

**UNITED STATES  
SECURITIES AND EXCHANGE COMMISSION  
WASHINGTON, D.C. 20549**

**FORM 10-K**

(Mark One)

**ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(D) OF THE SECURITIES EXCHANGE ACT OF 1934**  
For the fiscal year ended March 31, 2018

**TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(D) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the transition period from \_\_\_\_\_ to \_\_\_\_\_  
Commission File No. 001-34972

**Booz Allen Hamilton Holding Corporation**

(Exact name of registrant as specified in its charter)

**Delaware**  
(State or other jurisdiction of  
incorporation or organization)  
  
**8283 Greensboro Drive, McLean, Virginia**  
(Address of principal executive offices)

**26-2634160**  
(I.R.S. Employer  
Identification No.)  
  
**22102**  
(Zip Code)

**(703) 902-5000**  
Registrant's telephone number, including area code  
**Securities registered pursuant to Section 12(b) of the Act:**

<u>Title of Each Class</u>	<u>Name of Each Exchange on Which Registered</u>
Class A Common Stock	New York Stock Exchange

**Securities registered pursuant to Section 12(g) of the Act:**  
**None.**

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. Yes  No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. Yes  No

Note — Checking the box above will not relieve any registrant required to file reports pursuant to Section 13 or 15(d) of the Exchange Act from their obligations under those sections.

Indicate by check mark whether the registrant (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes  No

Indicate by check mark whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (§232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). Yes  No

Indicate by check mark if disclosure of delinquent filers pursuant to Item 405 of Regulation S-K (§ 229.405 of this chapter) is not contained herein, and will not be contained, to the best of registrant's knowledge, in definitive proxy or information statements incorporated by reference in Part III of this Form 10-K or any amendment to this Form 10-K.

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See definition of "large accelerated filer", "accelerated filer", "smaller reporting company" and "emerging growth company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer	<input checked="" type="checkbox"/>	Accelerated filer	<input type="checkbox"/>
Non-accelerated filer	<input type="checkbox"/> (Do not check if a smaller reporting company)	Smaller reporting company	<input type="checkbox"/>
		Emerging growth company	<input type="checkbox"/>

If an emerging growth company, indicate by check mark if the registrant has elected not to use the extended transition period for complying with any new or revised financial accounting standards provided pursuant to Section 13(a) of the Exchange Act.

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). Yes  No

As of September 29, 2017, the market value of the voting and non-voting common equity held by non-affiliates based on the closing price as of that day was \$5,293,214,554.

Indicate the number of shares outstanding of each of the issuer's classes of common stock, as of the latest practicable date.

	<b>Shares Outstanding as of May 23, 2018</b>
Class A Common Stock	143,367,775
Class B Non-Voting Common Stock	—
Class C Restricted Common Stock	—
Class E Special Voting Common Stock	—

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**DOCUMENTS INCORPORATED BY REFERENCE**

Portions of the registrant's Proxy Statement for its Annual Meeting of Stockholders scheduled for July 26, 2018 are incorporated by reference into Part III.

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## INTRODUCTORY NOTE

Unless the context otherwise indicates or requires, as used in this Annual Report on Form 10-K for the fiscal year ended March 31, 2018, references to: (i) “we,” “us,” “our” or our “company” refer to Booz Allen Hamilton Holding Corporation, its consolidated subsidiaries and predecessors; (ii) “Booz Allen Holding” refers to Booz Allen Hamilton Holding Corporation exclusive of its subsidiaries; (iii) “Booz Allen Investor” refers to Booz Allen Hamilton Investor Corporation, a wholly-owned subsidiary of Booz Allen Holding; (iv) “Booz Allen Hamilton” and “Booz Allen” refer to Booz Allen Hamilton Inc., our primary operating company and a wholly-owned subsidiary of Booz Allen Holding; and (v) “fiscal,” when used in reference to any twelve-month period ended March 31, refers to our fiscal years ended March 31. Unless otherwise indicated, information contained in this Annual Report is as of March 31, 2018. We have made rounding adjustments to reach some of the figures included in this Annual Report and, unless otherwise indicated, percentages presented in this Annual Report are approximate.

### Cautionary Note Regarding Forward-Looking Statements

Certain statements contained or incorporated in this Annual Report include forward-looking statements. In some cases, you can identify forward-looking statements by terminology such as “may,” “will,” “could,” “should,” “forecasts,” “expects,” “intends,” “plans,” “anticipates,” “projects,” “outlook,” “believes,” “estimates,” “predicts,” “potential,” “continue,” “preliminary,” or the negative of these terms or other comparable terminology. Although we believe that the expectations reflected in the forward-looking statements are reasonable, we can give you no assurance these expectations will prove to have been correct. These forward-looking statements relate to future events or our future financial performance and involve known and unknown risks, uncertainties and other factors that may cause our actual results, levels of activity, performance, or achievements to differ materially from any future results, levels of activity, performance, or achievements expressed or implied by these forward-looking statements. These risks and other factors include:

- cost cutting and efficiency initiatives, budget reductions, Congressionally mandated automatic spending cuts, and other efforts to reduce U.S. government spending, including automatic sequestration required by the Budget Control Act of 2011 (as subsequently amended);
- delayed funding of our contracts due to uncertainty relating to and a possible failure of Congressional efforts to approve funding of the U.S. government and to craft a long-term agreement on the U.S. government’s ability to incur indebtedness in excess of its current limits, or changes in the pattern or timing of government funding and spending (including those resulting from or related to cuts associated with sequestration);
- current and continued uncertainty around the timing, extent, nature, and effect of ongoing Congressional and other U.S. government action to address budgetary constraints, including, but not limited to, Congressional efforts to approve funding of the U.S. government and to craft a long-term agreement on the U.S. government’s ability to incur indebtedness in excess of its current limits and the U.S. deficit;
- any issue that compromises our relationships with the U.S. government or damages our professional reputation, including negative publicity concerning government contractors in general or us in particular;
- changes in U.S. government spending, including a continuation of efforts by the U.S. government to decrease spending for management support service contracts, and mission priorities that shift expenditures away from agencies or programs that we support;
- U.S. government shutdowns due to, among other reasons, a failure by elected officials to fund the government;
- the size of our addressable markets and the amount of U.S. government spending on private contractors;
- failure to comply with numerous laws and regulations, including, but not limited to, the Federal Acquisition Regulation (“FAR”), the False Claims Act, the Defense Federal Acquisition Regulation Supplement and FAR Cost Accounting Standards and Cost Principles;
- our ability to compete effectively in the competitive bidding process and delays or losses of contract awards caused by competitors’ protests of major contract awards received by us;
- the loss of General Services Administration Multiple Award schedule contracts, or GSA schedules, or our position as prime contractor on government-wide acquisition contract vehicles, or GWACs;
- changes in the mix of our contracts and our ability to accurately estimate or otherwise recover expenses, time, and resources for our contracts;
- continued efforts to change how the U.S. government reimburses compensation related and other expenses or otherwise limit such reimbursements, including recent rules that expand the scope of existing reimbursement limitations, such as a reduction in allowable annual employee compensation to certain contractors as a result of the Bipartisan Budget Act of 2013, and an increased risk of compensation being deemed unallowable or payments being withheld as a result of U.S. government audit, review or investigation;
- our ability to generate revenue under certain of our contracts;

- our ability to realize the full value of and replenish our backlog and the timing of our receipt of revenue under contracts included in backlog;
- changes in estimates used in recognizing revenue;
- an inability to attract, train, or retain employees with the requisite skills, experience, and security clearances;
- an inability to hire, assimilate, and deploy enough employees to serve our clients under existing contracts;
- an inability to timely and effectively utilize our employees or manage our cost structure;
- failure by us or our employees to obtain and maintain necessary security clearances;
- the loss of members of senior management or failure to develop new leaders;
- misconduct or other improper activities from our employees or subcontractors, including the improper use or release of our clients' sensitive or classified information;
- increased insourcing by various U.S. government agencies due to changes in the definition of "inherently governmental" work, including proposals to limit contractor access to sensitive or classified information and work assignments;
- increased competition from other companies in our industry;
- failure to maintain strong relationships with other contractors; or the failure of contractors with which we have entered into a sub- or prime-contractor relationship to meet their obligations to us or our clients;
- inherent uncertainties and potential adverse developments in legal or regulatory proceedings, including litigation, audits, reviews, and investigations, which may result in materially adverse judgments, settlements, withheld payments, penalties, or other unfavorable outcomes including debarment, as well as disputes over the availability of insurance or indemnification;
- internal system or service failures and security breaches, including, but not limited to, those resulting from external cyber attacks on our network and internal systems;
- risks related to changes to our operating structure, capabilities, or strategy intended to address client needs, grow our business or respond to market developments;
- risks associated with new relationships, clients, capabilities, and service offerings in our U.S. and international businesses;
- failure to comply with special U.S. government laws and regulations relating to our international operations;
- risks related to our indebtedness and credit facilities which contain financial and operating covenants;
- the adoption by the U.S. government of new laws, rules, and regulations, such as those relating to organizational conflicts of interest issues or limits;
- risks related to completed and future acquisitions, including our ability to realize the expected benefits from such acquisitions;
- an inability to anticipate or estimate the tax implications of changes in tax law, including the Tax Cuts and Jobs Act (the "2017 Tax Act"), or utilize existing or future tax benefits, including those related to our stock-based compensation expense, for any reason, including as a result of a change in law, such as the 2017 Tax Act;
- variable purchasing patterns under U.S. government GSA schedules, blanket purchase agreements and indefinite delivery, indefinite quantity, or IDIQ, contracts; and
- other risks and factors listed under "Item 1A. Risk Factors" and elsewhere in this Annual Report.

