Accenture United States Benefit Plans

General Information Summary

(Effective April 1, 2018)
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GENERAL INFORMATION

Introduction
The following constitutes a part of the summary plan descriptions of the benefit plans sponsored by Accenture LLP (“Accenture”) that are listed on the next two pages. This document is intended to provide general information related to each plan, as required by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). To the extent there are any inconsistencies, however, between the summary plan description and the applicable plan document, the applicable plan document always governs. You are welcome to examine the plan document. It is available from Accenture.

The term “you” as used in each of the summary plan descriptions, including this document, for the Accenture benefit plans listed below refers to an employee of Accenture or other adopting employer who otherwise meets all the applicable eligibility and participation requirements under the applicable benefit plan. Receipt of the summary plan description, including this document, does not guarantee that the recipient is in fact a participant under a benefit plan or otherwise eligible for benefits under a benefit plan. Also, effective January 8, 2018, Agility Services LLC (“Agility Services”) became known as Accenture Flex LLC (“Accenture Flex”). Any reference to Agility Services in each of the summary plans descriptions now means Accenture Flex.

Plan Sponsor and Administrator
Accenture is plan sponsor, plan administrator, and agent for service of legal process for the plans listed below. From time to time, Accenture amends the plans to keep them up-to-date with employees’ needs, to make other design changes and to conform them to federal laws and regulations. Plan members will be notified of amendments that affect their benefits under the plans.

To contact Accenture as plan sponsor, plan administrator, or agent for service of legal process for any of these welfare benefit and pension plans, write or call:

Plan Administrator
c/o Accenture
161 North Clark Street
Chicago, Illinois 60601
1-800-207-2109

Legal process related to profit sharing/401(k) benefits may also be served on The Northern Trust Company, as Trustee of the Accenture United States Profit Sharing and 401(k) Trust, 50 South LaSalle Street, Chicago, Illinois 60675. Legal process related to pension benefits may also be served on The Northern Trust Company, as Trustee of the Accenture United States Pension Trust, 50 South LaSalle Street, Chicago, Illinois 60675.

Accenture is responsible for formulating and carrying out all rules and regulations necessary to administer the plans and has the sole discretionary authority to make factual determinations and decisions regarding eligibility or benefits of employees and participants in the plans. Accenture has delegated to an Appeals Committee and to one or more Claims Administrators and Appeals 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 rights and benefits of employees and participants under certain of the plans. Benefits under the plans will be paid only if the Plan Administrator, the Appeals Committee, a Claims Administrator or an Appeals Administrator, as applicable, decides in its discretion that the claimant is entitled to them. Any interpretation of a plan and any good faith decision made by Accenture, the Appeals Committee, a Claims Administrator or an Appeals Administrator are final and binding on all persons. The Claims Administrators and Appeals Administrators for the various plans are identified in Appendix A. Appendix A includes contact information for the Claims Administrators, Appeals Administrators and the Appeals Committee. You must furnish such evidence, data, and information as may be required by the Plan Administrator.
The Accenture United States Group Health Plan consists of the following Participating Plans:

- **Participating Medical Plan:**
  - High Deductible Health Plans: Self-insured welfare plan providing medical benefits through an administrative services contract with Aetna – Contract Number 657455, Blue Cross Blue Shield of Illinois – Agreement Number 287823 and Cigna – Agreement Number 2499754. These plans include a Health Savings Account feature.
  - Preferred Provider Organization (PPO): Self-insured welfare plans providing medical benefits through an administrative services contract with Aetna - Contract Number 657455, Blue Cross Blue Shield of Illinois - Agreement Number 287823 and with Cigna – Agreement Numbers 2499754 and 2499755.
  - Exclusive Provider Organization (EPO): Self-insured welfare plan providing medical benefits through an administrative services contract with Kaiser – Contract No. 00120005.
  - Accenture-sponsored Local Health Plan (POS): Insured, state regulated medical plans within a prescribed geographic area.
  - Insured UnitedHealth PPO Dental (Dental Plan Number GS146, International Assignees)

- **Participating Vision Plan:**
  - Self-insured welfare plan providing vision benefits through an administrative services contract with EyeMed Vision Care – Group Number 9757600

- **Participating Dental Plan:**
  - Self-insured welfare plan providing dental benefits through an administrative services contract with Aetna - Contract Number 657455
  - Accenture-sponsored Dental Maintenance Organization (DMO): Insured, state regulated dental plan within a prescribed geographic area administered by Aetna – Contract Number 657455
  - Insured UnitedHealth PPO Dental (Dental Plan Number GS146, International Assignees)

- **Participating Flexible Benefits Plan (including the Health Care and Dependent Care Flexible Spending Accounts):** Plan established under Sections 105, 125 and 129 of the Internal Revenue Code to reimburse certain health and dependent care expenses on a pre-tax basis.
### Plan Name

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Type of Plan</th>
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<tbody>
<tr>
<td><strong>Accenture United States Group Health Plan</strong></td>
<td>• Participating Flexible Benefits Plan for Accenture Flex Employees (including the Health Care and Dependent Care Flexible Spending Accounts): Plan established under Sections 105, 125 and 129 of the Internal Revenue Code to reimburse certain health and dependent care expenses on a pre-tax basis</td>
</tr>
<tr>
<td>Plan Number 601 (continued)</td>
<td></td>
</tr>
<tr>
<td><strong>Accenture US Group Retiree Medical Plan</strong></td>
<td>• Provides retiree medical benefits through the Preferred Provider Organizations (PPO) with Aetna, Blue Cross Blue Shield of Illinois and Cigna and the Kaiser EPO</td>
</tr>
<tr>
<td>Plan Number 606</td>
<td></td>
</tr>
<tr>
<td><strong>Accenture United States Group Insurance Plan</strong></td>
<td>The Accenture United States Group Insurance Plan consists of the following Participating Plans:</td>
</tr>
<tr>
<td>Plan Number 603</td>
<td>• Participating Long Term Disability Insurance Plan: Insured welfare plan providing disability benefits through contract with Cigna Life Insurance Company of North America - Policy Number VDT980011</td>
</tr>
<tr>
<td></td>
<td>• Participating Life Insurance Plan: Insured welfare plan providing death and accidental death and dismemberment benefits through contract with MetLife - Contract Number 105819-2-G</td>
</tr>
<tr>
<td></td>
<td>• Participating Accidental Death and Dismemberment Insurance Plan: Insured welfare plan providing accidental death and dismemberment benefits through contract with MetLife - Contract Number 105819-2-G</td>
</tr>
<tr>
<td></td>
<td>• Participating Dependent Life Insurance Plan: Insured welfare plan providing death and accidental death and dismemberment benefits through contract with MetLife - Contract Number 105819-2-G</td>
</tr>
<tr>
<td><strong>Accenture US Group Legal Plan</strong></td>
<td>• Insured welfare plan providing group legal benefits through MetLife/Hyatt Legal – Contract 1500269</td>
</tr>
<tr>
<td>Plan Number 616</td>
<td></td>
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</tbody>
</table>

