than either natural parent.

When electing coverage for a foster child or child for whom you are the legal guardian for the first time, you must submit a Statement of Responsibility verifying that you have full parental responsibility (legal guardianship) and control of the child. In addition, when electing coverage for a domestic partner or the child(ren) of your domestic partner for the first time, you must complete and submit an Accenture Domestic Partner/Child of a Domestic Partner Tax Status Form. These forms are completed at the initial enrollment and do not need to be resubmitted each year.

Please note that some insured health plans may have other restrictions or requirements which are outside the eligibility requirements for Accenture. Please contact the Benefits Center at 1-877-332-2242 for more information regarding these plans.

If you are eligible for coverage under the Plan as both an employee and as a dependent spouse or a dependent child of an employee, you may be covered either as an employee or as a dependent, but not both. A dependent may not be covered as a dependent of more than one employee.

The Plan Administrator reserves the right to request proof of your dependent’s eligibility at any time. Failure to provide proof of dependent eligibility in accordance with the Plan Administrator’s procedures may result in your dependent being dropped from coverage.

Qualified Medical Child Support Orders
A qualified medical child support order (“QMCSO”) is a court or administrative order requiring child support for health coverage of your child or otherwise requiring Plan coverage for your child. You will be notified if Accenture receives a QMCSO that affects you.
If you receive a QMCSO, please contact Accenture. Accenture will determine, in its discretion and in accordance with its procedures, whether an order meets the requirements for a QMCSO. You and your beneficiaries may request a copy of the Plan’s QMCSO procedures from Accenture by contacting the Accenture Benefits Center.

ENROLLMENT

As an eligible employee, you may enroll in the coverage options available to you during the period starting with your first day of work and ending on the last day of the second month of employment, or, if you are an Accenture Flex employee, as otherwise set forth in Appendix A. (Special rules may apply if you were part of a transition from another employer and are communicated as part of your enrollment process.) Your coverage will begin on the first day of the month following the date you enroll. If you are an eligible employee and don’t enroll or decline coverage during this period, you will be automatically enrolled in the Cigna HDHP, “You only” coverage.

You will have to wait until the next annual enrollment period to change your coverage, unless you experience a life event or another event entitling you to change your elections under the Plan. If you are an Accenture Flex employee, please refer to Appendix A. The annual enrollment period is generally held during the last calendar quarter of the year. Each year during the annual enrollment period, you decide whether to change your Plan elections for the upcoming year.

Coverage Options

There are four types of medical plan coverage: (i) a High Deductible Health Plan (HDHP) with a Health Savings Account, namely, the Aetna HealthFund HDHP, the Blue Cross Blue Shield BlueEdge HDHP and the Cigna HDHP; (ii) a Preferred Provider Organization (PPO), namely, the Aetna PPO Plan, the Blue Cross Blue Shield PPO Plan, and Cigna PPO Plan; (iii) a nationwide Exclusive Provider Organization (EPO) known as the Aetna EPO Plan and (iv) the Local Health Plans, specifically, the Kaiser EPO and the Kaiser Added Choice POS Plan (only available in Hawaii). You and your dependents must be covered under the same option. Note: Notwithstanding the foregoing, if you are an Accenture Flex employee, you are not eligible for the medical plan coverage options described above. Please see “Coverage Options for Accenture Flex Employees” below for the medical plan coverage options available to you.

The three HDHP plans, three PPO plans and the Aetna EPO Plan are available to all eligible employees (other than Accenture Flex employees). (For a list of plans available to retired employees, please see the Retired Employee Medical Coverage section on page 12 of this summary.) Eligible employees in certain locations may also have the choice of a Local Health Plan. There are nine coverage options under the Plan:

- No Coverage
- Aetna HealthFund HDHP
- Blue Cross Blue Shield BlueEdge HDHP
- Cigna HDHP
- Aetna PPO Plan
- Blue Cross Blue Shield PPO Plan
- Cigna PPO Plan
- Aetna EPO Plan
- Local Health Plans (Kaiser EPO and Kaiser Added Choice POS – HI)

You must also select the number of people you wish to cover. The Plan uses an individual pricing model to determine the amount of premium you pay. Under individual pricing, a separate rate is assigned to each person being covered. There is one rate for employees, one rate for spouse/domestic partner and a third rate for each child being covered. For example, the premium to cover an employee, a spouse/domestic partner and two children is the total of four individuals at the appropriate rates. Although you can cover all of your eligible dependents, premiums will be capped at six dependents; an employee will not pay for more than six children or a spouse/domestic partner and five children. Please note that the individual pricing model is not applicable to retirees. Please see the “Retired Employee Medical Coverage” section of this document for a description of that coverage.
This summary provides general information about the Plan. For detailed information about the HDHP Plans, the PPO Plans, the Aetna EPO Plan or the Accenture Prescription Drug Plan, please refer to the respective Summary Plan Description for those plans which are available on the Live Well at Accenture website (http://resources.hewitt.com/accordion).

For information regarding the local health plans available in your service area, contact the Benefits Center. You should read all coverage information carefully before choosing a plan - there are differences among plans. Please contact the local health plan directly if you have any questions about specific services or treatment plans and to determine whether you live in the local health plan service area.

Coverage Options for Accenture Flex Employees
There are four types of medical plan coverage for Accenture Flex employees: (i) a High Deductible Health Plan (HDHP) with a Health Savings Account, namely, the Accenture Flex Aetna HealthFund HDHP, the Accenture Flex Blue Cross Blue Shield BlueEdge HDHP and the Accenture Flex Cigna HDHP; (ii) a Preferred Provider Organization (PPO), namely, the Accenture Flex Aetna PPO Plan, the Accenture Flex Blue Cross Blue Shield PPO Plan, and the Accenture Flex Cigna PPO Plan; (iii) a nationwide Exclusive Provider Organization (EPO) known as the Accenture Flex Aetna EPO Plan and (iv) the Accenture Flex Local Health Plans, specifically, the Accenture Flex Kaiser EPO and the Accenture Flex Kaiser Added Choice POS Plan (only available in Hawaii). You and your dependents must be covered under the same option.

The three HDHP plans, the three PPO plans and the Aetna EPO Plan described above are available to all eligible employees of Accenture Flex. Eligible employees in certain locations may also have the choice of an Accenture Flex Local Health Plan. There are nine coverage options under the Plan for Accenture Flex employees:

- No Coverage
- Accenture Flex Aetna HealthFund HDHP
- Accenture Flex Blue Cross Blue Shield BlueEdge HDHP
- Accenture Flex Cigna HDHP
- Accenture Flex Aetna PPO Plan
- Accenture Flex Blue Cross Blue Shield PPO Plan
- Accenture Flex Cigna PPO Plan
- Accenture Flex Aetna EPO Plan
- Accenture Flex Local Health Plans (Accenture Flex Kaiser EPO and Accenture Flex Kaiser Added Choice POS – HI)

You must also select the number of people you wish to cover. The Plan uses an individual pricing model to determine the amount of premium you pay. Under individual pricing, a separate rate is assigned to each person being covered. There is one rate for employees, one rate for spouse/domestic partner and a third rate for each child being covered. For example, the premium to cover an employee, a spouse/domestic partner and two children is the total of four individuals at the appropriate rates. Although you can cover all of your eligible dependents, premiums will be capped at six dependents; an employee will not pay for more than six children or a spouse/domestic partner and five children.

This summary provides general information about the Plan. For detailed information about the Accenture Flex HDHPs, the Accenture Flex PPO Plans, the Accenture Flex Aetna EPO Plan or the Accenture Prescription Drug Plan, please refer to the respective Summary Plan Description for those plans which are available on the Live Well at Accenture website (http://resources.hewitt.com/accordion).

For information regarding the local health plans available in your service area, contact the Benefits Center. You should read all coverage information carefully before choosing a plan - there are differences among plans. Please contact the local health plan directly if you have any questions about specific services or treatment plans and to determine whether you live in the local health plan service area.
Life Events
During the year, you may change your elections under the Plan if you experience a life event.

In general, you have 31 days from the date of the life event to change your current coverage. (See below for the longer enrollment period that applies in the event of a newly acquired dependent child or certain other events.) The day of the life event is the first day of the 31-day period. No changes can be made after 31 days, except as noted below. In addition, your change in election must be consistent with the life event, i.e., it must affect an individual’s eligibility for coverage under the Plan or the plan of another employer.

Life events and the permissible election changes are listed in the Life Event Change Matrix at the end of this summary.

Special Enrollment
If you or your dependents originally declined medical coverage under the Plan due to other health coverage, and that coverage is subsequently terminated as a result of either (i) a loss of eligibility for such coverage through no fault of your own or (ii) the termination of any employer contributions for such coverage, you and your dependents may be eligible to enroll in the Plan.