In light of these risks, uncertainties, and other factors, the forward-looking statements might not prove to be accurate and you should not place undue reliance upon them. All forward-looking statements speak only as of the date made and we undertake no obligation to update or revise publicly any forward-looking statements, whether as a result of new information, future events, or otherwise.

## PART I

### Item 1. Business

#### Overview

For more than 100 years, business, government, and military leaders have turned to Booz Allen Hamilton to solve their most complex problems. A values-driven organization with a guiding purpose to empower people to change the world, we remain focused on providing long-term solutions to our clients' emerging and ever-changing challenges. Our people are passionate about their service to our clients and their missions and the communities in which we live and work. This is our heritage, and it is as true today as when the company was founded in 1914.

A collaborative culture is an integral part of our unique operating model, which encourages our people to bring a diversity of ideas and talent to every client engagement. Building on our legacy of passionate client service and guided by our comprehensive Vision 2020 strategy, we blend deep expertise in management consulting with advanced technical capabilities to deliver powerful solutions. By investing in markets, capabilities, and talent and building new business models, including ventures, partnerships, and product offerings, we believe we are creating sustainable quality growth for the company.

Through our dedication to our clients' missions, and a commitment to evolving our business to address their needs, we have longstanding relationships with our clients, some more than 75 years. We support critical missions for a diverse base of federal government clients, including nearly all of the U.S. government's cabinet-level departments, as well as increasingly for top-tier commercial and international clients. We support our federal government clients by helping them tackle their most complex and pressing challenges such as protecting soldiers in combat and supporting their families, advancing cyber capabilities, keeping our national infrastructure secure, enabling and enhancing digital services, transforming the healthcare system, and improving governmental efficiency to achieve better outcomes. We serve commercial clients across industries including financial services, health and life sciences, energy, and transportation to solve the hardest and most consequential challenges, including through our cybersecurity products and services. Our international clients are primarily in the Middle East, and we have a growing presence in Southeast Asia.

#### History and Corporate Structure

We were founded in 1914 by Edwin Booz, one of the pioneers of management consulting. In 1940, we began serving the U.S. government by advising the Secretary of the Navy in preparation for World War II. As the needs of our clients have grown more complex, we have expanded beyond our management consulting foundation to develop deep expertise in the fields of analytics, digital solutions, engineering and cyber.

We are organized and operate as a corporation, but sometimes use the term "partner" to refer to our Chief Executive Officer and our Senior and Executive Vice Presidents. The use of the term "partner" reflects our collaborative culture, and is not meant to imply that we operate our company as, or have any intention to create a legal entity that is, a partnership.

Booz Allen Holding was incorporated in Delaware in May 2008 to serve as the top-level holding company for the consolidated Booz Allen Hamilton U.S. government consulting business. On July 31, 2008, Booz Allen Hamilton completed the separation of its U.S. government consulting business from its legacy commercial and international consulting business, the spin-off of the commercial and international business, and the sale of 100% of its outstanding common stock to Booz Allen Holding, or the Carlyle Acquisition, which was majority owned by The Carlyle Group and certain of its affiliated investment funds, or Carlyle. Our company is a corporation that is the successor to the U.S. government consulting business of Booz Allen Hamilton following the separation. Between 2013 and 2016, we registered the offering and sale of common stock by Carlyle, and on December 6, 2016, Carlyle disposed of its remaining shares of the Company's Class A Common Stock in a registered secondary offering.

#### Our Institution and Operating Model

We operate as a single profit/loss center with a single bonus pool for partners, vice presidents, principals, and senior associates. Our operating model encourages collaboration allowing us to bring a mix of the best talent to every client engagement. Our partnership-style culture provides the operational flexibility necessary to quickly mobilize people and capabilities to react to market changes faster than our competitors. As a result, we can go to market as a whole firm rather than as a collection of individual competing business units or profit centers. Our operating model also encourages and enables continuous investment in the right markets, capabilities, and talent to position the company for further growth by anticipating what government and commercial clients will need next.

Across all markets, we address our clients' complex and evolving needs by deploying multifaceted teams with a combination of deep mission understanding, market-leading functional capabilities, consulting talent, and true technical and engineering expertise. These client-facing teams, which are fundamental to our differentiated value proposition, better position us to create market-relevant growth strategies and plan for and meet current, future, and prospective market needs. They also

help us identify and deliver against diverse client needs in a more agile manner. Our significant win rates during fiscal 2018 on new and re-competed contracts of 63% and 87%, respectively, as compared to 62% and 90%, respectively, in fiscal 2017 demonstrate the strength of this approach.

## Our People

Our ability to deliver lasting value and results to our clients has always been, and continues to be, a product of the strong character, expertise and tremendous passion of our people. Our approximately 24,600 employees work to solve hard problems by making our clients' missions their own, combining decades of consulting and domain expertise with functional expertise in areas such as analytics, digital solutions, engineering, and cyber. Our talented people are supported by a culture of innovation and inclusion.

Our people at a glance:

- 77 partners
- Nearly 28% are veterans, including 17 partners
- Approximately 84% hold bachelor's degrees; approximately 40% hold master's degrees; and approximately 3% hold doctoral degrees
- Approximately 69% hold security clearances

We attract and retain the best people by providing them with opportunities to grow, build skills, and be appreciated for their contributions as they work on our clients' toughest challenges. This value proposition creates a virtuous circle in which our employees know they are making a difference while growing their careers, which furthers their commitment to Booz Allen and makes them ambassadors for future talent. Booz Allen has always recognized the importance of our people and culture, and we continue to build on that strong legacy as we support our employees to meet their full potential.

We also foster the spirit of innovation through events, partnerships, programs, and tools that facilitate collaboration to tackle a common challenge or pitch new products and capabilities. It is the diversity of our employees that fuels this innovation enhancing the way we work by bringing a wealth of experiences and expertise to any challenge. We celebrate difference in all forms, building an environment of inclusion regardless of ethnicity, religion, gender, sexual orientation, age or disability.

The importance we place on our people continues to receive external recognition. For the eighth consecutive year, Booz Allen has received a perfect score on the Corporate Equality Index (CEI), a national benchmarking survey on corporate policies and practices related to LGBTQ workplace equality administered by the Human Rights Campaign Foundation. In addition, for the third consecutive year, Booz Allen received a perfect score on the 2017 Disability Equality Index (DEI), and has been named a DEI "Best Place to Work." Vault.com ranked us as #1 in public sector consulting. *Fortune* named the company as one of the World's Most Admired Companies and *Forbes* selected us as one of the Top Employers for Veterans and one of the best Management Consulting Firms for 2017. We have also been honored with industry awards that showcase our employer brand, including "One of the 9 Best Management Consulting Firms" by *Business Insider*, a "Top Company for People with Disabilities" by *Diversity Inc.*, "Best for Vets" by *Military Times*, a "Top Company of 2017" by *LinkedIn*, "Working Mother Top 100", "#7 Best Places to Work in IT" by *Computer World* and the Alliance for Workplace Excellence Award.

Beyond their client work, our people and our Company demonstrate passionate service in their commitment to our country, military, and communities. Our social impact strategy connects people, organizations, and communities with transformational innovation and technological solutions that power human potential and wider social impact in a spirit of passionate service. For example, we support a variety of organizations assisting veterans and military families, including supporting training in cyber and science, technology, engineering, and math (STEM) careers, and providing data analytics and other tech solutions in support of operations. Our partners include USO of Metropolitan Washington-Baltimore, Hiring Our Heroes, Tragedy Assistance Program for Survivors, Blue Star Families and the Elizabeth Dole Foundation.

In the past year, we issued 379 volunteer service grants to 306 nonprofit groups for which employees volunteered more than 40 hours. Employees recorded more than 65,000 total hours of service during the year and donated generously to the American Red Cross National Disaster Relief Fund and other organizations responding to the recent and large-scale natural and man-made disasters across the United States. More broadly, we have taken a leadership role in eliminating the stigma around mental health and building more appreciation and awareness of emotional fitness in the corporate world as a partner to the nonprofit Give an Hour.

*Purpose and Values.* As one of the first organizations in the United States to adopt a formal code of business ethics, we have always believed that doing what's right and holding ourselves and others accountable is the only way to do business. Our people exemplify our purpose to "empower people to change the world" and live our values:

- Ferocious Integrity: Do right; hold ourselves accountable

- Unflinching Courage: Speak truth to power; maintain convictions; bring bold thinking
- Passionate Service: Embrace the mission; build community through generosity; make meaningful connections; listen and act with empathy
- Collective Ingenuity: Find the biggest problem and solve it; be resourceful and creative; seek to make the biggest difference; harness the power of diversity; be devoted to the team
- Champion's Heart: Crave being the best; bring joy to the pursuit; learn from failure; compete with passion

## Service Offerings

We offer five service offerings that drive our capacity to meet market demand. We provide a range of technological capabilities that have had an enduring impact for our clients, our people, and the communities where we live and work.