### Plan Name

<table>
<thead>
<tr>
<th>Plan Name</th>
<th>Type of Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accenture US New Pension Plan</strong></td>
<td>• Defined benefit plan.</td>
</tr>
<tr>
<td>Plan Number 106</td>
<td></td>
</tr>
<tr>
<td><strong>Accenture US 401(k) Match and Savings Plan</strong></td>
<td>• Defined contribution plan.</td>
</tr>
<tr>
<td>Plan Number 102</td>
<td></td>
</tr>
<tr>
<td><strong>Accenture US Discretionary Profit Sharing Plan</strong></td>
<td>• Defined contribution plan.</td>
</tr>
<tr>
<td>Plan Number 105</td>
<td></td>
</tr>
<tr>
<td><strong>Accenture US Defined Contribution Transfer Plan</strong></td>
<td>• Defined contribution plan.</td>
</tr>
<tr>
<td>Plan Number 103</td>
<td></td>
</tr>
</tbody>
</table>

Accenture also sponsors separation benefits plans, which are welfare benefit plans. Employees eligible for separation benefits will be provided with separate information (including a summary plan description) about those benefits. In addition, Accenture also provides employees with the opportunity to elect certain
voluntary benefits, such as Group Personal Excess Liability Coverage. Information regarding these benefits can be found on the Live Well at Accenture website at http://resources.hewitt.com/accenture.

Sponsor and Employer Identification
Accenture’s employer identification number (EIN) is 72-0542904. The EIN, the plan name and the plan number identify each Accenture employee benefit plan with the federal agencies governing employee benefit plan operations. The following subsidiaries of Accenture have adopted some or all of the plans for the benefit of their eligible employees:

<table>
<thead>
<tr>
<th>Participating Employer</th>
<th>Address</th>
<th>Employer ID #</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accenture Federal Services LLC</td>
<td>800 North Glebe</td>
<td>41-2048319</td>
</tr>
<tr>
<td></td>
<td>Arlington, VA 22203</td>
<td></td>
</tr>
<tr>
<td>Zenta Mortgage Services LLC</td>
<td>8215 Forest Point Blvd.</td>
<td>27-0319865</td>
</tr>
<tr>
<td></td>
<td>Charlotte, NC 28273</td>
<td></td>
</tr>
<tr>
<td>Accenture State Healthcare Services LLC</td>
<td>1501 S. MoPac Expy</td>
<td>46-5536511</td>
</tr>
<tr>
<td></td>
<td>Suite 300</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78746</td>
<td></td>
</tr>
<tr>
<td>Mortgage Cadence LLC</td>
<td>3411 Silverside Road</td>
<td>47-5664008</td>
</tr>
<tr>
<td></td>
<td>#104 Rodney Building</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wilmington, DE 19810</td>
<td></td>
</tr>
<tr>
<td>Accenture Puerto Rico LLC</td>
<td>Metro Office Park, Bldg. 7</td>
<td>66-0686987</td>
</tr>
<tr>
<td></td>
<td>Street 1, Ste 202 Guaynabo</td>
<td></td>
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<tr>
<td></td>
<td>San Juan, PR 00968</td>
<td></td>
</tr>
<tr>
<td>Accenture Flex LLC</td>
<td>3411 Silverside Road</td>
<td>81-4996118</td>
</tr>
<tr>
<td></td>
<td>#104 Rodney Building</td>
<td></td>
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<tr>
<td></td>
<td>Wilmington, DE 19810</td>
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</tbody>
</table>

Trustee of the Accenture Trusts
All contributions under the 401(k) Match and Savings Plan, the Discretionary Profit Sharing Plan and the Defined Contribution Transfer Plan are paid to the Accenture United States Profit Sharing and 401(k) Trust. All contributions under the New Pension Plan are paid to the Accenture United States Pension Trust. Contributions under certain of the welfare benefit plans sponsored by Accenture are paid to the Accenture United States Benefit Trust. The trustee of these trusts is The Northern Trust Company, 50 South LaSalle Street, Chicago, Illinois 60675.

Plan Year

Plan Amendment and Termination
Accenture expects and intends to continue these plans indefinitely but reserves the right, in its sole discretion, to terminate or amend any plan or to change or end contributions to any plan at any time, with or without notice. A plan may be amended or terminated by instrument signed by Accenture’s Managing Partner or by such other person or persons authorized to amend or terminate the plans.

EMPLOYEE RIGHTS AND PROTECTION

ERISA Rights Statement
The employee benefit plans sponsored and administered by Accenture meet the legal requirements established by the Employee Retirement Income Security Act of 1974, as amended (“ERISA”). As a plan
participant, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

- **Receive Information about Your Plans and Benefits**
  You may contact US Employee Benefits to examine, without charge, all governing plan documents, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the applicable plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration. You may also obtain copies of official plan documents and other documents governing the operation of the plans and copies of the latest annual reports (Form 5500 Series) and updated summary plan descriptions by writing to the Plan Administrator, c/o Accenture, 161 North Clark Street, 19th Floor, Chicago, Illinois 60601. The Plan Administrator may make a reasonable charge for the copies.

  You will automatically receive a written summary of the annual financial reports for your plans. The Plan Administrator is required by law to furnish each participant with a copy of these summary annual reports.

  You can obtain a statement advising you whether you have a right to receive a retirement benefit at normal retirement age and, if so, what your benefits would be at normal retirement age if you stopped working under the applicable plan now. If you do not have a right to a benefit, the statement will tell you how many more years you must work to obtain a right to a benefit under the applicable plan. This statement must be requested in writing and is not required to be given more than once every twelve (12) months. The plans must provide the statement free of charge.