You must enroll within 31 days of the loss of such other coverage or termination of employer contributions. The effective date of any coverage provided under the Plan will be retroactive to the date your other coverage was lost. If you fail to enroll within 31 days after the loss of other coverage, you must wait until the next annual enrollment period or the occurrence of a life event to apply for coverage.

Also, if you acquire a new dependent through birth, adoption, placement for adoption or marriage, such dependent shall be treated as immediately covered under the Plan if you enroll the dependent within 31 days, or, effective June 5, 2018, for a newly acquired dependent child, within six months, of acquiring the new dependent. If you enroll the dependent within this 31-day or six-month period, as applicable, coverage will become effective on the date of the birth, adoption, placement for adoption or marriage. In this event, you and your eligible spouse may also enroll for medical coverage, provided that you must do so within 31 days following the date the new dependent is acquired (i.e., the six month enrollment period only applies to the child’s enrollment).

If you do not enroll yourself or your dependents within 31 days or six months, as applicable, of these events, you, your new dependent and your eligible spouse will be required to wait until the next annual enrollment period or the occurrence of a life event to apply for coverage.

Notwithstanding the foregoing, if (1) you, your spouse or dependent lose eligibility for coverage under Medicaid, (2) you or your dependent loses eligibility for coverage under a state child health plan or (3) you or your dependent becomes eligible for premium assistance under a Medicaid plan or state child health plan, then you may have 60 days from the date of such life event in which to make changes. No changes can be made after the 60-day period ends.

Enrollment Information, Password Protection and Updating Contact Information
If you are eligible for the Plan, you will have online access to information and benefits related to the Plan. Detailed information regarding the online access will be provided to you separately. In order to use the online site, you will be required to set up a user ID and password. Please keep in mind that your password can be used to access your personal Plan information and take certain actions related to the Plan. It is also your legal signature for those transactions you can complete online, so you must be sure to maintain the confidentiality of your password. In addition to protecting your password, you should verify that your email address and permanent address on file with the Plan are up to date, especially if you recently moved, were divorced or separated from your spouse. This is important to protect your privacy and ensure that you receive important information related to the Plan, because Plan communications may be mailed to the permanent address on file with the Plan.

DOMESTIC PARTNER COVERAGE

The cost of domestic partner coverage is the same as that for a covered spouse. The cost of covering eligible children of domestic partners is the same as the cost to cover any dependent child. However, unless the individual qualifies as a tax dependent as defined by the Internal Revenue Code (IRC) Section 152, the cost of medical coverage for a domestic partner (or the child of a domestic partner who is not a tax dependent) must be paid in after-tax dollars.
The cost of domestic partner and domestic partner child coverage is also subject to imputed income. (For more information about imputed income and other tax consequences, see the following section, "Tax Considerations.")

As for working spouses covered under the Plan, there is an additional charge of $1,200 per year (effective January 1, 2017) to cover a domestic partner who declines medical coverage available from his or her employer. This surcharge will not apply to Accenture Flex employees. The additional contribution does not apply if:

- The domestic partner's employer does not offer medical coverage, or
- The domestic partner is covered by his or her employer's plan and an Accenture medical plan, or
- The domestic partner does not work, or
- The domestic partner works for Accenture.

**Tax Considerations**

Generally, a person who is a member of your household qualifies as your tax dependent under IRC Section 152 if:

- You provide more than 50% of his or her financial support, and
- The individual lives with you for the entire calendar year, and
- The individual is a citizen or resident of the United States, and
- Your relationship is not in violation of any local laws.

The requirement for satisfying the definition of a tax dependent under IRC Section 152 can be complex. Consequently, you may want to consult a tax advisor about your personal situation before declaring your domestic partner as a dependent.

If a domestic partner or domestic partner’s child meets meet the definition of a dependent under IRC Section 152, imputed income will not apply to the cost of his or her medical coverage, and premiums can be paid in pre-tax dollars. However, before imputed income can be waived, the employee or partner must declare that the tax status of the domestic partner or child meets the definition of a "tax dependent" under IRC Section 152. If the domestic partner or child does not meet the definition of a "tax dependent," imputed income will apply to the cost of his or her medical coverage, and premiums are paid in after-tax dollars.

**Imputed Income**

Imputed income, which is the dollar value of certain employer-sponsored benefit plans, is considered additional income, and is taxed at the employee's or domestic partner's normal income tax rate. (For example, if your tax rate is 28%, you will pay 28% of your imputed income in taxes.) Federal income tax, FICA, and, in some instances, state tax is deducted based on the imputed income amount. Personnel who cover a domestic partner or domestic partner’s child under the medical plans will have imputed income tax based on the company paid portion of the domestic partner’s or child’s premium.

**Domestic Partner Tax Status**

When you cover a domestic partner or the child of a domestic partner under the Plan, you must submit the Accenture Statement of Domestic Partner / Child of a Domestic Partner Tax Status Form before coverage will be effective. The information provided on the statement determines if your domestic partner coverage is subject to imputed income. The Statement is available by calling the Benefits Center at 1-877-332-2242.

**HOW THE PLAN WORKS**

You and Accenture share the cost of coverage. Your premium cost each calendar year depends on the option you choose and the dependents you cover. You were eligible to reduce your 2018 premiums by completing a wellness screening as part of the Wellness Program. (Employees hired in 2018 automatically receive this reduction.) However, Accenture Flex employees are not eligible for the premium reduction or the Wellness Program.
The cost of your coverage under the Plan might be also be affected by the following:

- You may need to pay a working spouse or domestic partner contribution of $1,200 per year if you are covering a spouse or domestic partner who is eligible for coverage under his or her employer’s plan. This surcharge will not apply if you are an Accenture Flex employee.

- If you or any of your covered dependents use tobacco products, you’ll pay a tobacco-user surcharge of $500 per year. However, you are not required to pay the tobacco-user surcharge if you provide the Plan Administrator with evidence that you are enrolled and participating in a smoking cessation program. Tobacco products are defined as tobacco in any form, including cigarettes, cigars, pipes and forms of smokeless tobacco, such as snuff, chewing tobacco and electronic cigarettes. If you believe that it is unreasonably difficult due to a medical condition for you to participate in such a program, please contact the Plan Administrator and we will work with you to develop another way to qualify.

Pre-Tax Contributions
The Plan allows you to make your contributions for medical coverage on a pre-tax basis, to the extent permitted by applicable law. Pre-tax contributions work like this:

- When you first enroll, you authorize Accenture or the adopting employer to reduce your gross pay each pay period by the amount of your contributions for the coverage you have elected.
- Accenture applies this money to pay the required contributions for your coverage.
- Because your contributions are paid on a pre-tax basis, you reduce your gross income for tax purposes. This means you pay less Social Security, federal income tax and, in most cases, state and local income taxes. However, if your earnings are less than the Social Security wage base, your election may slightly reduce your Social Security benefits at retirement.

The cost of Plan coverage and the amount of your contributions for coverage are subject to change. If the cost of your coverage increases or decreases during the year, the amount of your pre-tax contributions is adjusted automatically.

In addition, it should be noted that contributions made to the Plan through a retroactive payroll deduction must be made on after-tax basis.

Coordination of Benefits
Benefits are coordinated with benefits from other group plans, HMOs, no-fault auto insurance and government programs. If the plan is "primary," it pays benefits first. If the plan is "secondary," it pays benefits after the "primary" plan, but the total benefits from both plans will not exceed 100% of covered expenses under the Accenture medical plan. (Benefits are not coordinated with school insurance or individual policies paid totally by you or your spouse.) If an HMO is primary, coverage will be calculated as if the HMO’s covered services were received, whether or not the insured person used the HMO service or facility. For a more detailed description of the Coordination of Benefit provision applicable to your medical plan, please see the respective SPD.

If you are Medicare-eligible, you may request information about how prescription drug coverage under the Plan compares to Medicare Part D prescription drug coverage by contacting the Accenture Benefits Center (1-877-332-2242).

Overpayments, Reimbursement of Third Party Payments and Subrogation
The Claims Administrator has the right to collect overpayments from you, from the provider of services or supplies, or from another insurance company, service plan or organization that should have made payment.

If you or a covered dependent received payment or have a right to receive payment from a third party (for example as the result of a settlement or judgment), for an injury, sickness or other condition, the Plan will not cover the reasonable value of the services to treat such an injury or illness or the treatment of such an injury or illness.
If the Plan does pay or provide benefits for such an injury, sickness or other condition, you or your covered dependent (or your legal representatives, estate or heirs) shall promptly reimburse the Plan from any settlement, verdict, insurance proceeds, or other amounts received by the covered person (or by the legal representatives, estate or heirs of the covered person), for the reasonable value of the medical benefits paid for or provided by the Plan to the covered person.