Our service offerings:

- **Consulting** focuses on the talent and expertise needed to solve client problems and develop mission-oriented solutions for specific domains, business strategies, human capital, and operations through new and innovative approaches. We help clients boost organizational performance, deploy new technologies in smart ways, and change and streamline processes to achieve better outcomes.
- **Analytics** focuses on delivering transformational solutions in the areas of decision analytics (including operations research and cost estimation), automation, and data science (including predictive modeling and machine learning) as well as new or emerging areas such as deep learning and artificial intelligence. We pioneer new approaches to apply analytic technology to clients' problems, draft industry-defining publications, and introduce transformative products such as graphics processing unit (GPU) accelerated deep learning software, to the market.
- **Digital Solutions** combines the power of modern systems development techniques and cloud platforms with the power of machine learning to transform customer and mission experiences. We blend in-depth client mission understanding and digital technical expertise with a consultative approach. We develop, design, and implement powerful solutions built on contemporary methodologies and modern architectures. We accelerate clients to open, cloud native environments, where capability can be securely developed and deployed at scale, and effort allocated towards data management challenges is redirected to analysis and insights.
- **Engineering** delivers engineering services and solutions to define, develop, implement, sustain, and modernize complex physical systems such as the Launch and Test Range System (LTRS) for the U.S. Air Force Space Command or the Flush Air Data Systems (FADS) for NASA. We leverage mature engineering methodologies to solve our clients' most complex problems. We bring a holistic understanding of client needs and technical strategy as well as policy experts to deliver purpose-fit solutions to problems. Our engineering capabilities include external industry standard certifications (e.g., ISO 90001 and AS9100).
- **Cyber** focuses on active prevention, detection, and cost effectiveness. Active prevention includes methods of securing platforms and enterprises against cyber attacks; detection is the instrumentation of networks to provide lead indicators of penetrations; and cost effectiveness includes our integrated engineering capabilities. Our cyber capabilities are rooted in our decades of service to the U.S. federal intelligence community and today afford us the opportunity to maintain technical expertise in network security. With decades of mission intelligence combined with the most advanced tools available, we help clients understand the business value of cyber risk management as well as prepare for future cybersecurity needs with a lens toward efficiency and effectiveness.

## Innovation

With our solutions business, we are developing transformative solutions that build lasting value for our clients. We are advancing and creating the infrastructure and mechanics for new and disruptive business models by enabling a vibrant innovation culture, bringing a solutions mindset to our marketplace and sales force and building the company's presence and brand in the external innovation ecosystem. As a gateway to driving innovation, the solutions business combines market-prioritized needs with the company's capabilities and products. The solutions business enhances future revenue opportunities and accelerates solutions to clients, monetizes the firm's intellectual property, and creates differentiated business models and sales channels to drive greater value for our clients.

In addition, we are an essential partner in regional innovation communities all over the country. Through our innovation ecosystem, we are focused on solution co-creation and technology scouting, and are physically co-locating, co-creating, mentoring, incubating, contributing, and investing with organizations in Washington, D.C.; Boston, Massachusetts; Austin, Texas; San Francisco, California; and from Seattle, Washington to San Diego, California (the corridor of venture capitalists and digital powerhouses), with new hubs in Herndon, Virginia, Laurel, Maryland, and Charleston, South Carolina. We harness next-

generation technologies being created in academic, startup, and big technology firms to imagine and incubate new offerings, solutions, and growth for the company.

In addition to our service offerings, Booz Allen is driving focused innovation in areas expected to create integrated capabilities, drive next generation expertise, and develop business over the long term. These innovation areas include:

- **Machine Intelligence** applies and scales the use of machine learning and artificial intelligence to fundamentally transform how our clients perform their missions and run their organizations in a future where people and increasingly intelligent machines collaborate to solve our hardest problems. We are continuing to develop new capabilities in exciting areas, such as quantum computing and deep learning, to create long-term differentiation and value.
- **Directed Energy** technologies use high-energy lasers or high-powered microwaves to efficiently disrupt or damage targets with non-kinetic, speed-of-light engagement. Through our Directed Energy business, we can help clients as a technology maturation agent, integrator, and solutions provider.

### **Our Long-Term Growth Strategy**

Vision 2020 is a comprehensive strategy to transform Booz Allen and create sustainable quality growth for the company. Fiscal 2018 was the fifth year of implementing the strategy, but its design reaches back to before the government market began to contract in 2011 and 2012. We anticipated the market downturn and set in place a strategy that would allow us to emerge in a strong position vis-à-vis our competitors. Under Vision 2020, we are:

- Moving closer to the center of our clients' core missions
- Increasing the technical content of our work
- Attracting and retaining superior talent in diverse areas of expertise
- Leveraging innovation to deliver complex, differentiated, end-to-end solutions
- Creating a broad network of external partners and alliances
- Expanding into the commercial and international markets

The success of our strategy can be seen in:

- Backlog growth, which achieved record levels during fiscal 2018
- Headcount growth and a corresponding shift in our talent portfolio to more technical expertise in disciplines such as systems development, cyber, and analytics
- Continued strong performance in the global commercial market
- Execution against our capability focused acquisition strategy, most recently through the acquisition of technology firm, Morphick, Inc., which closed in October 2017, to expand Booz Allen's managed security portfolio and strengthen the firm's capability to help clients counter advanced cyber threats.

We have won highly technical, mission-critical work across our federal government business because we bring differentiated offerings that meet our clients' toughest challenges. To propel our success against our Vision 2020 long-term strategy, we have implemented initiatives to drive innovation deeper into our markets, enhancing our ability to collaborate and achieve more for our clients and differentiating Booz Allen in the talent market to enhance our ability to attract and retain the best and the brightest.

These initiatives are ultimately designed to accelerate revenue growth and move Booz Allen further toward our goal of delivering sustainable quality growth.

### **Our Clients**

Booz Allen is committed to solving our clients' toughest challenges, and we work with a diverse base of public and private sector clients across a number of industries, in the U.S. and internationally.

Our clients call us to work on their hardest problems, such as delivering effective healthcare, protecting soldiers in combat and their families and keeping our national infrastructure secure. We are investing in markets, capabilities, and talent and are building new business models through strategic ventures, partnerships, and product offerings.

Our government clients include substantially all of the cabinet-level departments of the U.S. government. We serve commercial clients across industries including financial services, health and life sciences, energy, and transportation to solve their hardest and most consequential challenges, including through our cybersecurity products and services, and have a thriving portfolio of international clients in the Middle East and Southeast Asia.

## ***A Large Addressable Market***

We believe that the U.S government is the world's largest consumer of management and technology consulting services. The U.S. government's budget for its fiscal year ended September 30, 2017 was close to \$4.0 trillion, excluding authorizations from Overseas Contingency Operations and supplemental funding for the Department of Defense. Of this amount, approximately \$1.2 trillion was for discretionary budget authority, including \$634 billion for the Department of Defense and intelligence community and \$586 billion for civil agencies. Based on data from the Federal Procurement Data System, approximately \$508 billion of the U.S. government's fiscal year 2017 discretionary outlays were non-intelligence agency funding-related products and services procured from private contractors. We estimate that \$124.4 billion of the spending directed towards private contractors in U.S. government fiscal year 2017 was for management, technology, and engineering services, with \$69.6 billion spent by the Department of Defense and \$54.8 billion spent by civil agencies. The agencies of the U.S. intelligence community that we serve represent an additional market. These numbers also exclude a large addressable market for our services and capabilities in the global commercial markets where we have a modest but growing footprint.

During Booz Allen's fiscal 2018:

- We derived 97% of our revenue from contracts where the end client was an agency or department of the U.S. government.
- We delivered services under 4,997 contracts and task orders.
- We derived 91% of our revenue in fiscal 2018 from engagements for which we acted as the prime contractor.
- The single largest entity that we served in fiscal 2018 was the Navy Marine Corps, which represented approximately 13% of our revenue in that period.

## ***Selected Long-Term Client Relationships***

<b>Client (1)</b>	<b>Relationship Length (Years)</b>
U.S. Navy	75+
U.S. Army	65+
Department of Energy	40+
U.S. Air Force	40+
National Security Agency	35+
Department of Homeland Security	35+
Federal Bureau of Investigation	25+
Department of Health and Human Services	20+
National Reconnaissance Office	20+
A U.S. intelligence agency	20+
Internal Revenue Service	20+

(1) Includes predecessor organizations.

## ***Defense and Intelligence Clients***

We count among our many defense and intelligence clients all four branches of the U.S. military, the Office of the Secretary of Defense, the Joint Staff and members of the intelligence community.

We help our military services take on new missions, tackle acquisition and budgeting challenges, and address the medical needs of soldiers in combat. We also help our defense and intelligence clients adopt innovative technologies, bridging the gap they face between rising mission responsibilities and declining mission funding with our heritage and expertise in consulting. In addition, we bring tools, techniques, and expertise to challenges and apply them in innovative ways.

The men and women we hire have served their country and have the experience and determination to help our defense clients keep our nation safe. Our experts in strategy development, acquisition, and operations help commanders and their staffs in the field share mission-critical information and make crucial battlefield decisions.

Revenue generated from defense clients was \$2.83 billion, or approximately 45.9% of our revenue in fiscal 2018 as compared to \$2.70 billion, or approximately 46.6% of our revenue in fiscal 2017. Our key defense clients include the Army, Navy/Marine Corps, Air Force, and Joint Combatant Commands. Revenue generated from defense clients also includes foreign military sales to non-U.S. government clients.