  You and your beneficiaries can obtain, without charge, a copy of a plan’s procedures governing qualified domestic relations order (“QDRO”) or qualified medical child support order (“QMCSO”) determinations by contacting the Plan Administrator.

- **Continue Group Health Plan Coverage**
  You have the right to continue health care coverage for yourself, your spouse, or your dependents if there is a loss of health care coverage under a plan to which COBRA applies as a result of a qualifying event.

  You or your dependents may have to pay for such coverage. Review the summary plan description and the documents governing the particular plan under which you seek continuation coverage to learn more about the rules governing your COBRA continuation coverage rights.

- **Prudent Actions by Plan Fiduciaries**
  In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plans. The people who operate your plans, called “fiduciaries” of the plans, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a retirement or welfare benefit or exercising your rights under ERISA.

- **Enforce Your Rights**
  If your claim for a retirement or welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

  If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court after exhausting the administrative review process described in the applicable “Appeals Procedures” section of this document. In addition, if you disagree with the Plan Administrator’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a Federal court.
If it should happen that the plan fiduciaries misuse a plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

**Assistance with Your Questions**

If you have any questions about your plans, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

### Pension Benefit Guaranty Corporation

The Pension Benefit Guaranty Corporation (“PBGC”) is a federal insurance agency established to insure benefits under certain types of pension plans. Pension benefits under the New Pension Plan are currently insured by the PBGC. Benefits under the 401(k) Match and Savings Plan, the Discretionary Profit Sharing Plan, the Defined Contribution Transfer Plan, and the welfare benefit plans, however, are not insured by the PBGC, because the PBGC only insures defined benefit pension plans. If the New Pension Plan terminates (ends) without enough money to pay all benefits, the PBGC will step in to pay pension benefits. Most people receive all of the pension benefits they would have received under their plan, but some people may lose certain benefits.

Generally, the PBGC guarantee covers: (1) normal and early retirement benefits; (2) disability benefits if you become disabled before the New Pension Plan terminates (if you were a Transfer Pension Plan Component participant); and (3) certain benefits for your survivors.

The PBGC guarantee generally does not cover: (1) benefits greater than the maximum guaranteed amount set by law for the year in which the plan terminates; (2) some or all of benefit increases and new benefits based on plan provisions that have been in place for fewer than 5 years at the time the plan terminates; (3) benefits that are not vested because you have not worked long enough for the company; (4) benefits for which you have not met all of the requirements at the time the plan terminates; (5) certain early retirement payments (such as supplemental benefits that stop when you become eligible for Social Security) that result in an early retirement monthly benefit greater than your monthly benefit at the plan’s normal retirement age; and (6) non-pension benefits, such as health insurance, life insurance, certain death benefits, vacation pay, and severance pay.

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

For more information about the PBGC and the benefits it guarantees, ask the Plan Administrator or contact the PBGC. Inquiries to the PBGC should be addressed to:

PBGC, Technical Assistance Division  
1200 K Street N.W., Suite 930  
Washington, D.C. 20005-4026  
(202) 326-4000 (not a toll-free number)

TTY/TDD users may call the federal relay service toll-free at 1-800-877-8339 and ask to be connected to (202) 326-4000. Additional information about the PBGC’s pension insurance program is available through the PBGC’s website on the Internet at [http://www.pbgc.gov](http://www.pbgc.gov).

### WELFARE PLANS – CLAIMS AND APPEALS PROCEDURES

Coverage under the welfare plans is offered under a variety of options. Some of these options are self-insured and other options are insured. Under the self-insured options, Accenture contracts with a third-
party administrator (the “Claims Administrator”) to administer the options. However, all benefits are paid directly from Accenture’s general assets or a benefits trust. As described below, Accenture has delegated to a third-party administrator (the “Appeals Administrator”) the final, discretionary authority to determine if a claim is payable under the terms of the plans.

If an option is fully-insured, for example an HMO, Accenture purchases an insurance contract from an insurer. All claims are paid from the insurer’s assets. Other than for questions related to eligibility, the insurer retains all final, discretionary authority to determine whether a claim is payable under a fully-insured option under the plans.

Appendix A to this summary lists the Claims and Appeals Administrators under the plans, the contact information for each Claims and Appeals Administrator, and whether the plan option is insured or self-insured. If you have any questions, you should contact the Plan Administrator at the number listed in the “Plan Sponsor and Administrator” section on page 1 of this summary.

Claims Procedures under the Accenture United States Group Health Plan - Participating Medical Plan and the Group Retiree Medical Plan

The claims procedures in this section only apply to the medical benefits under the self-insured options. If you participate in an insured option under the Participating Medical Plan or the Retiree Medical Plan, any claim for benefits and any appeal should be filed according to that plan’s claims procedures.

Either you or your authorized representative may file claims for plan benefits. An “authorized representative” means a person you authorize, in writing, to act on your behalf. The plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an Urgent Care Claim, a health care professional with knowledge of your condition may always act as your authorized representative. All communications from the plan will be directed to your authorized representative unless your written designation provides otherwise.

Your initial claim should be filed with the applicable Claims Administrator listed in Appendix A. All claims are treated as filed on the date they are received. If your claim is denied in whole or in part, you will receive a written notice of the denial directly from the Claims Administrator. The notice will explain the reason for the denial and the review procedures.

- Urgent Care Claims

  If the plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the plan or your physician determines that it is an Urgent Care Claim, you will be notifies whether the service, supply or procedure is payable under the plan no later than 72 hours after the claim is received, either orally or in writing.

  “Urgent Care Claim” means a claim for services received for an illness, injury or condition that could seriously jeopardize your life or health or your ability to regain maximum function or a condition that, in your treating physician’s opinion, could subject you to severe pain that cannot adequately be managed without such care or treatment.

  For Urgent Care Claims that name a specific claimant, medical condition, and service or supply for which approval is required, and that are submitted to the plan representative responsible for handling benefit matters, but otherwise fail to follow the plan’s procedures, you will be notified of the failure within 24 hours of receipt of the claim. You also will be informed of the proper procedures to be followed. The notice may be oral unless you or your authorized representative requests a written notification.

  If there is not sufficient information to decide the claim, your physician will be notified of the specific information necessary to complete the claim as soon as possible, but no later than 24 hours after receipt of the claim. Your physician will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information. Your physician will be notified of the decision no later than 48 hours after the end of the additional time period (or after receipt of the information, if earlier). If the decision is provided to you orally (unless you or your representative request a written notification), your physician will be provided a written or electronic notification no later than three days after you received the oral notification.