- Reimbursement will be made up to the full amount the covered person receives from the responsible party regardless of whether the settlement or judgment says that the money the covered person receives (all or part of it) is for medical expenses.

- Reimbursement will be made regardless of whether the responsible party admits liability and regardless of whether the covered person is fully compensated ("made whole") by the settlement, verdict, insurance proceeds, or other amounts.

In order to secure the rights of the Plan under this section, the covered person must grant to the Plan a first priority lien against the proceeds of any such settlement, verdict or other amounts received by the covered person (or his or her legal representatives, estate or heirs), assign to the Plan any benefits the covered person may have under any automobile policy or other coverage, to the extent of the Plan’s claims for reimbursement, and agree to the imposition of a constructive trust on the proceeds of any settlement, verdict or other amounts received by the covered person (or his or her legal representatives, estate or heirs). The Plan’s first priority lien shall not be reduced by the application of any so-called “Made Whole Doctrine,” “Rimes Doctrine,” “Common Fund Doctrine,” “Attorneys’ Fund Doctrine,” contributory or comparative negligence rules or statutes, uninsured motorist rules or statutes, or any doctrine purporting to defeat the Plan’s right to 100 percent first-dollar reimbursement by allocating the proceeds exclusively to non-medical expense damages or to reduce the Plan’s right of 100 percent first-dollar reimbursement for the covered person’s attorneys’ fees and court costs in recovering the proceeds.

The covered person shall sign and deliver, at the request of the Plan or its agents, any documents needed to protect such lien or to effect such assignment of benefits or constructive trust. If the Plan has not yet paid benefits relating to an injury or illness that was caused by a third party, the Plan may reduce or deny future benefits relating to that injury or illness on the basis of compensation that you, your dependents, your guardian or other representatives or beneficiaries received from the responsible parties.

The covered person shall cooperate with the Plan and its agents and shall sign and deliver such documents as the Plan or its agents reasonably request to protect the Plan’s right of reimbursement, provide any relevant information, and take such actions as the Plan or its agents reasonably request to assist the Plan making a full recovery of the reasonable value of the benefits provided. The covered person shall not take any action that prejudices the Plan’s rights. The Plan shall be responsible only for those legal fees and expenses to which it agrees in writing and shall not otherwise bear the costs of legal representatives retained by the covered person.

The Plan is subrogated to all of the rights of the covered person against any party liable for the covered person's injury or illness or for the payment for the medical treatment of such injury or occupational illness (including any insurance carrier), to the extent of the reasonable value of the medical benefits provided to the covered person under the Plan. The Plan may assert this right independently of the covered person.

The covered person is obligated to cooperate with the Plan and its agents in order to protect the Plan's subrogation rights. Cooperation means providing the Plan or its agents with any relevant information requested by them, signing and delivering such documents as the Plan or its agents reasonably request to secure the Plan's subrogation claim, and obtaining the consent of the Plan or its agents before releasing any party from liability for payment of medical expenses.

If the covered person enters into litigation or settlement negotiations regarding the obligations of other parties, the covered person must not prejudice, in any way, the subrogation rights of the Plan. The costs of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the covered person shall be borne solely by the covered person.

The information above provides basic information about how these provisions are administered in the medical plan. For a more detailed description of the Overpayment, Reimbursement of Third Party Payments and the Subrogation provisions applicable to your medical plan, please see the respective SPD.
WELLNESS PROGRAM

Our Wellness Program (Accenture Active) includes a digital wellness platform that provides employees and their spouses/domestic partners, who are enrolled in an Accenture medical plan, with the opportunity to track individual health goals and earn rewards for participation through a variety of personalized programs, tools and resources. You are not eligible to participate in the Wellness Program if you are employed by Accenture Flex.

In addition, the Wellness Program provides employees who complete a wellness screening (in accordance with wellness screening program guidelines) with an annual medical premium reduction of $150. If you also cover a spouse/domestic partner you will receive an annual $300 medical Premium reduction if you both complete the wellness screening. If you don’t participate in the wellness screening program, you will still be able to access medical coverage, but you will not receive a premium reduction.

More information about the Wellness Program including the Accenture Active app powered by Jiff, can be found on the Accenture Active page on the Accenture Portal.

TELADOC

Accenture also offers participants in an HDHP, a PPO plan, or the Aetna EPO Plan, an option to receive health care outside of a physician’s office via Teladoc. Teladoc is available 24 hours a day, seven days a week. It is not a program to replace your Personal Network Physician, but an added medical benefit. A co-payment of $40 for Teladoc’s services may apply. You may consider using Teladoc when you need immediate care for a non-emergency issue, if your doctor is unavailable, if you’re considering the Emergency Room/Department or an Urgent Care center for a non-emergency issue, if you’re on vacation, a business trip or away from home or for short-term prescription refills. More information is available at teladoc.com and by calling 1-800-Teladoc (1-800-835-2362). You may also download the mobile app at Teladoc.com/mobile.

BEST DOCTORS

Accenture offers you access to Best Doctors as part of your participation in the Plan. See below for information regarding the services that Best Doctors provides. Best Doctors is a voluntary and confidential service provided at no cost to you.

Best Doctors offers the following services:

- In-Depth Medical Review (InterConsultation®)
  If you have a complicated medical condition, are questioning a diagnosis, or are unsure of your treatment options, this service can help you get the answers you need to make an informed medical decision. A dedicated Best Doctors Member Advocate will have an in-depth conversation with you about your medical condition, including obtaining a full health history of you and your family. After the discussion, following your written authorization, Best Doctors will gather all of your medical records concerning your present condition and diagnosis.

  When the records are received, the Best Doctors clinical team conducts a comprehensive analysis of your clinical information. They select the appropriate expert(s) for your medical condition to evaluate your case. Once the Best Doctors expert has completed the in-depth medical case review, you will receive a report with the expert’s findings and recommendations.

  Your Member Advocate will speak with you about the report’s findings and then, provided that you authorize it, Best Doctors can also deliver the report to your treating physician. Throughout the process, your Member Advocate is available to answer your questions.

- Ask the Expert™
  For basic questions about your health condition and treatment plan options, Ask the Expert provides you with the answers. A dedicated member of the Best Doctors clinical team will discuss any necessary medical information with you and work with you to determine the questions you want answered. Your questions and unique medical information will be sent to an expert physician for review. In about seven business days you’ll receive a personalized report with the expert’s answers, along with recommendation for treatment options.
• Find a Best Doctor™
With this service, Best Doctors seeks to match you with one or more doctors who meet your specific needs and who have been chosen as the best in their field by other leading physicians. Best Doctors takes into account your age, medical history and health condition, and then searches their proprietary network of more than 53,000 Best Doctors expert physicians in more than 450 specialties and subspecialties.

• Critical Care Support
Best Doctors can help ensure that you have the right diagnosis and treatment when it matters the most – after an acute or catastrophic medical event. Renowned medical experts can provide early intervention for some of the most serious cases, significantly improving outcomes while reducing unnecessary expenses.

• Medical Records eSummary
Even if you are not facing an immediate medical need, Best Doctors can collect and organize all your medical records and provide them to you on an easy-to-access secure flash drive, which you can use for future doctor visits. Best Doctors will also provide a Health Alert Summary based on your medical history, with a checklist of steps to take in the next 12 to 24 months in order to stay healthy.

• Treatment Decision Support (TDS)
The Best Doctors service provides you with additional support that can help you understand all medical options when you’re considering surgery or another medical procedure. This service helps you make the treatment decision that’s right for you. It includes:

- Telephonic health coaching from a registered nurse
- Online interactive decision aides that explain multiple treatment options and consider lifestyle preferences
- Information about all the treatment options available to you
- Help making the right medical decision

Although the Best Doctors program is provided at no additional cost to you, please be aware that any additional tests or services you elect to undertake as a result of information contained in your Best Doctors Expert Report will be paid according to the provisions of the Plan. If you have a concern regarding the cost of any additional test or service, it is recommended that you check with your provider before proceeding.

Confidentiality
Best Doctors will NOT share your medical records, medical information or the contents of your Best Doctors report with anyone at your employer or your health plan unless you specifically authorize such disclosure.

In addition, Best Doctors represents that it complies with all relevant state, national, and international laws and regulations including the U.S. Health Insurance Portability and Accountability Act (HIPAA) of 1996. You can find their Privacy Policy at http://www.bestdoctors.com/us/Privacy-Policy.aspx. Unless required by law, your specific name and medical information will NOT be shared with anyone without your written consent. Only de-identified and aggregate information will be used for program evaluation and improvement purposes.

Contact Information
To get started, call Best Doctors at 1-866-904-0910 or visit members.bestdoctors.com.