Revenue generated from intelligence clients was \$1.49 billion, or approximately 24.2% of our revenue in fiscal 2018 as compared to \$1.34 billion, or approximately 23.1% of our revenue in fiscal 2017. Our key intelligence clients include U.S. intelligence agencies, such as the National Security Agency, National Geospatial-Intelligence Agency, and National Reconnaissance Office; and military intelligence agencies, such as the Defense Intelligence Agency, Service Intelligence Centers, and Intelligence Surveillance Reconnaissance units.

### **Civil Clients**

Whether ensuring the safety, security, and well-being of citizens, or boosting national competitiveness, we work with leaders in civil government to support their public service missions. We excel at tackling the most complex challenges from reforming financial regulatory oversight and evolving our healthcare system to improving information sharing among law enforcement organizations and supporting green building initiatives.

Our work spans the full breadth of civil government, including energy and the environment, financial services, health, homeland security, law enforcement, transportation, grants, international development and diplomacy, and benefits and entitlements.

We work with leaders so they make better decisions and foster better user experiences both inside and outside of their organizations.

Revenue generated from civil government was \$1.65 billion, or approximately 26.7% of our revenue in fiscal 2018 as compared to \$1.61 billion, or approximately 27.7% of our revenue in fiscal 2017. Our major civil government clients include the Departments of Homeland Security, Health and Human Services, Veterans Affairs, Treasury and Justice.

### **Global Commercial Clients**

We work alongside public and private sector leaders of the world's most prestigious organizations to help shape and execute their critical agendas.

Following the 2011 expiration of our non-competition agreement with our spun-off commercial business, we re-entered the Middle East and North Africa (MENA) and Southeast Asia (SEA) markets. We originally established our international offices located in MENA more than six decades ago and our offices in SEA more than three decades ago. Since re-entering these markets, our strategy and technology consultants have empowered our clients in these regions with the knowledge and experience they need to build their own local resources and capabilities.

Revenue generated from global commercial clients was \$197.0 million, or approximately 3.2% of our revenue in fiscal 2018 as compared to \$152.1 million, or approximately 2.6% of our revenue in fiscal 2017. Global commercial clients are comprised of U.S. commercial and international clients. We serve commercial clients in a variety of industries including financial services, health and life sciences, energy and transportation. Our international clients include non-U.S. governments and commercial entities in the MENA region and select Asian markets.

### **Contracts**

Booz Allen's approach has long been to ensure that we have prime or subcontractor positions on a wide range of contracts that allow clients maximum opportunity to access our services. Our diverse contract base provides stability to our business. This diversity shows that more than 75% of our revenue for fiscal 2018 was derived from 3,956 active task orders under IDIQ contract vehicles. Our top IDIQ contract vehicle represented approximately 6.2% of our revenue in our fiscal 2018. Our largest task order under an IDIQ contract vehicle accounted for approximately 2.7% of our revenue in our fiscal 2018. Our largest definite contract represented approximately 2.2% of our revenue in our fiscal 2018.

The U.S. government procures services through two predominant contracting methods: indefinite contract vehicles and definite contracts. Each of these is described below:

- Indefinite contract vehicles provide for the issuance by the client of orders for services or products under the terms of the contract. Indefinite contracts are often referred to as contract vehicles or ordering contracts. IDIQ contracts may be awarded to one contractor (single award) or several contractors (multiple award). Under a multiple award IDIQ contract, there is no guarantee of work as contract holders must compete for individual work orders. IDIQ contracts will often include pre-established labor categories and rates, and the ordering process is streamlined (usually taking less than a month from recognition of a need to an established order with a contractor). IDIQ contracts often have multiyear terms and unfunded ceiling amounts, thereby enabling but not committing the U.S. government to purchase substantial amounts of products and services from one or more contractors in a streamlined procurement process.
- Definite contracts call for the performance of specified services or the delivery of specified products. The U.S. government procures services and solutions through single award, definite contracts that specify the scope of services that will be delivered and identify the contractor that will provide the specified services. When an agency recognizes a need for services or products, it develops an acquisition plan, which details how it will procure those

services or products. During the acquisition process, the agency may release a request for information to determine if qualified bidders exist, a draft request for a proposal to allow the industry to comment on the scope of work and acquisition strategy, and finally a formal request for a proposal. Following the evaluation of submitted proposals, the agency will award the contract to the winning bidder.

Listed below are our top IDIQ contracts for fiscal 2018 and the number of active task orders under these contracts as of March 31, 2018.

	Fiscal 2018 Revenue	% of Total Revenue	Number of Task Orders as of March 31, 2018	Expiration Date <sup>(1)</sup>
	(in millions)			
Alliant	\$ 382.6	6.2%	34	4/30/2019
One Acquisition Solution for Integrated Services	378.6	6.1%	44	9/2/2024
System Engineering and Analysis/Advanced Technology Support	275.4	4.5%	36	12/31/2019
Information Technology Schedule 70	245.0	4.0%	51	3/22/2019
Defense Systems Technical Area Tasks	242.3	3.9%	47	6/22/2019
VA TAC Transformation Twenty One Total Technology	173.7	2.8%	25	6/30/2016
Professional Services Schedule	163.3	2.6%	127	9/30/2035
Mission Oriented Business Integrated Services	120.6	2.0%	51	9/30/2017
Chief Information officer - Solutions & Partners 3	117.5	1.9%	25	5/31/2022
Booz Allen Engineering Services - Alliant	116.8	1.9%	2	4/30/2019

(1) Expiration date applies to the IDIQ vehicle. Task orders awarded under the IDIQ can run past the expiration of the IDIQ itself.

Under their Category Management initiative, the General Services Administration (“GSA”) has undertaken an effort to improve its professional service schedule offerings. As a result of this initiative, GSA consolidated multiple contract vehicles under the schedule program. The result for Booz Allen has been the consolidation of the scope of six schedules into one professional services schedule contract. The GSA Schedule contracts to be consolidated under the new professional services schedule are: Advertising and Integrated Marketing Solutions (AIMS), Environmental Services (ES), Financial and Business Services (FABS), Logistics Worldwide (LOGWORLD), Mission Oriented Business Integrated Services (MOBIS), and Professional Engineering Services (PES).

Booz Allen’s migration request was accepted in October of 2015 and, as a result, our individual schedules included in the GSA’s consolidation will remain in place through the end of the current option period of each individual contract to prevent the interruption of services. The revenue generated under these individual schedules will begin to decrease during this transition period. We anticipate that the decrease in revenue on the individual schedules will be offset by growth under the new professional service schedule. We anticipate this transition will have negligible impact on future revenues.

Listed below for each specified revenue band is the number of, revenue derived from, and average duration of our task orders as of March 31, 2018. The table includes revenue earned during fiscal 2018 under all task orders that were active during fiscal 2018 under these IDIQ contracts and the number of active task orders on which this revenue was earned. Average duration reflected in the table below is calculated based on the inception date of the task order, which may be prior to the beginning of fiscal 2018, and the completion date which may have been prior or subsequent to March 31, 2018. As a result, the actual average remaining duration for task orders included in this table may be less than the average duration shown in the table, and task orders included in the table may have been complete on March 31, 2018.

Segmentation of Task Order by Revenue Fiscal 2018	Number of Task Orders Active During Fiscal 2018	Fiscal 2018 Revenue (in millions)	% of Total Revenue	Average Duration (Years)
Less than \$1 million	3,143	\$ 538.3	9%	1.3
Between \$1 million and \$3 million	504	880.1	14%	2.0
Between \$3 million and \$5 million	113	439.8	7%	2.3
Between \$5 million and \$10 million	105	765.4	12%	2.5
Greater than \$10 million	91	2,035.6	33%	2.8
Total	3,956	4,659.2	75%	1.5

Listed below are our top definite contracts for fiscal 2018 and revenue recognized under these contracts. Classified contracts that cannot be named are noted generically in the table:

	Fiscal 2018 Revenue (in millions)	% of Total Revenue	Expiration Date
Classified Contract	\$ 132.9	2.2%	9/30/2021
Classified Contract	81.0	1.3%	3/7/2023
Classified Contract	51.4	0.8%	10/31/2018
Classified Contract	50.7	0.8%	6/30/2018
InnoVision Future Solutions Program	48.5	0.8%	8/31/2018
Classified Contract	35.6	0.6%	12/31/2020
Classified Contract	35.0	0.6%	9/30/2019
DTRA CTR Advisory and Assistance Services	33.4	0.5%	5/26/2021
Classified Contract	32.4	0.5%	9/30/2019
Classified Contract	27.4	0.4%	4/30/2018

## Backlog

We define backlog to include the following three components:

- *Funded Backlog.* Funded backlog represents the revenue value of orders for services under existing contracts for which funding is appropriated or otherwise authorized less revenue previously recognized on these contracts.
- *Unfunded Backlog.* Unfunded backlog represents the revenue value of orders (including optional orders) for services under existing contracts for which funding has not been appropriated or otherwise authorized.
- *Priced Options.* Priced contract options represent 100% of the revenue value of all future contract option periods under existing contracts that may be exercised at our clients' option and for which funding has not been appropriated or otherwise authorized.

Backlog does not include any task orders under IDIQ contracts except to the extent that task orders have been awarded to us under those contracts.