- Pre-Service and Post-Service Claims

  If the plan requires you to obtain advance approval of a service, supply or procedure before a benefit
will be payable, such a claim will be considered a Pre-Service Claim. You will be notified of the
decision no later than 15 days after receipt of the Pre-Service Claim. All other claims will be deemed
to be Post-Service Claims. You will be notified of a Post-Service Claim decision no later than 30 days
after receipt of such claim.

For Pre-Service Claims that name a specific claimant, medical condition, and service or supply for
which approval is required, and that are submitted to the plan representative responsible for handling
benefit matters, but which otherwise fail to follow the plan’s procedures, you will be notified of the
failure within 5 days for Pre-Service Claims. You also will be informed of the proper procedures to be
followed. The notice may be provided to you orally unless you or your representative request written
notification.

For either a Pre-Service or a Post-Service Claim, the time period in which the decision must be made
may be extended up to an additional 15 days due to circumstances beyond the plan’s control. In that
case, you will be notified of the extension before the end of the initial 15 or 30-day period.

If there is not sufficient information to decide the claim, the notice of extension will specifically
describe the information necessary to complete the claim. You will have at least 45 days from the
date you receive the notice to provide the specified information. The Claims Administrator’s period
for making the determination will exclude the period of time from the date the notification of the
extension is sent to you until the date you respond to the request for additional information. If you fail
to supply the requested information within the 45-day period, your claim will be denied.

- **Ongoing Course of Treatment**
  If you are receiving an ongoing course of treatment, you will be notified in advance if the plan intends
to terminate or reduce previously authorized benefits for the course of treatment so that you will have
the opportunity to appeal the decision before the termination or reduction takes effect. If the course
of treatment involves an Urgent Care Claim, and you request an extension of the course of treatment
at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt
of the request.

- **Filing an Appeal of an Adverse Benefits Determination**
  You will have 180 days following receipt of an adverse benefit decision to appeal the decision. With
the exception of Urgent Care Claims, your appeal must be in writing and submitted to the appropriate
Claims Administrator listed in Appendix A. You will be notified of the decision no later than 15 days
(for Pre-Service Claims) or 30 days (for Post-Service Claims) after the appeal is received.

  Along with your claim for benefits, you may submit written comments, documents, records and other
information related to your claim, whether or not the comments, documents, records or information
were submitted in connection with the initial claim. You also may request that the plan provide you,
free of charge, copies of all documents, records and other information relevant to the claim.

  The review will be made by a person different from the person who made the initial determination,
and no deference will be afforded to the initial determination. The individual making the appeal
determination will not be a subordinate of the original decision maker. In the case of a claim denied
on the grounds of a medical judgment, a health professional with appropriate training and experience
will be consulted. The health care professional who is consulted on appeal will not be the individual
who was consulted during the initial determination or a subordinate to such person. If the advice of a
medical expert was obtained in connection with the denial of your claim, the names of each such
expert will be provided upon request, regardless of whether the advice was relied upon.

  If your claim involves an Urgent Care Claim, an expedited appeal may be initiated by a telephone call
to the Member Services telephone number on your Identification Card. You or your authorized
representative may appeal Urgent Care Claim denials either orally or in writing. All necessary
information, including the appeal decision, will be communicated between you or your authorized
representative and the plan by telephone, facsimile, or other similar method. If the appeal decision is
communicated to you orally, you will receive a written determination within three days following the
oral determination. You will be notified of the decision no later than 36 hours after the appeal is
received.

If you disagree with the appeal determination, you may file a second level of appeal. This appeal
should be made in writing within 60 days of receipt of the first level appeal decision.
• **Second Level of Appeal**
  If you receive coverage under a self-insured option, you may appeal the Claims Administrator’s final adverse benefit determination by filing a written appeal with the Appeals Administrator. Such appeal must be filed within 60 days of the final denial for Pre-Service and Post-Service Claims. The Appeals Administrator will make its determination on a Pre-Service Claim no later than 15 days after the appeal is received by the Appeals Administrator and will make its determination on a Post-Service Claim no later than 30 days after the appeal is received by the Appeals Administrator.

If your appeal involves an Urgent Care Claim, an expedited appeal to the Appeals Administrator may be initiated by a telephone call to the Member Services telephone number on your Identification Card. You or your authorized representative may appeal the Claims Administrator’s final adverse benefit determination on an Urgent Care Claim either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the plan by telephone, facsimile, or other similar method. If the appeal decision is communicated to you orally, you will receive a written determination within three days following the oral determination. You will be notified of the Appeals Administrator’s determination no later than 36 hours after the appeal is received.

• **External Review**
  If, after exhausting your internal appeals, you are not satisfied with the final determination, you may choose to participate in the External Review Program. This program is available only if the adverse benefit determination is based on:
  - clinical reasons (including, but not limited to, reasons based on the requirements for medical necessity, appropriateness of care, health care setting, level of care or effectiveness of a covered benefit);
  - exclusions for experimental or investigational services;
  - rescission of coverage (coverage that was cancelled or discontinued retroactively); or
  - as otherwise required by applicable law.

The external review program is not available if the coverage determination is based on explicit benefit exclusions, defined benefit limits or claims regarding eligibility for benefits.

The external review program offers an independent review process to review the denial of a requested service or procedure or the denial of payment for a service or procedure. The process is available at no charge to you after exhausting the appeals process identified above if you receive a decision that is unfavorable. If the above conditions are satisfied, you may request an independent external review of the adverse benefit determination. You will not have an opportunity to meet with the reviewer or otherwise participate in the reviewer’s decision.

All requests for an independent review must be made within four (4) months of the date you receive the adverse benefit determination. If your request is incomplete, you will be notified of the information required to complete the request. You will have until the end of the original four (4) month filing period, or within 48 hours, following receipt of this notification, whichever is longer, to perfect your request. You or an authorized designated representative may request an independent review by contacting the toll-free number on your ID card or by sending a written request to the address on your ID card.

The independent review will be performed by an independent physician, or by a physician who is qualified to decide whether the requested service or procedure is a covered health service under the Plan. The entity that will perform the review, known as an Independent Review Organization (IRO), is accredited under federal law, has contracted with the Claims Administrator and has no material affiliation or interest with the Claims Administrator or Accenture. The Claims Administrator will choose the IRO based on a rotating list of appropriately accredited IROs. In certain cases, the independent review may be performed by a panel of physicians, as deemed appropriate by the IRO.