Exclusions and Eligibility
Employees, retirees and COBRA participants enrolled in an Accenture medical plan coverage option and their covered family members may take advantage of the Best Doctors program. Effective June 1, 2018, the eligibility criteria for the Best Doctors program was expanded to also include the extended family (parents, parents-in-law, siblings, nieces and nephews) of the participant enrolled in Accenture medical plan coverage.
Please note that certain types of cases cannot be reviewed by Best Doctors. For instance, cases of mental health disorders that do not have physical ailments are not serviced by Best Doctors as there is insufficient data contained within the records to perform an informed analysis, and in-person evaluations are more appropriate. If you are unsure if your case can be reviewed by Best Doctors, please call 1-866-904-0910.

HEALTH SAVINGS ACCOUNT

Employees who enroll in an HDHP may also be eligible to participate in a Health Savings Account. A Health Savings Account (HSA) can be used to pay for health care expenses for you, your spouse and your eligible tax dependents or to save for future health expenses. The HSA is sponsored, maintained and administered by PayFlex. The HSA is not an Accenture plan and is not covered by ERISA.

You can make pre-tax contributions to the HSA through payroll deduction up to the limits set by IRS. For the 2018 plan year, those amounts are $3,450 if you have Employee-only coverage or $6,900 if you have Family coverage. If you are age 55 or older, you are eligible to make catch-up contributions up to an additional $1,000 in 2018.

In addition, Accenture will contribute $500 to your HSA if you are covering yourself only and $1,000 if you are covering another family member, provided you are an active member of an HDHP. If you enroll in an HDHP medical plan option mid-year due to a qualified life event or new hire enrollment, the Accenture HSA contribution will be prorated based upon when you join the plan. Accenture contributions made to your HSA count toward the IRS limits.

Rules regarding eligibility, contribution limits and other HSA plan provisions can be complex. For example, employees who enroll in an HDHP will not be eligible to participate in an HSA if they have other health coverage, including coverage under a general purposes health flexible spending account or a spouse’s non-high deductible health plan.

For more detailed information regarding the Health Savings account, please refer to the “High Deductible Health Plan and Health Savings Account Overview” on the Live Well at Accenture website (http://resources.hewitt.com/accenture). For information regarding your HSA balance, reimbursement of eligible expenses from your HSA or other administrative questions, you can contact PayFlex at 888-678-8242 or online at www.payflex.com.

WHEN YOUR PARTICIPATION ENDS

Subject to the COBRA continuation coverage rules described below, your participation in the Plan automatically ends on the last day of the month in which the earliest of the following occurs: (i) you terminate employment, die or retire; (ii) you revoke your elections due to a life event; (iii) you or your dependent cease to be eligible for benefits under the Plan; (iv) you cease to pay the required premium when due; (v) subject to the terms of the Uniformed Services Employment and Reemployment Rights Act (“USERRA”), you or your dependent enters full-time active military service; or (vi) Accenture terminates the Plan or coverage for a group of which you are a member. If none of the foregoing events occur, participation ends on the last day of the calendar year in which an election is revoked during annual enrollment.

Reemployment

If you terminate employment with, and are rehired by, Accenture (or Accenture Flex, as applicable) within 30 days of the date of your earlier termination, your prior elections under the Plan will automatically be reinstated. Your coverage effective date will be the first of the month following your rehire date. If you terminate employment with, and are rehired by, Accenture (or Accenture Flex, as applicable) more than 30 days from the date of your earlier termination from Accenture (or Accenture Flex, as applicable), you will be treated as a new hire and may make new elections under the Plan. Furthermore, if you terminate employment with Accenture and are subsequently hired by Accenture Flex, and vice versa, you will be treated as a new hire and may make new elections under the Plan. Your coverage effective date will be the first of the month following the date you enroll in the Plan. In all cases, your participation under the Plan is subject to the Plan’s eligibility rules. If you are an Accenture Flex employee, see Appendix A for more information, including information related to rehires.
In addition, if you retired from Accenture and are subsequently rehired by Accenture as an active employee or Leader, your retiree coverage will be suspended upon rehire and you will be enrolled in active employee or Leader coverage, subject to the coverage effective dates noted above. At the time of your subsequent retirement date, you will be eligible to elect retiree coverage based upon the plan provisions in effect at that time. Notwithstanding the foregoing, if you retired from Accenture and are subsequently hired by Accenture Flex as an active employee, you may continue your retiree coverage while employed by Accenture Flex. If you discontinue your Accenture retiree coverage while employed by Accenture Flex, you will not again be eligible for Accenture retiree coverage because Accenture Flex is not an adopting employer of the Accenture United States Group Retiree Medical Plan.

Retired Employee Medical Coverage

- **Eligibility for Coverage** - Accenture retiree medical benefits are provided under the Accenture United States Group Retiree Medical Plan. (For retired Accenture Leadership / Senior Executive Level 1-3 medical benefits, refer to the Accenture Leadership United States Benefit Plans Summary Plan Description.) Employees of Accenture Flex are not eligible for retiree medical benefits because Accenture Flex is not an adopting employer of the Accenture United States Group Retiree Medical Plan.

To qualify for retired employee medical coverage, you must, at the time you retire:

- Be retiring from an employer that has adopted the Accenture United States Group Retiree Medical Plan;
- Be at least age 55; and
- Have at least 10 years of aggregate full-time and/or part-time service with Accenture or an adopting employer.

You do not have to be enrolled in the Plan at the time you retire to be eligible for retiree medical coverage. However, if you do not enroll in the Retiree Medical Plan at the time you retire, you will not be able to elect medical coverage in the future for yourself or any dependents for any reason. As a retiree, you can be enrolled in the Aetna PPO Plan, Blue Cross Blue Shield PPO Plan, Cigna PPO Plan or the Kaiser EPO Plan (pre-65 retirees only). Retirees cannot be enrolled in an HDHP or the Aetna EPO Plan. If you are enrolled in either the Kaiser EPO Plan post-65, an HDHP or the Aetna EPO Plan and you do not elect coverage in one of the other available medical plans, you will automatically be defaulted to the Cigna PPO Plan.

In addition, if you do not cover your existing eligible dependents under the Plan at the time you retire, you will not be able to add them to the Retiree Medical Plan in the future for any reason. Eligible dependent children you acquire through birth or placement for adoption after you retire can be enrolled in the Retiree Medical Plan during the 31-day, or effective June 5, 2018, the six-month period following the date of birth or placement for adoption, as applicable, provided that you are enrolled in the Retiree Medical Plan at that time. Newly acquired children who are not enrolled during this six-month period will not be eligible for future enrollment in the Retiree Medical Plan, except as may otherwise be required by law. No other newly acquired dependents will be eligible for coverage under the Retiree Medical Plan, including spouses and dependent children you acquire through marriage after retirement. If you did not cover an eligible spouse/domestic partner at retirement or chose to drop them from coverage at a later date because they were covered under an Accenture medical plan as an employee, you may add them back to coverage when they retire or terminate from Accenture. Also, if you have a dependent child who is eligible for coverage under the Plan as an employee, that child may only be covered as an employee when you retire. If you decide not to enroll in medical coverage at the time you retire, you may be able to continue your coverage under the Plan under COBRA, as described below.

During retirement, you can change your current elections during annual enrollment or upon the occurrence of a life event. However, if at any time you decline medical coverage for you or your dependents, you cannot rejoin the Plan for any reason. In addition, you forfeit any rights your qualifying surviving spouse or domestic partner may have to medical coverage at your death.
As noted above, if you retired from Accenture and are subsequently hired by Accenture Flex as an active employee, you may continue your retiree coverage while employed by Accenture Flex. If you discontinue your Accenture retiree coverage while employed by Accenture Flex, you will not again be eligible for Accenture retiree coverage because Accenture Flex is not an adopting employer of the Accenture United States Group Retiree Medical Plan.

- **Cost of Coverage** - The cost of your medical coverage under the Retiree Medical Plan depends on the option you choose, the dependents you cover, your age and the age of your covered dependents. Depending on your Career Track (or former Workforce), Accenture may contribute to the cost through a Medical Premium Credit.

- **Medical Premium Credit Eligibility** – Eligibility for the Medical Premium Credit is determined by your employment status.

  Prior to September 1, 2014, employees below Accenture Leadership were eligible to accrue service towards the credit if they were one of the following workforces/levels:
  - Services employees
  - Enterprise employees
  - Solutions Workforce Senior Managers
  - San Antonio Delivery Center Level A Employees
  - Acquisition Specific Business Area*

  *For purposes of the SPD, the term “Acquisition Workgroup” is the term that was previously used in place of “Acquisition Specific Business Area” and has the same meaning. However, it should be noted that prior to the inception of Acquisition Workgroup effective January 1, 2008, not all acquisitions were eligible to participate in the retiree medical plan and accrue a medical premium credit.