The following table summarizes the value of our contract backlog as of the respective dates presented:

	As of March 31,	
	2018	2017
	(In millions)	
Funded	\$ 2,685	\$ 2,815
Unfunded	4,161	3,098
Priced options	9,174	7,679
Total backlog	\$ 16,020	\$ 13,592

We may never realize all of the revenue that is included in our total backlog, and there is a higher degree of risk in this regard with respect to unfunded backlog and priced options. See "Item 7. Management's Discussion and Analysis of Financial

Condition and Results of Operations — Factors and Trends Affecting Our Results of Operations — Sources of Revenue—Contract Backlog” for additional disclosure regarding our backlog. See also “Item 1A. Risk Factors—Risks Related to Our Business—We may not realize the full value of our backlog, which may result in lower than expected revenue.”

## **Competition**

The government services market is highly fragmented and competition within the government professional services industry has intensified due to market pressure. In addition to professional service companies like ours that focus principally on the provision of services to the U.S. government, other companies active in our markets include large defense contractors; diversified consulting, technology, and outsourcing service providers; and small businesses.

Changing government policies and market dynamics are impacting the competitive landscape. In the past, the government's focus on organizational conflicts of interest have driven divestitures, which have changed the competitive landscape. More recently, there has been increasing pressure from government clients to utilize small businesses, due in large part to a push by both past and present administrations to bolster the economy by helping small business owners. Finally, due to the foregoing factors and the drive in our markets to quickly build competencies in growth areas and achieve economies of scale, we believe that consolidation activity among market participants will continue.

In the course of doing business, we compete and collaborate with companies of all types and sizes. We strive to maintain positive and productive relationships with these organizations. Some of them hire us as a subcontractor, and we hire some of them to work with us as our subcontractors. Our major competitors include: (1) contractors focused principally on the provision of services to the U.S. government, (2) large defense contractors that provide both products and services to the U.S. government, and (3) diversified service providers. We compete based on our technical expertise and client knowledge, our ability to successfully recruit appropriately skilled and experienced talent, our ability to deliver cost-effective multifaceted services in a timely manner, our reputation and relationship with our clients, our past performance, security clearances, and the size and scale of our company. In addition, to maintain our competitive position, we routinely review our operating structure, capabilities, and strategy to determine whether we are effectively meeting the needs of existing clients, effectively responding to developments in our markets, and successfully building a platform intended to provide the foundation for the future growth of our business.

## **Patents and Proprietary Information**

Our management and technology consulting services business utilizes a variety of proprietary rights in delivering products and services to our clients. We claim a proprietary interest in certain of our service offerings, products, software tools, methodologies, and know-how and also have certain licenses to third-party intellectual property that may be significant to our business. While we have several patents issued in the United States and patents pending both in the United States and in certain foreign countries, we do not consider our overall business to be materially dependent on the protection of such patents. In addition, we have a number of trade secrets that contribute to our success and competitive position, and we endeavor to protect this proprietary information. While protecting trade secrets and proprietary information is important, we are not materially dependent on any specific trade secret or group of trade secrets.

We rely on a combination of nondisclosure agreements and other contractual arrangements, as well as copyright, trademark, patent, and trade secret laws to protect our proprietary information. We also enter into proprietary information and intellectual property agreements with employees, which require them to disclose any inventions created during employment, to convey such rights to inventions to us, and to restrict any disclosure of proprietary information. We have a variety of proprietary marks registered in the United States and certain foreign countries, including "Booz Allen Hamilton." Generally, registered trademarks have perpetual life, provided that they are renewed on a timely basis and continue to be used properly as trademarks. We have registered trademarks related to our name and logo in the United States, with the earliest renewal in March 2020, while the earliest renewal for our trademarks outside of the United States is October 2019.

For our work under U.S. government funded contracts and subcontracts, the U.S. government obtains certain rights to data, software, and related information developed under such contracts or subcontracts. These rights generally allow the U.S. government to disclose such data, software, and related information to third parties, which may include our competitors in some instances. In the case of our work as a subcontractor, our prime contractor may also have certain rights to data, information, and products we develop under the subcontract.

Booz Allen Hamilton and other trademarks or service marks of Booz Allen Hamilton Inc. appearing in this Annual Report are the trademarks or registered trademarks of Booz Allen Hamilton Inc. Trade names, trademarks, and service marks of other companies appearing in this Annual Report are the property of their respective owners.

## Regulation

As a contractor to the U.S. government, as well as state and local governments, we are heavily regulated in most fields in which we operate. We deal with numerous U.S. government agencies and entities, and, when working with these and other entities, we must comply with and are affected by unique laws and regulations relating to the formation, administration, and performance of public government contracts. Some significant laws and regulations that affect us include:

- the Federal Acquisition Regulation (the "FAR"), and agency regulations supplemental to the FAR, which regulate the formation, administration, and performance of U.S. government contracts. For example, FAR 52.203-13 requires contractors to establish a Code of Business Ethics and Conduct, implement a comprehensive internal control system, and report to the government when the contractor has credible evidence that a principal, employee, agent, or subcontractor, in connection with a government contract, has violated certain federal criminal laws, violated the civil False Claims Act, or has received a significant overpayment;
- the False Claims Act, which imposes civil and criminal liability for violations, including substantial monetary penalties, for, among other things, presenting false or fraudulent claims for payments or approval;
- the False Statements Act, which imposes civil and criminal liability for making false statements to the U.S. government;
- the Truth in Negotiations Act, which requires certification and disclosure of cost and pricing data in connection with the negotiation of a contract, modification, or task order;
- the Procurement Integrity Act, which regulates access to competitor bid and proposal information and certain internal government procurement sensitive information, and our ability to provide compensation to certain former government procurement officials;
- laws and regulations restricting the ability of a contractor to provide gifts or gratuities to employees of the U.S. government;
- post-government employment laws and regulations, which restrict the ability of a contractor to recruit and hire current employees of the U.S. government and deploy former employees of the U.S. government;
- laws, regulations, and executive orders restricting the handling, use and dissemination of information classified for national security purposes or determined to be "controlled unclassified information" or "for official use only" and the export of certain products, services, and technical data, including requirements regarding any applicable licensing of our employees involved in such work;
- laws, regulations, and executive orders, including the Anti-Kickback Act, regulating the handling, use, and dissemination of personally identifiable information in the course of performing a U.S. government contract;
- international trade compliance laws, regulations and executive orders that prohibit business with certain sanctioned entities and require authorization for certain exports or imports in order to protect national security and global stability;
- laws, regulations, and executive orders governing organizational conflicts of interest that may restrict our ability to compete for certain U.S. government contracts because of the work that we currently perform for the U.S. government or may require that we take measures such as firewalling off certain employees or restricting their future work activities due to the current work that they perform under a U.S. government contract;
- laws, regulations and executive orders that impose requirements on us to ensure compliance with requirements and protect the government from risks related to our supply chain;
- laws, regulations and mandatory contract provisions providing protections to employees or subcontractors seeking to report alleged fraud, waste, and abuse related to a government contract;
- the Contractor Business Systems rule, which authorizes Department of Defense agencies to withhold a portion of our payments if we are determined to have a significant deficiency in our accounting, cost estimating, purchasing, earned value management, material management and accounting, and/or property management system; and
- the Cost Accounting Standards and Cost Principles, which impose accounting requirements that govern our right to reimbursement under certain cost-based U.S. government contracts and require consistency of accounting practices over time.

Given the magnitude of our revenue derived from contracts with the Department of Defense, the Defense Contract Audit Agency, or DCAA, is our cognizant government audit agency. The DCAA audits the adequacy of our internal control systems and policies including, among other areas, compensation. The Defense Contract Management Agency, or DCMA, our cognizant government contract management agency, may determine that a portion of our employee compensation is unallowable based on

the findings and recommendations in the DCAA's audits. In addition, the DCMA directly reviews the adequacy of certain other business systems, such as our purchasing system. See "Item 1A. Risk Factors — Risk Related to Our Industry — Our contracts, performance, and administrative processes and systems are subject to audits, reviews, investigations, and cost adjustments by the U.S. government, which could reduce our revenue, disrupt our business, or otherwise materially adversely affect our results of operations." We are also subject to audit by Inspectors General of other U.S. government agencies.

The U.S. government may revise its procurement practices or adopt new contract rules and regulations at any time. In order to help ensure compliance with these laws and regulations, all of our employees are required to attend ethics training at least annually, as well as other compliance training relevant to their position. Internationally, we are subject to special U.S. government laws and regulations (such as the Foreign Corrupt Practices Act), local government regulations and procurement policies and practices, including regulations relating to import-export control, investments, exchange controls, and repatriation of earnings, as well as varying currency, political, and economic risks.

U.S. government contracts are, by their terms, subject to termination by the U.S. government either for its convenience or default by the contractor. In addition, U.S. government contracts are conditioned upon the continuing availability of Congressional appropriations. Congress usually appropriates funds for a given program on a September 30 fiscal year basis, even though contract performance may take many years. As is common in the industry, our company is subject to business risks, including changes in governmental appropriations, national defense policies, service modernization plans, and availability of funds. Any of these factors could materially adversely affect our company's business with the U.S. government in the future.

The U.S. government has a broad range of actions that it can instigate in order to enforce its procurement law and policies. These include proposing a contractor, certain of its operations or individual employees for debarment or suspending or debarring a contractor, certain of its operations or individual employees from future government business. In addition to criminal, civil and administrative actions by the U.S. government, under the False Claims Act, an individual alleging fraud related to payments under a U.S. government contract or program may file a qui tam lawsuit on behalf of the government against us; if successful in obtaining a judgment or settlement, the individual filing the suit may receive up to 30% of the amount recovered by the government.