Within applicable timeframes of the Claims Administrator’s receipt of a request for independent review, the request will be forwarded to the IRO, together with:
  - all relevant medical records;
all other documents relied upon by the Claims Administrator in making a decision on the case; and

all other information or evidence that you or your physician have already submitted to the Claims Administrator.

If there is any information or evidence you or your physician wish to submit in support of the request that was not previously provided, you may include this information with the request for an independent review, and the Claims Administrator will include it with the documents forwarded to the IRO. The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for external review. This process can be expedited in certain circumstances where the adverse benefit determination involves a medical condition for which the standard timeframe would seriously jeopardize your life or health or jeopardize your ability to regain maximum function, or if the final adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not been discharged from the facility. In that case, the IRO will provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review.

If the reviewer needs additional information to make a decision, this time period may be extended. The independent review process will be expedited if you meet the criteria for an expedited external review as defined by applicable law. Any statute of limitations or other defense based on timelines will be tolled during the time that an appeal is pending under the voluntary external review program.

The reviewer’s decision will be in writing and will include the clinical basis for the determination. The IRO will provide you and the Claims Administrator with the reviewer’s decision, a description of the qualifications of the reviewer and any other information deemed appropriate by the organization and/or as required by applicable law.

If the final independent decision is to approve payment or referral, the Plan will accept the decision and provide benefits for such service or procedure in accordance with the terms and conditions of the Plan. If the final independent review decision is that payment or referral will not be made, the Plan will not be obligated to provide benefits for the service or procedure. If you are not satisfied or you do not agree with the final decision, you have the right to bring a civil action under Section 502(a) of ERISA.

You may contact the Claims Administrator at the toll-free number on your ID card for more information regarding your external appeal rights and the independent review process.

- Exhaustion of Appeal Process
  You must exhaust the applicable first and second levels of appeal (and external review, if applicable) under this Appeal Procedure before you initiate any litigation or other legal proceeding related to your plan benefits. Any such determination shall be final and binding. After receiving such a determination, you will have exhausted your administrative remedies under the Plan, and you will have a right to bring an action for benefits under ERISA Section 502(a)(1)(B). Benefits will be paid under the plan only if the Appeals Administrator determines in its discretion that you are entitled to them.

Claims Procedures under the Accenture United States Group Health Plan - Participating Vision Plan

- Filing Claims under the Plan
  You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from First American Administrators (FAA), a wholly owned subsidiary of EyeMed Vision Care, LLC (EyeMed). The notice will explain the reason for the denial and the review procedure.
  An “authorized representative” means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

You will be notified of the decision not later than 30 days after receipt of the claim. This time period may be extended up to an additional 15 days due to circumstances outside the Plan’s control. In that case, you will be notified of the extension before the end of the initial 30-day period. For example, the time period may be extended because you have not submitted sufficient information, in which case
you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan’s claim decision no later than 30 days after the end of that additional period (or after receipt of the information, if earlier).

- **Filing an Appeal of an Adverse Benefit Determination**
  You will have 180 days following receipt of an adverse benefit decision to appeal the decision by contacting FAA. The appeal must be in writing and should include the applicable claim number or a copy of the FAA denial information or Explanation of Benefits, the item of your vision coverage that you feel was misinterpreted or inaccurately applied and any additional information from your eye care provider that will assist in completing the review of the appeal. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim. You will be notified of the decision not later than 30 days after the appeal is received.

The appeal determination shall be final and binding. After receiving such a determination, you will have exhausted your administrative remedies under the plan, and you will have a right to bring an action for benefits under ERISA Section 502(a)(1)(B).

- **Exhaustion of Appeal Process**
  You must exhaust the applicable level of appeal under this Appeal Procedure before you initiate any litigation or other legal proceeding regarding any matter related to your plan benefits. Benefits will be paid under the plan only if the Appeals Administrator determines in its discretion that you are entitled to them.

**Claims Procedures under the Accenture United States Group Health Plan - Participating Dental Plan**

- **Filing Dental Claims under the Plan**
  You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and the review procedures.

  An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

- **Urgent Care Claims**
  If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your dentist determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

  “A claim involving urgent care” is any claim for dental care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a dentist with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

  If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

- **Other Claims (Pre-Service and Post-Service)**
  If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.
For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan’s control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan’s claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, dental condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan’s procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

- **Ongoing Course of Treatment**
  If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

- **Filing an Appeal of an Adverse Benefit Determination**
  You will have 180 days following receipt of an adverse benefit decision to appeal the decision to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

  If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. Aetna’s Member Services telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

  If you are dissatisfied with the appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Send your appeal request to the Aetna Appeals Resolution Team along with any additional information you would like them to consider. Aetna will make its determination no later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

  If your second level appeal involves an Urgent Care Claim, an expedited appeal to Aetna may be initiated by a telephone call to the Member Services telephone number on your Identification Card. You or your authorized representative may appeal Aetna’s final adverse benefit determination on an Urgent Care Claim either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. If the appeal decision is communicated to you orally, you will receive a written determination within three days following the oral determination. You will be notified of Aetna’s determination no later than 36 hours after the appeal is received.

  Any second level appeal determination shall be final and binding. After receiving such a determination, you will have exhausted your administrative remedies under the plan, and you will have a right to bring an action for benefits under ERISA Section 502(a)(1)(B).
Exhaustion of Appeal Process
You must exhaust the applicable first and second levels of appeal under this Appeal Procedure before you initiate any litigation or other legal proceeding regarding an alleged breach of the policy terms by Aetna Life Insurance Company or any matter related to your plan benefits. Benefits will be paid under the plan only if the Appeals Administrator determines in its discretion that you are entitled to them.

Claims Procedures under the Accenture United States Group Health Plan Participating Flexible Benefits Plan or the Participating Flexible Benefits Plan for Accenture Flex Employees - Health Care Flexible Spending Account Option

Filing Claims under the Plan
You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from PayFlex. The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

You will be notified of the decision not later than 30 days after receipt of the claim. This time period may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 30-day period. For example, the time period may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 30 days after the end of that additional period (or after receipt of the information, if earlier).

Filing an Appeal of an Adverse Benefit Determination
You will have 180 days following receipt of an adverse benefit decision to appeal the decision by contacting PayFlex Customer Service to initiate the appeal process. Alternatively, you can also choose to initiate the appeal process online by logging on to www.payflex.com. You may also submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim. You will be notified of the decision not later than 30 days after the appeal is received.