Beginning on September 1, 2014, if you were otherwise receiving credit under one of the Workforces/Groups listed above, you will continue to accrue credit in the new Career Track model.

If you subsequently moved to one of the following Career Tracks or Groups after September 1, 2014, you are no longer eligible for future service accrual. Any past Medical Premium Credit accrual you may have earned is frozen.

  - Client & Market
  - Innovation & Thought Leadership
  - Client Delivery & Operations aligned with the Technology Delivery Center below the level of Associate Director or Senior Manager
  - San Antonio Delivery Center below the level of Associate Director or Senior Manager

If you were hired or rehired after September 1, 2014, you are not eligible for future Medical Premium Credit service accrual regardless of Career Track. Any Medical Premium Credit service accrual you may have earned during your prior employment will be restored.

- **Medical Premium Credit Formula** - The credit is based on your service accrual years in an eligible classification as described above (up to 25 years), the Credit Factor (3.5%) and the cost of the Cigna PPO Plan. Credit maximums will apply. If you and your covered dependents have “split” coverage (pre-65 and post-65 coverage), separate premiums will be calculated for each group and added together for the full premium amount. For more information about the calculation of the retiree premiums, please contact the Accenture Benefits Center (1-877-332-2242).

- **Medicare** - When Medicare becomes effective for you or your covered spouse, Medicare will provide primary coverage. The Retiree Medical Plan will provide secondary coverage and coordinate benefits with Medicare.

**Surviving Spouse Medical Coverage**

- **Coverage** – If you are covered under the Plan (other than as an Accenture Flex employee) or Retiree Medical Plan on your date of death, your surviving spouse may be eligible to continue medical coverage under the Plan or Retiree Medical Plan, as applicable, when you die if your spouse meets all of the following requirements:
Your domestic partner at the time of your death is also eligible to continue medical coverage under the Plan or Retiree Medical Plan, as applicable, provided he or she is covered under the Plan or Retiree Medical Plan at the time of your death and otherwise satisfies the criteria above.

Coverage can be changed during annual enrollment or upon the occurrence of a life event. However, if at any time your surviving spouse/domestic partner declines medical coverage under the Plan, he or she cannot rejoin the Plan for any reason. Coverage automatically ends for a qualifying surviving spouse/domestic partner when the spouse remarries or the domestic partner enters another domestic partner relationship, or when the spouse or domestic partner becomes eligible for Medicare or other group medical coverage. However, for a qualifying surviving spouse/domestic partner of a retired employee, coverage will not automatically end when the survivor becomes eligible for Medicare.

Coverage can be continued for your children if they are covered under the Plan at the time of your death. This coverage may continue until the children reach age 26, subject to the dependent eligibility requirements, as long as your surviving spouse or domestic partner remains covered under the Plan. However, if the child meets the Plan's definition of an incapacitated child, coverage may continue beyond age 26.

For clarity, surviving spouses of Accenture Flex employees are not eligible for this benefit.

- **Cost of Coverage**
  - **Surviving Spouse/Domestic Partner of Active Employees:** Your spouse/domestic partner will pay the active employee premium.
  - **Surviving Spouse/Domestic Partner of Retired Employees:** The cost of coverage for your spouse/domestic partner will depend on the option they chose, the dependents they cover and their age and the age of their covered dependents. Accenture may contribute to the cost through a Medical Premium Credit. The credit your spouse/domestic partner receives, if any, is based on your service accrual years in an eligible classification as described in the section above. For more information about the calculation of the survivor premiums, please contact the Accenture Benefits Center (1-877-332-2242).

**Surviving Dependent Child Medical Coverage**
If you and your spouse/domestic partner die or if you are unmarried when you die and you are covered under the Plan (other than as an Accenture Flex employee), coverage can continue for your surviving children who are covered under the Plan at the time of your death. Surviving dependent children can remain covered under the Plan until they reach age 26, subject to the dependent eligibility requirements. However, coverage may continue beyond age 26 if you have a child that meets the Plan’s definition of an incapacitated child.

**COBRA Continuation Coverage**
COBRA, a federal law, requires most employers sponsoring group health plans to offer employees and certain eligible dependents the opportunity to purchase a temporary extension of health coverage (called "continuation coverage") at group rates in certain instances where coverage under the Plan would otherwise end. This description is intended to inform you, in a summary fashion, of your rights and obligations under the continuation coverage provisions of this federal law. Although COBRA does not apply to domestic partners and their dependent children, the Plan provides them with COBRA-like coverage as described below.

If you are an employee covered by the Plan, you have a right to choose COBRA continuation coverage if you lose your coverage under the Plan because of the termination of your employment (for reasons other than gross misconduct on your part) or reduction in hours of employment. If you terminate employment following a leave of absence qualifying under the Family and Medical Leave Act, the event that will trigger continuation coverage is the earlier of the date that you indicate you will not be returning to work following the leave or the last day of the leave.
If you are the covered spouse, covered domestic partner or covered dependent of a covered employee, you have the right to purchase continuation coverage for yourself if you lose coverage under the Plan for any of the following five reasons:

1. The death of the covered employee;
2. A termination of the covered employee's employment (for reasons other than gross misconduct);
3. Divorce, legal separation or end of domestic partner relationship;
4. The covered employee becomes entitled to benefits under Medicare; or
5. The dependent ceases to qualify as a dependent under the Plan.

A child who is born to or placed for adoption with the covered employee during the continuation coverage period has the same continuation coverage rights as a dependent child described above.

You and your eligible dependents have the responsibility to inform Accenture of a divorce, legal separation, end of domestic partner relationship or a child losing dependent status under the Plan within 60 days after the later of (1) the date of such event or (2) the date you or your eligible dependent would lose coverage on account of such event. You or a family member must notify the Accenture Benefits Center of the qualifying event by calling 1-877-332-2242. Failure to timely notify Accenture of these events will make you or your eligible dependents ineligible for continuation coverage.

When Accenture is notified that one of these events has happened, it will in turn notify you that you have the right to choose continuation coverage by sending you a COBRA Enrollment Notice. Under COBRA, you have 60 days after the later of (1) the date you would lose coverage because of one of the events described above or (2) the date you are sent notice of your right to elect whether you want to purchase continuation coverage. To elect continuation coverage, you must call the Accenture Benefits Center at 1-877-332-2242 by the enrollment deadline provided on the COBRA Enrollment Notice. You must make your initial premium payment no later than 45 days following the date of your election to purchase COBRA continuation coverage.

You will receive a Billing Notice confirming the amount of the first payment. This payment will cover the period of coverage from the date of the COBRA election retroactive to the date of the qualifying event. Thereafter, premiums are due on a monthly basis as explained more fully in the Billing Information section on your COBRA Enrollment Notice.

If you do not choose continuation coverage, your coverage under the Plan will end. If you choose continuation coverage, Accenture is required to give you coverage which, as of the time coverage is being provided, is similar to the coverage provided under the Plan to similarly situated non-COBRA beneficiaries.

COBRA generally requires that you be afforded the opportunity to purchase continuation coverage for a limited period of 18 or 36 months from the later of the qualifying event or the date you lose coverage under the Plan. However, if you lost coverage under the Plan because of a termination of your employment, the maximum continuation coverage period is 18 months from the later of the qualifying event or the date you lose coverage under the Plan.

The following chart shows specific qualifying events, the qualified beneficiaries who are entitled to continuation coverage, and the maximum period of continuation coverage, based on the qualifying events.

<table>
<thead>
<tr>
<th>QUALIFYING EVENT</th>
<th>QUALIFIED BENEFICIARIES</th>
<th>MAXIMUM PERIOD OF CONTINUATION COVERAGE</th>
</tr>
</thead>
</table>
| Termination (for reasons other than gross misconduct) or reduction in hours of employment | Employee  
Spouse/Domestic Partner | 18 months |
| Divorce, legal separation or the end of a domestic partnership | Spouse/Domestic Partner  
Dependent Child | 36 months |
| Death of an employee | Spouse/Domestic Partner  
Dependent Child | 36 months |
| Loss of “dependent child” status under the plan | Dependent Child | 36 months |
| Employee enrollment in Medicare | Employee  
Spouse/Domestic Partner  
Dependent Child | 36 months |
If you or your dependent is determined to be disabled under Title II or Title XVI of the Social Security Act within the first 60 days of continuation coverage, you or your dependent may be eligible to continue coverage for up to 29 months from the date of the qualifying event under certain circumstances.

The affected individual must inform Accenture within 60 days after the date of the Social Security determination and within 18 months of the termination of employment and must remain disabled and timely pay the increased premium for coverage during the continuation coverage period, which extends past 18 months. Certain eligible dependents may be entitled under certain circumstances to extend the continuation coverage period in the event that you become entitled to Medicare benefits.