See "Item 1A. Risk Factors—Risks Related to Our Business—We are required to comply with numerous laws and regulations, some of which are highly complex, and our failure to comply could result in fines or civil or criminal penalties or suspension or debarment by the U.S. government that could result in our inability to continue to work on or receive U.S. government contracts, which could materially and adversely affect our results of operations."

#### **Available Information**

We file annual, quarterly, and current reports and other information with the Securities and Exchange Commission, or SEC. You may read and copy any documents that we file at the SEC's public reference room at 100 F Street, N.E., Washington, D.C. 20549. You may call the SEC at 1-800-SEC-0330 to obtain further information about the public reference room. In addition, the SEC maintains a website ([www.sec.gov](http://www.sec.gov)) that contains reports, proxy and information statements, and other information regarding registrants that file electronically with the SEC, including us. You may also access, free of charge, our reports filed with the SEC (for example, our Annual Report on Form 10-K, our Quarterly Reports on Form 10-Q, and our Current Reports on Form 8-K and any amendments to those forms) through the "Investors" portion of our website ([www.boozallen.com](http://www.boozallen.com)). Reports filed with or furnished to the SEC will be available as soon as reasonably practicable after they are filed with or furnished to the SEC. Our website is included in this Annual Report as an inactive textual reference only. The information found on our website is not part of this or any other report filed with or furnished to the SEC.

#### **Item 1A. Risk Factors**

*You should consider and read carefully all of the risks and uncertainties described below, as well as other information included in this Annual Report, including our consolidated financial statements and related notes. The risks described below are not the only ones facing us. The occurrence of any of the following risks or additional risks and uncertainties not presently known to us or that we currently believe to be immaterial could materially and adversely affect our business, financial condition, and results of operations. This Annual Report also contains forward-looking statements and estimates that involve risks and uncertainties. Our actual results could differ materially from those anticipated in the forward-looking statements as a result of specific factors, including the risks and uncertainties described below.*

#### **Risks Related to Our Business**

***We depend on contracts with U.S. government agencies for substantially all of our revenue. If our relationships with such agencies are harmed, our future revenue and operating profits would decline.***

The U.S. government is our primary client, with revenue from contracts and task orders, either as a prime or a subcontractor, with U.S. government agencies accounting for 97% of our revenue for fiscal 2018. Our belief is that the

successful future growth of our business will continue to depend primarily on our ability to be awarded work under U.S. government contracts, as we expect this will be the primary source of substantially all of our revenue in the foreseeable future. For this reason, any issue that compromises our relationship with the U.S. government generally or any U.S. government agency that we serve would cause our revenue to decline. Among the key factors in maintaining our relationship with U.S. government agencies are our performance on contracts and task orders, the strength of our professional reputation, compliance with applicable laws and regulations, and the strength of our relationships with client personnel. In addition, the mishandling or the perception of mishandling of sensitive information, such as our failure to maintain the confidentiality of the existence of our business relationships with certain of our clients, including as a result of misconduct or other improper activities by our employees or subcontractors, or a failure to maintain adequate protection against security breaches, including those resulting from cyber attacks, could harm our relationship with U.S. government agencies. See "—Our employees or subcontractors may engage in misconduct or other improper activities, which could harm our ability to conduct business with U.S. government." Our relationship with the U.S. government could also be damaged as a result of an agency's dissatisfaction with work performed by us, a subcontractor, or other third parties who provide services or products for a specific project for any reason, including due to perceived or actual deficiencies in the performance or quality of our work, and we may incur additional costs to address any such situation and the profitability of that work might be impaired. Further, negative publicity concerning government contractors in general or us in particular may harm our reputation with federal government contractors. To the extent our reputation or relationships with U.S. government agencies is impaired, our revenue and operating profits could materially decline.

***U.S. government spending and mission priorities could change in a manner that adversely affects our future revenue and limits our growth prospects.***

Our business depends upon continued U.S. government expenditures on defense, intelligence, and civil programs for which we provide support. These expenditures have not remained constant over time, have been reduced in certain periods and, recently, have been affected by the U.S. government's efforts to improve efficiency and reduce costs affecting federal government programs generally. Our business, prospects, financial condition, or operating results could be materially harmed, among other causes, by the following:

- budgetary constraints, including Congressionally mandated automatic spending cuts, affecting U.S. government spending generally, or specific agencies in particular, and changes in available funding;
- a shift in expenditures away from agencies or programs that we support;
- reduced U.S. government outsourcing of functions that we are currently contracted to provide, including as a result of increased insourcing by various U.S. government agencies due to changes in the definition of "inherently governmental" work, including proposals to limit contractor access to sensitive or classified information and work assignments;
- further efforts to improve efficiency and reduce costs affecting federal government programs;
- changes or delays in U.S. government programs that we support or related requirements;
- a continuation of recent efforts by the U.S. government to decrease spending for management support service contracts;
- U.S. government shutdowns due to, among other reasons, a failure by elected officials to fund the government (such as that which occurred during government fiscal year 2014 and, to a lesser extent, government fiscal year 2018) or weather-related closures in the Washington, D.C. area and other potential delays in the appropriations process;
- U.S. government agencies awarding contracts on a technically acceptable/lowest cost basis in order to reduce expenditures;
- delays in the payment of our invoices by government payment offices;
- an inability by the U.S. government to fund its operations as a result of a failure to increase the federal government's debt ceiling, a credit downgrade of U.S. government obligations or for any other reason; and
- changes in the political climate and general economic conditions, including a slowdown of the economy or unstable economic conditions and responses to conditions, such as emergency spending, that reduce funds available for other government priorities.

In addition, any disruption in the functioning of U.S. government agencies, including as a result of U.S. government closures and shutdowns, terrorism, war, natural disasters, destruction of U.S. government facilities, and other potential calamities could have a negative impact on our operations and cause us to lose revenue or incur additional costs due to, among other things, our inability to deploy our staff to client locations or facilities as a result of such disruptions.

The U.S. government budget deficits, the national debt, and the prevailing economic condition, and actions taken to address them, could continue to negatively affect the U.S. government expenditures on defense, intelligence, and civil programs for which we provide support. The Department of Defense is one of our significant clients and cost cutting, including through consolidation and elimination of duplicative organizations and insourcing, has become a major initiative for the Department of Defense. In particular, the Budget Control Act of 2011 (as subsequently amended) provides for automatic spending cuts (referred to as sequestration) totaling approximately \$1.2 trillion between 2013 and 2021, including an estimated \$500 billion in federal defense spending cuts over this time period. Most recently, the Bipartisan Budget Act of 2018 amended the discretionary spending limits established by the Budget Control Act of 2011, as amended, for the government fiscal 2018 and 2019 budgets across the federal government and increased the prior discretionary spending cap in both defense and non-defense. Pursuant to the Consolidated Appropriations Act, 2018, the new Department of Defense spending limit is approximately \$660 billion for government fiscal 2018, including an allocation of \$65 billion in overseas contingency operations funding. While recent budget actions reflect a more measured and strategic approach to addressing the U.S. government's fiscal challenges, there remains uncertainty as to how exactly budget cuts, including sequestration, will impact us, and we are therefore unable to predict the extent of the impact of such cuts on our business and results of operations. However, a reduction in the amount of or reductions, delays, or cancellations of funding for, services that we are contracted to provide to the Department of Defense as a result of any of these related initiatives, legislation or otherwise could have a material adverse effect on our business and results of operations. In addition, in response to an Office of Management and Budget mandate, government agencies have reduced management support services spending in recent years. If federal awards for management support services continue to decline, our revenue and operating profits may materially decline and further efforts by the Office of Management and Budget to decrease federal awards for management support services could have a material and adverse effect on our business and results of operations.

These or other factors could cause our defense, intelligence, or civil clients to decrease the number of new contracts awarded generally and fail to award us new contracts, reduce their purchases under our existing contracts, exercise their right to terminate our contracts, or not exercise options to renew our contracts, any of which could cause a material decline in our revenue.

***We are required to comply with numerous laws and regulations, some of which are highly complex, and our failure to comply could result in fines or civil or criminal penalties or suspension or debarment by the U.S. government that could result in our inability to continue to work on or receive U.S. government contracts, which could materially and adversely affect our results of operations.***

As a U.S. government contractor, we must comply with laws and regulations relating to the formation, administration, and performance of U.S. government contracts, which affect how we do business with our clients. Such laws and regulations may potentially impose added costs on our business and our failure to comply with them may lead to civil or criminal penalties, termination of our U.S. government contracts, and/or suspension or debarment from contracting with federal agencies. Some significant laws and regulations that affect us include:

- the FAR, and agency regulations supplemental to the FAR, which regulate the formation, administration, and performance of U.S. government contracts. For example, FAR 52.203-13 requires contractors to establish a Code of Business Ethics and Conduct, implement a comprehensive internal control system, and report to the government when the contractor has credible evidence that a principal, employee, agent, or subcontractor, in connection with a government contract, has violated certain federal criminal laws, violated the civil False Claims Act, or has received a significant overpayment;
- the False Claims Act, which imposes civil and criminal liability for violations, including substantial monetary penalties, for, among other things, presenting false or fraudulent claims for payments or approval;
- the False Statements Act, which imposes civil and criminal liability for making false statements to the U.S. government;
- the Truth in Negotiations Act, which requires certification and disclosure of cost and pricing data in connection with the negotiation of a contract, modification, or task order;
- the Procurement Integrity Act, which regulates access to competitor bid and proposal information and certain internal government procurement sensitive information, and our ability to provide compensation to certain former government procurement officials;
- laws and regulations restricting the ability of a contractor to provide gifts or gratuities to employees of the U.S. government;
- post-government employment laws and regulations, which restrict the ability of a contractor to recruit and hire current employees of the U.S. government and deploy former employees of the U.S. government;