If you are dissatisfied with the appeal decision, you may file a second level appeal with theAccenture ERISA Appeals Committee within 60 days of receipt of the level one appeal decision. Send your appeal request to the Accenture ERISA Appeals Committee along with any additional information you would like them to consider. The Accenture ERISA Appeals Committee will make its determination no later than 30 days after the appeal is received.

Any second level appeal determination shall be final and binding. After receiving such a determination, you will have exhausted your administrative remedies under the plan, and you will have a right to bring an action for benefits under ERISA Section 502(a)((1)(B).

Exhaustion of Appeal Process
You must exhaust the applicable first and second levels of appeal under this Appeal Procedure before you initiate any litigation or other legal proceeding regarding any matter related to your plan benefits. Benefits will be paid under the plan only if the Appeals Administrator determines in its discretion that you are entitled to them.

Claims Procedures under the Accenture United States Group Health Plan Participating Flexible Benefits Plan or the Participating Flexible Benefits Plan for Accenture Flex Employees – Dependent Care Flexible Spending Account Option

Filing Claims under the Plan
You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through
an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from PayFlex. The notice will explain the reason for the denial and the review procedures.

An “authorized representative” means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf.

You will be notified of the decision not later than 30 days after receipt of the claim. This time period may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 30-day period. For example, the time period may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan’s claim decision no later than 30 days after the end of that additional period (or after receipt of the information, if earlier).

- Filing an Appeal of an Adverse Benefit Determination

You will have 180 days following receipt of an adverse benefit decision to appeal the decision by contacting PayFlex Customer Service to initiate an appeal. You may also submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim. You will be notified of the decision not later than 60 days after the appeal is received.

This decision will be final and binding. After receiving such a decision, you will have exhausted your administrative remedies under the plan. Under the terms of the plan, any further legal action against Accenture, the plan, or its delegates must be filed in a court of law no later than 120 days after the date of the decision.

Claims Procedures under the Accenture United States Group Insurance Plan - Participating Long Term Disability Plan

When a claim for long term disability plan benefits is denied, you or an authorized representative may appeal that denial. An “authorized representative” is a person you authorize in writing to act on your behalf.

The Claims Administrator will provide you with notice of the status of your claim within a reasonable period of time after a complete claim has been filed, but no later than 45 days after receipt of your claim for benefits. The Claims Administrator may request an additional 30-day extension if special circumstances warrant by notifying you of the extension before the expiration of the initial 45-day period. If a decision still cannot be made within this 30-day extension period due to circumstances outside the plan’s control, the time period may be extended for an additional 30 days, in which case you will be notified before the expiration of the original 30-day extension.

If you have not submitted sufficient information to the Claims Administrator to process your claim, you will be notified of the incomplete claim and given 45 days to submit additional information. This will extend the time in which the Claims Administrator has to respond to your claim from the date the notice of insufficient information is sent to you until the date you respond to the request. If you do not submit the requested missing information to the Claims Administrator within 45 days of the date of the request, your claim will be denied.

If your claim is denied, you will receive a notice which will include (i) the specific reasons for the denial, (ii) reference to the pertinent plan provisions upon which the denial is based, (iii) a description of any additional information you might be required to provide with an explanation of why it is needed, and (iv) an explanation of the plan’s claims review and appeal procedures. A denial notice will also include a discussion of the decision, including an explanation of a basis for disagreeing or not with the following, as applicable: (i) the views presented by you to the plan of health care professionals treating you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, without regard to whether the advice was relied upon in making the denial; and (iii) a disability determination regarding you made by the Social Security Administration that you have presented to the plan. If the denial is based on a medical necessity...
or experimental treatment or similar exclusion or limit, the notice will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. The notice will also include either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the denial or a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist. Finally, the notice will contain a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. The notice will be provided in a culturally and linguistically appropriate manner.

You, or a duly authorized representative, may appeal a denial of a claim for benefits by filing a written request with the Appeals Administrator within 180 days of your receipt of the initial denial notice.

In connection with your appeal, you may request that the plan provide you, free of charge, copies of all documents, records and other information relevant to the claim. You may also submit written comments, records, documents and other information relevant to your appeal, whether or not such documents were submitted in connection with the initial claim. The Appeals Administrator may consult with medical or vocational experts in connection with deciding your claim for benefits. The Appeals Administrator will provide to you as soon as possible, free of charge, any new or additional evidence or rationale considered, relied upon or generated by the plan, insurer or other person making the benefit determination in connection with the claim, giving you a reasonable opportunity to respond prior to making a decision on your appeal.

The Appeals Administrator will conduct a full and fair review of the documents and evidence submitted and will ordinarily render a decision no later than 45 days after receipt of your request for review on appeal. If there are special circumstances, the decision will be made as soon as possible, but not later than 90 days after receipt of your request for review on appeal. If such an extension of time is needed, you will be notified in writing prior to the end of the first 45-day period. The Appeals Administrator’s final written decision will include (i) specific reasons for the decision, (ii) specific references to the pertinent plan provisions on which the decision is based, and (iii) an explanation of your rights under ERISA’s claims and appeals rules, including (A) any voluntary appeal procedures offered by the plan (and your right to obtain information about such procedures), and (B) a description of any applicable contractual limitations period that applies to your right to bring a claim and the calendar date that any such period expires. The Appeals Administrator’s final written decision will also include a discussion of the decision, including an explanation of a basis for disagreeing or not with the following, as applicable: (i) the views presented by you to the plan of health care professionals who treated you and vocational professionals who evaluated you; (ii) the views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with the denial, without regard to whether the advice was relied upon in making the denial; and (iii) a disability determination regarding you made by the Social Security Administration that you have presented to the plan. If the final written decision is based on a medical necessity or experimental treatment or similar exclusion or limit, the final written decision will include either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. The final written decision will also include either the specific internal rules, guidelines, protocols, standards or other similar criteria of the plan relied upon in making the denial or a statement that such rules, guidelines, protocols, standards or other similar criteria of the plan do not exist. The final written decision will be provided in a culturally and linguistically appropriate manner. Any such decision will be final and binding.

After receiving such a decision, you will have exhausted your administrative remedies under the plan, and you will have a right to bring an action for benefits under ERISA Section 502(a)(1)(B). Benefits will be paid under the plan only if the Appeals Administrator determines in its discretion that you are entitled to them.