However, COBRA also provides that your continuation coverage will be cut short for any of the following reasons:

1. Accenture no longer provides group health coverage to any of its employees;
2. The premium for your continuation coverage is not timely paid;
3. After you elect COBRA continuation coverage, you become covered under another group health plan (as an employee or dependent) that does not contain any exclusion or limitation applicable to any pre-existing condition for which coverage would be excluded or limited under such health plan. If a pre-existing condition exclusion does apply, this Plan will be the primary plan as to the excluded condition only and shall be the secondary plan as to all other applicable coverage;
4. After you elect COBRA continuation coverage, you become entitled to benefits under Medicare; or
5. A final determination is made that you or your dependent is no longer disabled under Title II or XVI of the Social Security Act.

You do not have to show that you are insurable to choose continuation coverage. However, under COBRA, you will have to timely pay the entire cost for your continuation coverage plus a 2% administrative fee.

Second Qualifying Event (Extending COBRA Coverage)
To the extent required by COBRA, an 18-month extension of coverage will be available to your spouse or domestic partner and dependents if they experience a second qualifying event during their first 18 months of COBRA continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months.

These second qualifying events include:
- The employee’s death
- The employee’s divorce or legal separation
- The employee’s entitlement to Medicare (under Part A, Part B, or both)
- A dependent’s loss of coverage under the Accenture–provided health plan

The events described above will be treated as a second qualifying event only if the event would have caused the qualified beneficiary to lose coverage under the Accenture–provided health plan if the first qualifying event had not occurred. To receive this additional coverage, you, your covered spouse/domestic partner, or your covered dependents must notify the Accenture Benefits Center within 60 days after a second qualifying event occurs and the individual seeking the extension must be receiving COBRA coverage when the event occurs. To notify the Accenture Benefits Center of the second qualifying event, call 1 (877) 332–2242.

Leave of Absence
If you are absent from work due to military service leave qualifying under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"), you may elect to continue the type of coverage in effect on the day immediately prior to the start of such leave. Such coverage will continue until the earlier to occur of the date you fail to return to active employment as required under USERRA, or 24 months. In order to continue coverage, you must continue to pay the required contribution under the Plan as outlined in the applicable Human Resource Policy.

If you decide to forego coverage under the Plan during a military leave qualifying under USERRA and return to employment following the leave (within the time period specified by USERRA), you will be reinstated in the Plan. Upon resumption of coverage, any expenses you incur relating to any illness or injury incurred in, or aggravated during, the performance of military service will not be covered under the Plan.
If you are absent from active employment with your employer due to an authorized leave of absence, you and your covered dependents shall continue to be covered by the Plan until the last day of the month in which such leave expires, provided that you make any contributions required for such coverage while on authorized leave. If you are absent from active employment with your employer due to a disability leave or a leave that qualifies under the Family and Medical Leave Act (a "qualifying leave"), you and your covered dependents shall continue to be covered by the Plan until the last day of the qualifying leave, provided you make the same contributions, if any, as are required of active employees for the same coverage.

Employees’ contributions must be paid in advance of the period for which coverage is to be provided. If such amounts are not paid when due, coverage under the Plan shall terminate, subject to continuation coverage provisions. If you are on a qualifying leave, were covered under the Plan prior to your qualifying leave, and return to active employment with your employer at the end of the leave, you and your eligible dependents will again become covered under the Plan immediately upon your return to active employment.

Coverage History Notice
Upon termination of you or your dependents’ coverage under the Plan, including termination of any COBRA continuation coverage, you will receive a Coverage History Notice which outlines the continuous coverage you had under the plan. This Notice is for informational purposes only. If you have any questions about the Coverage History Notice, please contact the Accenture Benefits Center at 1-877-332-2242.

MATERNITY HOSPITAL STAY

Group health plans, including HMOs, may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable) after the birth. In any case, the Plan may not, under federal law, require that the attending physician or the expectant mother obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours, where applicable).

WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998

The Women’s Health and Cancer Rights Act of 1998 (the “Act”) requires that all group health plans, including HMOs, that provide medical and surgical benefits for a mastectomy also must provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and coverage for any complications in all stages of mastectomy, including lymphedemas.

The Act requires that coverage be provided in a manner that is consistent with other benefits provided by the Plan. The coverage may be subject to annual deductibles and/or to copayments. The Act prohibits any group health plan from:

- Denying a participant or a beneficiary eligibility to enroll or renew coverage in order to avoid the requirements of the Act;
- Penalizing, reducing, or limiting reimbursement to the attending provider (e.g., the attending physician, clinic or hospital) to induce the provider to give care that is inconsistent with the Act; and
- Providing monetary or other incentives to an attending provider to induce the provider to give care that is inconsistent with the Act.

PRIVACY OF HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), as amended and its implementing regulations, is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. As an employee welfare benefit plan under ERISA, the Plan (other than those components herein that are not subject to ERISA) is subject to the HIPAA privacy rules. Pursuant to the HIPAA privacy rules, the Plan will not use or disclose your Protected Health Information (“PHI”) without your authorization, except for purposes of treatment, payment, health care operations, Plan administration or as required or permitted by law.
A description of the Plan’s uses and disclosures of your PHI and your rights and protections under the HIPAA privacy rules is set forth in the Plan’s Notice of Privacy Practices, which was previously provided to you, or if you are a new participant, will be sent you from the Benefits Center. This Notice may also be required by contacting the Plan’s Privacy Officer at 1-800-207-2109.

CLAIMS PROCEDURES

See the General Information Summary for information about submitting and appealing claims, identification of the Plan’s Claims Administrators and your rights under ERISA.

AMENDMENT AND TERMINATION

The Plan may be amended at any time by Accenture, at its discretion, to increase or otherwise change the cost to you for coverage, to change the type of benefits provided under the Plan, the conditions of participation, and any other terms of the Plan, to require additional contributions from participants, or to terminate the Plan in whole or part at any time.
NOTICE OF NONDISCRIMINATION
ACCENTURE UNITED STATES GROUP RETIREE MEDICAL PLAN

The following notice is provided by Accenture LLP ("Accenture") in accordance with the requirements of Section 1557 of the Affordable Care Act. Accenture complies with applicable Federal civil rights laws and does not discriminate under the Accenture United States Group Retiree Medical Plan (the "Retiree Medical Plan") on the basis of race, color, national origin, age, disability, or sex. Accenture does not exclude people or treat them differently under the Retiree Medical Plan because of race, color, national origin, age, disability, or sex. With respect to the Retiree Medical Plan, Accenture provides:

- free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats); and
- free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you are a participant under the Retiree Medical Plan and need these services, contact Toni Corban. If you believe that Accenture has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, with respect to the Retiree Medical Plan, you can file a grievance with: Toni Corban, North America Employee Relations Director, 500 Campus Drive, Florham Park, NJ 07942, 1-973-301-1350 (Telephone), 1-973-225-3979 (Confidential Fax), toni.l.corban@accenture.com (email). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, Toni Corban is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–868–1019, 800–537–7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATTENTION: Language assistance services, free of charge, are available to you. Call 1-877-332-2242 (TTY: Dial 711).


[Chinese] 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-877-332-2242（TTY：711）。


Participating Medical Plan

Notice matters: Japanese speaking, free language support is available. Call 1-877-332-2242 (TTY: 711) for assistance.

[Japanese] 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-332-2242（TTY: 711）まで、お電話にてご連絡ください。


[Persian (Farsi)]توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌کنیم. با 1-877-332-2242 تماس بگیرید (TTY: 711).
APPENDIX A
Accenture Flex Employee Eligibility

If you are employed by Accenture Flex, you are eligible to participate in the Plan if you are employed on average 20 or more hours per week in the United States or Puerto Rico* and you are treated or classified as an employee by Accenture Flex for purposes of withholding federal employment and income taxes.

Generally, in all cases, you are not eligible to participate in the Plan if you are a leased employee, an independent contractor, or an employee whose employment is subject to the terms of a collective bargaining agreement. If you do not satisfy the applicable eligibility requirements described above, any subsequent determination by your employer, a government agency, a court, or other third party that you are an eligible employee will not have a retroactive effect for purposes of your eligibility to participate in the Plan, even if the determination is applicable to prior years.

*If your principal place of employment is in Puerto Rico, different rules apply to enrollment, medical plan options and your eligibility for participation under the Participating Flexible Benefits Plan for Accenture Flex is limited to paying for certain premiums on a pre-tax basis (federal only) through the Pretax Premium Option for Accenture Flex. For more information, please contact the Accenture Benefits Center at 1-877-332-2242.