- laws, regulations, and executive orders restricting the handling, use and dissemination of information classified for national security purposes or determined to be “controlled unclassified information” or “for official use only” and the export of certain products, services, and technical data, including requirements regarding any applicable licensing of our employees involved in such work;
- laws, regulations, and executive orders, including the Anti-Kickback Act, regulating the handling, use, and dissemination of personally identifiable information in the course of performing a U.S. government contract;
- international trade compliance laws, regulations and executive orders that prohibit business with certain sanctioned entities and require authorization for certain exports or imports in order to protect national security and global stability;
- laws, regulations, and executive orders governing organizational conflicts of interest that may restrict our ability to compete for certain U.S. government contracts because of the work that we currently perform for the U.S. government or may require that we take measures such as firewalling off certain employees or restricting their future work activities due to the current work that they perform under a U.S. government contract;
- laws, regulations and executive orders that impose requirements on us to ensure compliance with requirements and protect the government from risks related to our supply chain;
- laws, regulations and mandatory contract provisions providing protections to employees or subcontractors seeking to report alleged fraud, waste, and abuse related to a government contract;
- the Contractor Business Systems rule, which authorizes Department of Defense agencies to withhold a portion of our payments if we are determined to have a significant deficiency in our accounting, cost estimating, purchasing, earned value management, material management and accounting, and/or property management system; and
- the FAR Cost Accounting Standards and Cost Principles, which impose accounting requirements that govern our right to reimbursement under certain cost-based U.S. government contracts and require consistency of accounting practices over time.

In addition, the U.S. government adopts new laws, rules, and regulations from time to time that could have a material impact on our results of operations. Adverse developments in legal or regulatory proceedings on matters relating to, among other things, cost accounting practices and compliance, contract interpretations and statute of limitations, could also result in materially adverse judgments, settlements, withheld payments, penalties, or other unfavorable outcomes.

Our performance under our U.S. government contracts and our compliance with the terms of those contracts and applicable laws and regulations are subject to periodic audit, review, and investigation by various agencies of the U.S. government and the current environment has led to increased regulatory scrutiny and sanctions for non-compliance by such agencies generally. In addition, from time to time we report potential or actual violations of applicable laws and regulations to the relevant governmental authority. Any such report of a potential or actual violation of applicable laws or regulations could lead to an audit, review, or investigation by the relevant agencies of the U.S. government. If such an audit, review, or investigation uncovers a violation of a law or regulation, or improper or illegal activities relating to our U.S. government contracts, we may be subject to civil or criminal penalties or administrative sanctions, including the termination of contracts, forfeiture of profits, the triggering of price reduction clauses, withholding of payments, suspension of payments, fines and suspension, or debarment from contracting with U.S. government agencies. Such penalties and sanctions are not uncommon in the industry and there is inherent uncertainty as to the outcome of any particular audit, review, or investigation. If we incur a material penalty or administrative sanction or otherwise suffer harm to our reputation, our profitability, cash position, and future prospects could be materially and adversely affected.

Further, if the U.S. government were to initiate suspension or debarment proceedings against us or if we are indicted for or convicted of illegal activities relating to our U.S. government contracts following an audit, review, or investigation, we may lose our ability to be awarded contracts in the future or receive renewals of existing contracts for a period of time which could materially and adversely affect our results of operations or financial condition. We could also suffer harm to our reputation if allegations of impropriety were made against us, which would impair our ability to win awards of contracts in the future or receive renewals of existing contracts. See "Item 1. Business — Regulation."

***We derive a majority of our revenue from contracts awarded through a competitive bidding process, and our revenue and profitability may be adversely affected if we are unable to compete effectively in the process or if there are delays caused by our competitors protesting major contract awards received by us.***

We derive a majority of our revenue from U.S. government contracts awarded through competitive bidding processes. We do not expect this to change for the foreseeable future. Our failure to compete effectively in this procurement environment would have a material adverse effect on our revenue and profitability.

The competitive bidding process involves risk and significant costs to businesses operating in this environment, including:

- the necessity to expend resources, make financial commitments (such as procuring leased premises) and bid on engagements in advance of the completion of their design, which may result in unforeseen difficulties in execution, cost overruns and, in the case of an unsuccessful competition, the loss of committed costs;
- the substantial cost and managerial time and effort spent to prepare bids and proposals for contracts that may not be awarded to us;
- the ability to accurately estimate the resources and costs that will be required to service any contract we are awarded;
- the expense and delay that may arise if our competitors protest or challenge contract awards made to us pursuant to competitive bidding, and the risk that any such protest or challenge could result in the resubmission of bids on modified specifications, or in termination, reduction, or modification of the awarded contract; and
- any opportunity cost of not bidding and winning other contracts we might have otherwise pursued.

In circumstances where contracts are held by other companies and are scheduled to expire, we still may not be provided the opportunity to bid on those contracts if the U.S. government determines to extend the existing contract. If we are unable to win particular contracts that are awarded through the competitive bidding process, we may not be able to operate in the market for services that are provided under those contracts for the duration of those contracts to the extent that there is no additional demand for such services. An inability to consistently win new contract awards over any extended period would have a material adverse effect on our business and results of operations.

The current competitive environment has resulted in an increase in the number of bid protests from unsuccessful bidders on new program awards. It can take many months for the relevant U.S. government agency to resolve protests by one or more of our competitors of contract awards we receive. Bid protests may result in significant expense to us, contract modification or loss of an awarded contract as a result of the award being overturned. Even where we do not lose the awarded contract, the resulting delay in the startup and funding of the work under these contracts may cause our actual results to differ materially and adversely from those anticipated.

***A significant majority of our revenue is derived from task orders under indefinite delivery/indefinite quantity, or IDIQ, contract vehicles where we perform in either a prime or subcontract position.***

We believe that one of the key elements of our success is our position as the holder of 3,956 active task orders under IDIQ contract vehicles as of March 31, 2018. Our ability to maintain our existing business and win new business depends on our ability to maintain our prime and subcontractor positions on these contracts. The loss, without replacement, of certain of these contract vehicles could have a material adverse effect on our ability to win new business and our operating results. In addition, if the U.S. government elects to use a contract vehicle that we do not hold, we will not be able to compete for work under that contract vehicle as a prime contractor.

***We may earn less revenue than projected, or no revenue, under certain of our contracts.***

Many of our contracts with our clients are IDIQ contracts. IDIQ contracts provide for the issuance by the client of orders for services or products under the contract, and often contain multi-year terms and unfunded ceiling amounts, which allow but do not commit the U.S. government to purchase products and services from contractors. Our ability to generate revenue under each of these types of contracts depends upon our ability to be awarded task orders for specific services by the client. IDIQ contracts may be awarded to one contractor (single award) or several contractors (multiple award). Multiple contractors must compete under multiple award IDIQ contracts for task orders to provide particular services, and contractors earn revenue only to the extent that they successfully compete for these task orders. A failure to be awarded task orders under such contracts would have a material adverse effect on our results of operations and financial condition.

***Our earnings and profitability may vary based on the mix of our contracts and may be adversely affected by our failure to accurately estimate or otherwise recover the expenses, time, and resources for our contracts.***

We enter into three general types of U.S. government contracts for our services: cost-reimbursable, time-and-materials, and fixed-price. For fiscal 2018, we derived 51% of our revenue from cost-reimbursable contracts, 25% from time-and-materials contracts and 24% from fixed-price contracts.

Each of these types of contracts, to varying degrees, involves the risk that we could underestimate our cost of fulfilling the contract, which may reduce the profit we earn or lead to a financial loss on the contract and adversely affect our operating results.

Under cost-reimbursable contracts, we are reimbursed for allowable costs up to a ceiling and paid a fee, which may be fixed or performance-based. If our actual costs exceed the contract ceiling or are not allowable under the terms of the contract

or applicable regulations, we may not be able to recover those costs. In particular, there is increasing focus by the U.S. government on the extent to which government contractors, including us, are able to receive reimbursement for employee compensation, including the adoption of interim rules by federal agencies implementing a section of the Bipartisan Budget Act of 2013 that substantially decreased the level of allowable compensation cost for executive-level employees and further applied the newly reduced limitation to all employees. In addition, there is an increased risk of compensation being deemed unallowable or payments being withheld as a result of U.S. government audit, review or investigation.

Under time-and-materials contracts, we are reimbursed for labor at negotiated hourly billing rates and for certain allowable expenses. We assume financial risk on time-and-materials contracts because our costs of performance may exceed these negotiated hourly rates.

Under fixed-price contracts, we perform specific tasks for a predetermined price. Compared to time-and-materials and cost-reimbursable contracts, fixed-price contracts generally offer higher margin opportunities because we receive the benefits of any cost savings, but involve greater financial risk because we bear the impact of any cost overruns. The U.S. government has generally indicated that it intends to increase its use of fixed price contract procurements. Because we assume the risk for cost overruns and contingent losses on fixed-price contracts, an increase in the percentage of fixed-price contracts in our contract mix would increase our risk of suffering losses.