Claims Procedures under the Accenture United States Group Insurance Plan - Participating Life and AD&D Plan and Participating Dependent Life and AD&D Plan

If you or your beneficiary apply for life or dependent life/AD&D plan benefits and the application is denied, the Claims Administrator will notify the claimant of such denial in writing within 90 days, or within 180 days if the Claims Administrator notifies the claimant in writing that special circumstances require additional
time for processing the claim. The notice will (i) explain the reason for the denial, (ii) refer to the pertinent plan provisions on which the denial is based, (iii) describe any additional material necessary to perfect the claim and explain why such material is necessary, and (iv) explain the steps to be taken if the claimant wishes to submit the claim for review.

A claimant (or his or her duly authorized representative) may appeal the Claims Administrator’s denial of a claim by filing a written appeal with the Appeals Administrator within 60 days of the original denial. The appeal must contain (i) the date on which the original application was filed, (ii) the specific portions of the denial the claimant wishes the Appeals Administrator to review, (iii) a statement setting forth the reasons the denial should be reversed, and (iv) any written material the claimant wishes the Appeals Administrator to examine when reconsidering the claim. The Appeals Administrator will permit the claimant to examine any documents that are relevant to his or her claim.

The Appeals Administrator will notify the claimant of its decision on the appeal in writing within 60 days, or within 120 days if the Appeals Administrator notifies the claimant in writing that special circumstances require additional time for reviewing the appeal. The Appeals Administrator’s decision will be final and binding on all parties. After receiving such a decision, the claimant will have exhausted his or her administrative remedies under the plan, and will have a right to bring an action for benefits under ERISA Section 502(a)(1)(B). Benefits will be paid under the plan only if the Appeals Administrator determines in its discretion that the claimant is entitled to them.

Claims Procedures under the Accenture United States Group Legal Plan
Hyatt Legal verifies eligibility using information provided by Accenture. When you call for services, you will be advised if you are ineligible and Hyatt Legal Plans will contact Accenture for assistance. If you are not satisfied with the final determination of eligibility, you have the right to a formal review and appeal. Send a letter within 30 days explaining why you believe you are eligible to the following address. Within 30 days, you will be provided with a written explanation.

Accenture ERISA Appeals Committee
c/o Accenture – US Benefits
161 North Clark Street, 19th Floor.
Chicago, IL  60601

If you are denied coverage by Hyatt Legal Plans or by any Plan Attorney, you may appeal by sending a letter to:

Hyatt Legal Plans, Inc.
Director of Administration
1111 Superior Avenue 8th Fl
Cleveland, Ohio 44114-2507
(For Florida plans contact Hyatt Legal Plans of Florida, Inc. at the above address.)

The Director will issue Hyatt Legal Plans’ final determination within 30 days of receiving your letter. This determination will include the reasons for the denial with reference to the specific Plan provisions on which the denial is based and a description of any additional information that might cause Hyatt Legal Plans to reconsider the decision, an explanation of the review procedure and notice of the right to bring a civil action under Section 502(a) of ERISA.

WELFARE PLANS CLAIMS AND APPEALS PROCEDURES

ELIGIBILITY AND ENROLLMENT MATTERS

The circumstances under which your current coverage can be changed are explained in the “Eligibility and Enrollment” section of the applicable plan summary. It is your responsibility to understand these rules and their impact on your future coverage choices before you make annual enrollment elections or change your coverage upon experiencing a life event.

To make a claim about an eligibility or enrollment matter related to new employee enrollment, annual enrollment, life event changes, enrollment deadlines, or dependent coverage, contact the Benefits Center (1-877-332-2242).
Call between the hours of 9:00 am and 5:00 p.m. (Central time) and speak to a Benefits Center representative. If the representative is unable to assist you, he or she will ask you to file a written claim with the Benefits Center. Your case will be reviewed based on the plan’s enrollment and eligibility rules, and you will receive an explanation of that review within 60 days of the date your claim is received.

If your claim to the Benefits Center is denied and you feel you have a circumstance not addressed by the plan’s enrollment and eligibility rules, you may request a review by the Appeals Committee. Your request must be made in writing within 60 days of receiving the denial from the Benefits Center. Your appeal must provide the following information:

<table>
<thead>
<tr>
<th>Personal Information</th>
<th>Appeal Information</th>
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<tbody>
<tr>
<td>▪ Name</td>
<td>▪ Type of appeal</td>
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<tr>
<td>▪ Social Security number</td>
<td>▪ Date of appeal</td>
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<tr>
<td>▪ Date of hire</td>
<td>▪ Date of initial appeal to the Benefits Center</td>
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<tr>
<td>▪ Termination date (if applicable)</td>
<td>▪ Date initial appeal was denied by the Benefits Center</td>
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<tr>
<td>▪ Email address</td>
<td>▪ Reason for the denial</td>
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<tr>
<td>▪ Daytime phone number</td>
<td>▪ Brief description of the situation</td>
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<tr>
<td></td>
<td>▪ Additional information you feel is pertinent to your case</td>
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</table>

Before submitting your appeal, make a copy for your records. Send your appeal by inter-office mail or U.S. mail to the Accenture ERISA Appeals Committee, c/o Accenture, 161 North Clark Street, 19th Floor, Chicago, Illinois 60601. Your appeal will be reviewed, and you will be notified of the decision within 60 days of the date your appeal is received.

401(K), PROFIT SHARING AND PENSION PLANS

CLAIMS AND APPEALS PROCEDURES

The following provisions apply if you have a claim under the 401(k) Match and Savings Plan, the Discretionary Profit Sharing Plan, the Defined Contribution Transfer Plan or the New Pension Plan. (Claims and appeals procedures for the Accenture United States Pension Plan can be found in the Summary Plan Description for that plan on the Live Well at Accenture website http://resources.hewitt.com/aceture).

If you or your beneficiary file a claim for benefits under one of the plans listed above, such claim must be in writing and filed with the Plan Administrator. If a claim is denied, the Plan Administrator will notify the claimant in writing within 90 days after it receives the claim (or within 180 days if special circumstances warrant additional time and the claimant is notified of the extension). The notification of denial will set forth the specific reasons for the denial, with references to the plan provisions on which the denial is based, and will describe the additional information necessary to perfect the claim, if any, and the procedure for requesting a review of the denial.