You may become eligible for coverage under the Plan in one of two ways:

1. Accenture Flex reasonably expects you to work at least 20 hours per week; or
2. You can qualify for coverage if you are credited with enough “hours of service” to qualify you as an employee employed on average 20 or more hours per week during a period of time called a “measurement period.” This option is available to employees who are initially considered to be variable hour employees on their dates of hire.

If Accenture Flex does not reasonably expect you to work at least 20 hours per week, Accenture Flex will use a look-back measurement method to determine whether you are an employee employed on average 20 or more hours per week for purposes of Plan coverage.

Continued eligibility for coverage under the Plan requires that you continue to satisfy the requirement that you are credited with enough “hours of service” to qualify as an employee employed on average 20 or more hours per week during each measurement period, whether or not you are initially classified as a full-time employee or a variable hour employee.

The look-back measurement method involves three different periods:

- A measurement period for counting an employee’s hours of service (also called a standard measurement period or an initial measurement period, each as described below);
- A stability period when the employee is either treated, for Plan eligibility purposes, as employed on average 20 or more hours per week or not employed on average 20 or more hours per week; and
- An administrative period that allows time for Plan enrollment and disenrollment.

The rules for the look-back measurement method vary depending on whether an employee is an ongoing employee or a new employee, and whether a new employee is expected to be a variable hour employee. The following definitions are solely for determining whether an employee is employed on average 20 or more hours per week for purposes of Plan coverage.

- Full-time employee - is reasonably expected to be employed, on average, at least 20 hours per week.
- Variable hour employee - is an employee whose hours of service we cannot determine at the time of hire will average at least 20 hours per week.
Part-time employee - is reasonably expected to be employed, on average, less than 20 hours per week.

Ongoing employee - has been employed for a full standard measurement period.

New employee - has been employed for less than one full standard measurement period.

New Employees Expected to Work Full Time

If Accenture Flex hires an employee who is reasonably expected to work 20 hours per week, then that employee will be classified as a full-time employee and offered health coverage under the regular eligibility rules for new employees. In addition, a new variable hour or part-time employee who, following his or her date of hire, is classified as a full-time employee because he or she is subsequently expected to work 20 or more hours per week will be offered health coverage effective the date of the status change, as determined by Accenture Flex. The employee’s status is determined based upon the hours of service for each calendar month until that employee becomes an ongoing employee. Once the employee becomes an ongoing employee, Accenture Flex will include that employee in the standard measurement period and stability period calculations for the purpose of Plan eligibility.

New Variable Hour or Part-time Employees

For a new variable hour or new part-time employee, Accenture Flex will use the look-back measurement method to determine if the employee is full-time for purposes of Plan coverage. Accenture Flex will measure the employee’s hours of service using an initial measurement period (or “IMP”) during which we will “look back” and count an employee’s hours of service. The IMP begins on the employee’s start date and lasts 11 consecutive months. The look-back measurement method for new variable hour and part-time employees also utilizes a stability period, which is the period during which coverage may need to be provided, depending on the employee’s hours of service during the IMP. An administrative period is also used to make eligibility determinations and notify and enroll employees. The administrative period is a short period between the IMP and the stability period. The administrative period will be 60 days from the initial administrative period begin date, rounded to the end of the month. If the calculated administrative period end date exceeds 90 days from the initial administrative period begin date, the end date will be adjusted to the end of the previous month. The stability period lasts 12 months, beginning on the first day after the end of the administrative period.

If a new variable hour or part-time employee was employed, on average, at least 20 hours of service per week (or 86.67 hours per month) during the IMP, the employee is treated as a full-time employee for a set period into the future, known as the stability period. This means that the employee is eligible for Plan coverage during the stability period, regardless of the employee’s number of hours of service during the stability period, as long as he or she remains an employee and makes the required employee premium contributions. There are exceptions to this general rule for employees who experience changes in employment status.

For example: If you are hired on May 5, 2018 as a variable hour employee, you will not be immediately eligible for coverage under the Plan. However, if you are credited with an average of 20 or more hours of service per week during your IMP of May 5, 2018 through April 4, 2019, you will qualify as a full-time employee for purposes of Plan coverage for the 12-month stability period beginning July 1, 2019. You may then elect coverage effective July 1, 2019 by timely completing the correct enrollment process.

Ongoing Employees

For ongoing employees, Accenture Flex determines full-time status by looking at a standard measurement period (“SMP”). The SMP is a period of time during which we will look back and measure an employee’s hours of service. The SMP lasts 12 consecutive months and starts on each October 16th and ends on October 15th of the next year. An employee’s hours of service during the SMP will determine his or her Plan eligibility for the subsequent stability period. Accenture Flex also uses an administrative period between the SMP and the stability period. The administrative period runs from October 16th to December 31st. The administrative period overlaps with the prior stability period to prevent any gaps in coverage for employees enrolled in coverage because of their full-time status during a prior measurement period. The stability period then begins on January 1 and ends on December 31 of the same year.
If an ongoing employee was employed, on average, for at least 20 hours of service per week (or 86.67 hours per month) during the SMP, the employee is treated as a full-time employee for the subsequent stability period. As a general rule, your status as a full-time employee or a non-full-time employee is “locked in” for the stability period, regardless of how many hours you work during the stability period, as long as you remain an employee of Accenture Flex and make the required employee contributions.

**Note:** If your hire date is October 17 through November 1 of any given year, there will be a one month gap (December 1 – December 31) between the stability periods related to your IMP and SMP. As a result, the status established during your initial stability period will remain in place during the one month gap.

**For example:** If you are an ongoing employee as of September 1, 2018, Accenture Flex will track your hours of service based upon the standard measurement period from October 16, 2018 through October 15, 2019. If you are credited with an average of 20 or more hours of service per week from October 16, 2018 through October 15, 2019, Accenture Flex will classify you as a full-time employee for purposes of Plan coverage for the stability period beginning January 1, 2020. You may then elect coverage effective January 1, 2020 by timely completing the enrollment process. Your stability period would run from January 1, 2020 through December 31, 2020.

**Transitioning from a New Employee to an Ongoing Employee**

Once a new employee has been employed for a full standard measurement period, they become an ongoing employee. The employee will be tested for full-time status, beginning with that standard measurement period, at the same time and under the same conditions as other ongoing employees. This means that there is likely to be some overlap between an individual’s IMP and that individual’s first SMP.

**For example:** If you are hired as a variable hour employee on May 15, 2018, your initial measurement period will be from May 15, 2018 until April 14, 2019. This will be your IMP and your hours of service during this period will determine eligibility for health care benefits. As of April 14, 2019, you will have completed the initial measurement period. You would then transition to the ongoing employee measurement period. We would begin tracking your hours during the standard measurement period applicable to ongoing employees: October 16, 2018 through October 15, 2019.

**How Hours are Counted to Determine Full-Time Status**

If you are paid on an hourly basis, your “hours of service” include those hours for which you are paid to work and the hours for which you are paid for vacation, holiday, illness, incapacity (including disability), jury duty, military duty, or leave of absence.

In addition, a special averaging method applies when measurement periods include special unpaid leave (that is, leave under the Family and Medical Leave Act (FMLA) or the Uniformed Services Employment and Reemployment Rights Act (USERRA)). Under the averaging method, we will determine the average hours of service per week for the employee during the measurement period, excluding the special unpaid leave period, and use that average as the average for the entire measurement period.

**Rehired Employees**

If an employee who has terminated employment is subsequently rehired, the following treatment will apply:

- If the employee goes at least 13 consecutive weeks without an hour of service before being rehired and earning an hour of service, he or she is treated as a new employee for purposes of determining the employee’s full-time status under the look-back measurement method.
- If the employee goes less than 13 consecutive weeks without an hour of service before being rehired and earning an hour of service, the employee will be treated as a continuing employee, and the measurement and stability periods that would have applied to the employee had he or she not experienced the period of termination will continue to apply upon the employee’s return to employment.
**Transferred Employees**

If you transfer to Accenture Flex from Accenture or another adopting employer other than Accenture Flex, you will retain your status as a full-time employee during the remainder of the stability period in which such transfer occurs.

Further, the effective date of your new coverage options and the respective premiums is the first of the month following the date of your transfer to Accenture Flex or vice versa (to Accenture or another adopting employer from Accenture Flex).

**For example:** You transfer to Accenture from Accenture Flex on April 20, 2018. Your Accenture Flex coverage and premium amounts remain in effect through April 30, 2018. Your new Accenture coverage and premium amounts would be effective May 1, 2018.
APPENDIX B: Life Event Change Matrix – Active Personnel

The chart below is intended to provide a quick-glance summary of the rules related to changes that may be permitted as a result of a life event. In all cases, the actual changes permitted will be subject to applicable law as well as the terms and conditions of the applicable plan.

<table>
<thead>
<tr>
<th>Type of Event</th>
<th>Medical Coverage</th>
<th>Dental Coverage</th>
<th>Vision Coverage</th>
<th>Flexible Spending Account Health Care</th>
<th>Flexible Spending Account Dependent Care</th>
<th>Basic Life/AD&amp;D Optional Life/AD&amp;D</th>
<th>Dependent Life/AD&amp;D</th>
<th>Group LTD</th>
<th>Legal &amp; Personal Liability Plans</th>
<th>Accenture Leadership</th>
<th>Where to Make Changes</th>
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(For information regarding mid-year HDHP/HSA elections, please see the “High Deductible Health Plan and Health Savings Account Overview” on the Live Well at Accenture website.)
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<tr>
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<td>Placement of a Child for Adoption</td>
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<td>Increase/ decrease coverage</td>
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<td>Gain Dependent Status</td>
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<td>Addition of Foster Child or Stepchild</td>
<td>Add spouse</td>
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<td>Increase/ decrease deposits</td>
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<tr>
<td>Start of a Legal Guardianship</td>
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<td>Start of Adoption Proceedings</td>
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<th>Accenture Leadership Provided Life &amp; AD&amp;D, LTD</th>
<th>Where to Make Changes</th>
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<tbody>
<tr>
<td>A Judgment, Decree, or Court Order Requiring Employee to Cover a Dependent Child (QMCSO)</td>
<td>• Enroll employee • Add affected dependent child(ren) • Change medical plan if required by court order</td>
<td>• Enroll employee • Add affected dependent child(ren) • Add affected child(ren)</td>
<td>• Enroll employee • Add affected dependent child(ren) • Add affected child(ren)</td>
<td>• Start an account • Increase deposits</td>
<td>• No Change Allowed</td>
<td>• Increase coverage • Decrease coverage</td>
<td>• Enroll for first time</td>
<td>• Increase/ decrease coverage</td>
<td>• No Change Allowed</td>
<td>• No Change Allowed</td>
<td>• Benefits Center Rep</td>
</tr>
<tr>
<td>A Judgment, Decree, or Court Order Requiring Spouse to Cover Dependent Child (QMCSO)</td>
<td>• Drop affected dependent child(ren)</td>
<td>• Drop affected dependent child(ren) • Add affected child(ren)</td>
<td>• Add affected dependent child(ren) • Add affected child(ren)</td>
<td>• Enroll for first time</td>
<td>• Increase/ decrease coverage</td>
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<tr>
<td>Loss of Dependent Status; Child Reaching Disqualifying Age; End of Adoption Proceedings; Loss of a Foster Child or Stepchild; End of a Legal Guardianship</td>
<td>• Drop affected dependent child(ren)</td>
<td>• Drop affected dependent child(ren)</td>
<td>• Add affected dependent child(ren)</td>
<td>• Enroll for first time</td>
<td>• Increase/ decrease coverage</td>
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<td>Going on a Leave of Absence</td>
<td>• Drop coverage • Drop spouse • Drop dependent child(ren)</td>
<td>• Drop coverage • Drop spouse • Drop dependent child(ren)</td>
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<td>• Stop an account • Decrease deposits</td>
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<td>• Stop an account • Decrease deposits</td>
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<td>• Decrease coverage • Drop coverage</td>
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<tr>
<td>Returning from a Leave of Absence</td>
<td>• Enroll employee • Add spouse • Add dependent child(ren)</td>
<td>• Enroll employee • Add spouse • Add dependent child(ren)</td>
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<td>• Start an account • Increase deposits</td>
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<td>• Start an account • Increase deposits</td>
<td>• Start an account • Increase deposits</td>
<td>• Increase coverage • Decrease coverage</td>
<td>• Enroll for first time</td>
<td>• Increase/ decrease coverage</td>
<td>• Drop coverage • Reinstatet coverage</td>
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<tr>
<td>Change in Your Work Site or Residence</td>
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<th>Where to Make Changes</th>
</tr>
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<tbody>
<tr>
<td>Midyear End of Another Employer’s COBRA Coverage for You or a Dependent</td>
<td>• Enroll employee • Add spouse • Add affected dependent child(ren) • Change medical plan</td>
<td>• Enroll employee • Add spouse • Add affected dependent child(ren)</td>
<td>• Enroll employee • Add spouse • Add affected dependent child(ren)</td>
<td>• Start an account • Increase deposits</td>
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<td>Benefits Center Rep</td>
</tr>
<tr>
<td>Benefit Option Added to a Dependent’s Plan</td>
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<td>Benefit Option Eliminated from a Dependent’s Plan</td>
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<td>Benefits Center Rep</td>
</tr>
<tr>
<td>Significant Curtailment or End of Your Plan or Dependent’s Plan</td>
<td>• Enroll employee • Add spouse • Add affected dependent child(ren) • Change medical plan only if employer stops subsidy</td>
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<td>Benefits Center Rep</td>
</tr>
<tr>
<td>Significant Cost Increase for Your Plan or Dependent’s Plan</td>
<td>• Enroll employee • Add spouse • Add affected dependent child(ren) • Change medical plan only if employer stops subsidy</td>
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<tbody>
<tr>
<td>You or a Dependent Lose Eligibility for Government or Educational Institution Coverage</td>
<td>Enroll employee</td>
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<td>Add affected dependent child(ren)</td>
<td>Change medical plan</td>
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<td>Add affected dependent child(ren)</td>
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<td>No Change Allowed</td>
<td>Increase coverage</td>
<td>Decrease coverage</td>
<td>Enroll for first time</td>
</tr>
<tr>
<td>Dependent’s Annual Enrollment Period Doesn’t Coincide with Your Annual Enrollment</td>
<td>Enroll employee</td>
<td>Add spouse</td>
<td>Add affected dependent child(ren)</td>
<td>Drop coverage if being added to spouse’s plan</td>
<td>Enroll employee</td>
<td>Add spouse</td>
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<td>Start/stop account</td>
<td>Increase coverage</td>
<td>Decrease coverage</td>
<td>Enroll for first time</td>
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<tr>
<td>You or a Dependent Become Eligible for Medicare</td>
<td>Drop coverage</td>
<td>Drop spouse</td>
<td>Drop dependent child(ren)</td>
<td>Change medical plan if losing eligibility</td>
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### Life Event Change Matrix – Active Personnel

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<th>Accenture-Provided Life &amp; AD&amp;D, LTD</th>
<th>Where to Make Changes</th>
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<tr>
<td>You or a Dependent Become Eligible for Medicaid /CHIP</td>
<td>Drop coverage</td>
<td>Drop coverage</td>
<td>Drop coverage</td>
<td>Start/stop account</td>
<td>No Change Allowed</td>
<td>Increase coverage</td>
<td>Increase coverage</td>
<td>Enroll for first time</td>
<td>No Change Allowed</td>
<td>No Change Allowed</td>
<td>Benefits Center Rep</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Drop spouse</td>
<td>Drop spouse</td>
<td>Drop spouse</td>
<td>Increase/ decrease deposits</td>
<td></td>
<td>Decrease coverage</td>
<td></td>
<td>Increase/ decrease coverage</td>
<td>No Change Allowed</td>
<td>No Change Allowed</td>
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<tr>
<td></td>
<td>Drop dependent</td>
<td>Drop dependent</td>
<td>Drop dependent</td>
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<td></td>
<td>Drop coverage</td>
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<tr>
<td></td>
<td>child(ren)</td>
<td>child(ren)</td>
<td>child(ren)</td>
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<tr>
<td>You or a Dependent Lose Eligibility for Medicaid /CHIP</td>
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<td>Increase coverage</td>
<td>Enroll for first time</td>
<td>No Change Allowed</td>
<td>No Change Allowed</td>
<td>Benefits Center Rep</td>
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<tr>
<td></td>
<td>Add spouse</td>
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<td>Add spouse</td>
<td>Increase/ decrease deposits</td>
<td></td>
<td>Decrease coverage</td>
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<td>Add dependent</td>
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<tr>
<td></td>
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<td>child(ren)</td>
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<td>Increase coverage</td>
<td>Enroll for first time</td>
<td>No Change Allowed</td>
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<td>Benefits Center Rep</td>
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<tr>
<td>Dependent Care Provider Change</td>
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<td>Increase/ decrease deposits</td>
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<td>No Change Allowed</td>
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<td>Increase or Decrease in the Cost of Dependent Care</td>
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<td></td>
<td>Enroll for first time</td>
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<td>Drop coverage</td>
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<tr>
<td>Dependent Care Provider Change</td>
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<td>No Change Allowed</td>
<td>No Change Allowed</td>
<td>Benefits Center Rep</td>
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</table>

(For information regarding mid-year HDHP/HSA elections, please see the “High Deductible Health Plan and Health Savings Account Overview” found on the Live Well at Accenture website.)