A claimant (or his or her duly authorized representative) may request a review of the denial of a claim for benefits by filing a written application with the Appeals Committee within 60 days after he or she receives notice of the denial. Such a claimant is entitled to review pertinent plan documents and submit written issues and comments to the Appeals Committee. The Appeals Committee will furnish the claimant with written notice of its decision within 60 days after it receives a request for review (or within 120 days if special circumstances warrant additional time and the claimant is notified of the extension). The Appeals Committee’s notice will set forth the specific reasons for the decision, with references to the plan provisions on which the decision is based. The Appeals Committee’s decision will be final and binding on all parties. After receiving such a decision, the claimant will have exhausted his or her administrative remedies under the plan, and will have a right to bring an action for benefits under ERISA Section 502(a)(1)(B). Benefits will be paid under the plans only if the Appeals Committee decides in its discretion that the claimant is entitled to them.
ALL PLAN CLAIMS – LIMITATION ON TIME FOR SUITS

If your claim for benefits is finally denied by the Appeals Committee or Appeals Administrator, as applicable, then you may bring suit in federal court. You may not commence a suit in court for benefits under a plan until the plan’s claim process (and external review, if applicable) has been completed. However, you may only bring suit in federal court if you file such action within 120 days after the date of the final denial of your claim by the Appeals Committee, Appeals Administrator, or Independent Review Organization, as applicable.
# APPENDIX A

## CLAIMS AND APPEALS ADMINISTRATORS - CONTACT INFORMATION

<table>
<thead>
<tr>
<th>Type of Plan</th>
<th>Provider</th>
<th>Address</th>
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<tbody>
<tr>
<td><strong>Self-Insured Medical Plans</strong></td>
<td>Aetna PPO Plan</td>
<td>Aetna P.O. Box 981106</td>
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<tr>
<td></td>
<td>Aetna HealthFund HDHP</td>
<td>El Paso, TX 79998-1106</td>
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<td>Aetna EPO Plan</td>
<td>855/240-0835</td>
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<td>Fax: 859/455-8650 (Claims)</td>
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<td>Aetna P.O. Box 14463</td>
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<td>Lexington, KY 40512</td>
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<td></td>
<td>855/240-0835</td>
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<td></td>
<td></td>
<td>Fax: 859/425-3379 (Appeals)</td>
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<td></td>
<td>Blue Cross Blue Shield PPO Plan</td>
<td>Blue Cross Blue Shield of Illinois P.O. Box 805107</td>
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<td>BCBS BlueEdge Plan HDHP</td>
<td>Chicago, IL 60680-4112</td>
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<td>800/435-0108 (Claims)</td>
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<td>Blue Cross Blue Shield of Illinois Claim Review Section</td>
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<td></td>
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<td>P.O. Box 2401</td>
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<td>Chicago, IL 60690 (Appeals)</td>
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<td></td>
<td>Cigna PPO Plan</td>
<td>Cigna P.O. Box 182223</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chattanooga, TN 37422-7223</td>
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<tr>
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<td>855/611-8131</td>
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<tr>
<td><strong>Prescription Drug (Aetna, Blue Cross Blue Shield and Cigna PPOs, Aetna HealthFund HDHP, BCBS BlueEdge HDHP, Cigna HDHP and Aetna EPO Plan)</strong></td>
<td>Express Scripts</td>
<td>--Clinical Review Requests--</td>
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<td>Express Scripts Attn: Clinical Appeals Dept.</td>
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<td></td>
<td>P.O. Box 66588</td>
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<td></td>
<td></td>
<td>St. Louis, MO 63166-6588</td>
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<tr>
<td></td>
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<td>Fax: 877/852-4070</td>
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<td>--Administrative Review Requests--</td>
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<tr>
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<td></td>
<td>Fax: 877/328-9660</td>
</tr>
<tr>
<td><strong>Self-Insured Medical EPO</strong></td>
<td>Kaiser EPO</td>
<td>Kaiser Permanente Insurance Company 3701 Boardman-Canfield Road</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Canfield, OH 44406 (Medical)</td>
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<tr>
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<td>Kaiser Permanente Attn: SFAS National Self Funding 3840 Murphy Canyon</td>
</tr>
<tr>
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<td>Road San Diego, CA 92123 (Pharmacy)</td>
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<td><strong>Fully Insured Medical POS</strong></td>
<td>Kaiser Added Choice Plus POS</td>
<td>Kaiser Foundation Health Plan 80 Mahalani St.</td>
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<tr>
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<td>Plan (residents of Hawaii only)</td>
<td>Wailuku, HI 96793</td>
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<td>877/875-3805</td>
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</table>
| Fully Insured Global Medical Plan / Fully Insured PPO Dental (International Assignees) | United Healthcare | UnitedHealth International  
P.O. Box 740111  
Atlanta, GA  30374-0111 |
|---|---|---|
| Self-Insured Vision Plan | EyeMed Vision Care | FAA/EyeMed Vision Care, LLC  
Att: Quality Assurance Dept.  
4000 Luxottica Place  
Mason, OH  45040  
866/723-0513 |
| Self-Insured PPO Dental Plan | Aetna | Aetna  
P.O. Box 14094  
Lexington, KY  40512-4094  
800/525-4207 (Claims)  
Aetna Appeals Resolution Team  
P.O. Box 14597  
Lexington, KY  40512 (Appeals) |
| Insured DMO | Aetna | Aetna  
P.O. Box 14094  
Lexington, KY  40512-4094  
877/238-6200 |
| Flexible Spending Accounts | PayFlex | PayFlex System USA, Inc.  
P.O. Box 4000  
Richmond, KY  40476-4000  
855/288-7345 |
| Insured Long Term Disability Plan | Cigna Life Insurance Company of North America | Cigna Life Insurance Company of North America  
1640 Dallas Parkway  
Plano, TX  75093  
800/352-0611 |
| Insured Life and AD&D  
Insured Dependent Life/AD&D | MetLife | Metropolitan Life Insurance Company  
P.O. Box 3016  
Utica, NY  13504-3016 |
| Insured Legal Plan | Hyatt Legal | Hyatt Legal Plans, Inc.  
1111 Superior Avenue  
Cleveland, OH  44114-2407  
800/821-6400 |
| Appeals Committee | Accenture ERISA Appeals Committee | c/o Accenture  
161 North Clark Street, 19th Floor  
Chicago, IL  60601 |