Additionally, our profits could be adversely affected if our costs under any of these contracts exceed the assumptions we used in bidding for the contract. For example, we may miscalculate the costs, resources, or time needed to complete projects or meet contractual milestones as a result of delays on a particular project, including delays in designs, engineering information, or materials provided by the customer or a third party, delays or difficulties in equipment and material delivery, schedule changes, and other factors, some of which are beyond our control. We have recorded provisions in our consolidated financial statements for losses on our contracts, as required under accounting principles generally accepted in the United States, or GAAP, but our contract loss provisions may not be adequate to cover all actual losses that we may incur in the future.

***Our professional reputation is critical to our business, and any harm to our reputation could decrease the amount of business the U.S. government does with us, which could have a material adverse effect on our future revenue and growth prospects.***

We depend on our contracts with U.S. government agencies for substantially all of our revenue and if our reputation or relationships with these agencies were harmed, our future revenue and growth prospects would be materially and adversely affected. Our reputation and relationship with the U.S. government is a key factor in maintaining and growing revenue under contracts with the U.S. government. Negative press reports regarding poor contract performance, employee misconduct, information security breaches, or other aspects of our business, or regarding government contractors generally, could harm our reputation. In addition, to the extent our performance under a contract does not meet a U.S. government agency's expectations, the client might seek to terminate the contract prior to its scheduled expiration date, provide a negative assessment of our performance to government-maintained contractor past-performance data repositories, fail to award us additional business under existing contracts or otherwise, and direct future business to our competitors. If our reputation with these agencies is negatively affected, or if we are suspended or debarred from contracting with government agencies for any reason, such actions would decrease the amount of business that the U.S. government does with us, which would have a material adverse effect on our future revenue and growth prospects.

***We use estimates in recognizing revenue and if we make changes to estimates used in recognizing revenue, our profitability may be adversely affected.***

Revenue from our fixed-price contracts is primarily recognized using the percentage-of-completion method with progress toward completion of a particular contract based on actual costs incurred relative to total estimated costs to be incurred over the life of the contract. Revenue from our cost-reimbursable-plus-award-fee contracts are based on our estimation of award fees over the life of the contract. Estimating costs at completion and award fees on our long-term contracts is complex and involves significant judgment. Adjustments to original estimates are often required as work progresses, experience is gained, and additional information becomes known, even though the scope of the work required under the contract may not change. Any adjustment as a result of a change in estimate is recognized as events become known.

In the event updated estimates indicate that we will experience a loss on the contract, we recognize the estimated loss at the time it is determined. Additional information may subsequently indicate that the loss is more or less than initially recognized, which requires further adjustments in our consolidated financial statements. Changes in the underlying assumptions, circumstances, or estimates could result in adjustments that could have a material adverse effect on our future results of operations.

***We may not realize the full value of our backlog, which may result in lower than expected revenue.***

As of March 31, 2018, our total backlog was \$16.0 billion, of which \$2.7 billion was funded. We define backlog to include the following three components:

- *Funded Backlog.* Funded backlog represents the revenue value of orders for services under existing contracts for which funding is appropriated or otherwise authorized, less revenue previously recognized on these contracts.
- *Unfunded Backlog.* Unfunded backlog represents the revenue value of orders (including optional orders) for services under existing contracts for which funding has not been appropriated or otherwise authorized.
- *Priced Options.* Priced contract options represent 100% of the revenue value of all future contract option periods under existing contracts that may be exercised at our clients' option and for which funding has not been appropriated or otherwise authorized.

Backlog does not include any task orders under IDIQ contracts, except to the extent that task orders have been awarded to us under those contracts.

We historically have not realized all of the revenue included in our total backlog, and we may not realize all of the revenue included in our total backlog in the future. There is a somewhat higher degree of risk in this regard with respect to unfunded backlog and priced options. In addition, there can be no assurance that our backlog will result in actual revenue in any particular period. This is because the actual receipt, timing, and amount of revenue under contracts included in backlog are subject to various contingencies, including congressional appropriations, many of which are beyond our control. In particular, delays in the completion of the U.S. government's budgeting process and the use of continuing resolutions could adversely affect our ability to timely recognize revenue under our contracts included in backlog. Furthermore, the actual receipt of revenue from contracts included in backlog may never occur or may be delayed because: a program schedule could change or the program could be canceled; a contract's funding or scope could be reduced, modified, delayed, or terminated early, including as a result of a lack of appropriated funds or as a result of cost cutting initiatives and other efforts to reduce U.S. government spending and/or the automatic federal defense spending cuts required by sequestration; in the case of funded backlog, the period of performance for the contract has expired; in the case of unfunded backlog, funding may not be available; or, in the case of priced options, our clients may not exercise their options. In addition, consulting staff headcount growth is the primary means by which we are able to recognize revenue growth. Any inability to hire additional appropriately qualified personnel or failure to timely and effectively deploy such additional personnel against funded backlog could negatively affect our ability to grow our revenue. We may also not recognize revenue on funded backlog due to, among other reasons, the tardy submissions of invoices by our subcontractors and the expiration of the relevant appropriated funding in accordance with a predetermined expiration date such as the end of the U.S. government's fiscal year. The amount of our funded backlog is also subject to change, due to, among other factors: changes in congressional appropriations that reflect changes in U.S. government policies or priorities resulting from various military, political, economic or international developments; changes in the use of U.S. government contracting vehicles, and the provisions therein used to procure our services; and adjustments to the scope of services under, or cancellation of contracts, by the U.S. government at any time. Furthermore, even if our backlog results in revenue, the contracts may not be profitable.

***We may fail to attract, train and retain skilled and qualified employees, which may impair our ability to generate revenue, effectively serve our clients, and execute our growth strategy.***

Our business depends in large part upon our ability to attract and retain sufficient numbers of highly qualified individuals who may have advanced degrees in areas such as information technology as well as appropriate security clearances. We compete for such qualified personnel with other U.S. government contractors, the U.S. government, and private industry, and such competition is intense. Personnel with the requisite skills, qualifications, or security clearance may be in short supply or generally unavailable. In addition, our ability to recruit, hire, and internally deploy former employees of the U.S. government is subject to complex laws and regulations, which may serve as an impediment to our ability to attract such former employees, and failure to comply with these laws and regulations may expose us and our employees to civil or criminal penalties. If we are unable to recruit and retain a sufficient number of qualified employees, or fail to deploy such employees or obtain their appropriate security clearances in a timely manner, our ability to maintain and grow our business and to effectively serve our clients could be limited and our future revenue and results of operations could be materially and adversely affected. Furthermore, to the extent that we are unable to make necessary permanent hires to appropriately serve our clients, we could be required to engage larger numbers of contracted personnel, which could reduce our profit margins.

If we are able to attract sufficient numbers of qualified new hires, training and retention costs may place significant demands on our resources. In addition, to the extent that we experience attrition in our employee ranks, we may realize only a limited or no return on such invested resources, and we would have to expend additional resources to hire and train replacement employees. The loss of services of key personnel could also impair our ability to perform required services under some of our contracts and to retain such contracts, as well as our ability to win new business.

***We may fail to obtain and maintain necessary security clearances which may adversely affect our ability to perform on certain contracts.***

Many U.S. government programs require contractor employees and facilities to have security clearances. Depending on the level of required clearance, security clearances can be difficult and time-consuming to obtain. If we or our employees are unable to obtain or retain necessary security clearances, we may not be able to win new business, and our existing clients could terminate their contracts with us or decide not to renew them. To the extent we are not able to obtain and maintain facility security clearances or engage employees with the required security clearances for a particular contract, we may not be able to bid on or win new contracts, or effectively rebid on expiring contracts, as well as lose existing contracts, which may adversely affect our operating results and inhibit the execution of our growth strategy.

***Our profitability could suffer if we are not able to timely and effectively utilize our employees or manage our cost structure.***

The cost of providing our services, including the degree to which our employees are utilized, affects our profitability. The degree to which we are able to utilize our employees in a timely manner or at all is affected by a number of factors, including:

- our ability to transition employees from completed projects to new assignments and to hire, assimilate, and deploy new employees;
- our ability to forecast demand for our services and to maintain and deploy headcount that is aligned with demand, including employees with the right mix of skills and experience to support our projects;
- our employees' inability to obtain or retain necessary security clearances;
- our ability to manage attrition; and
- our need to devote time and resources to training, business development, and other non-chargeable activities.

If our employees are under-utilized, our profit margin and profitability could suffer. Additionally, if our employees are over-utilized, it could have a material adverse effect on employee engagement and attrition, which would in turn have a material adverse impact on our business.

Our profitability is also affected by the extent to which we are able to effectively manage our overall cost structure for operating expenses, such as wages and benefits, overhead and capital and other investment-related expenditures. If we are unable to effectively manage our costs and expense and achieve efficiencies, our competitiveness and profitability may be adversely affected.

***We may lose one or more members of our senior management team or fail to develop new leaders, which could cause the disruption of the management of our business.***

We believe that the future success of our business and our ability to operate profitably depends on the continued contributions of the members of our senior management and the continued development of new members of senior management. We rely on our senior management to generate business and execute programs successfully. In addition, the relationships and reputation that many members of our senior management team have established and maintain with our clients are important to our business and our ability to identify new business opportunities. We have employment agreements with only our four most senior executives. The loss of any member of our senior management or our failure to continue to develop new members could impair our ability to identify and secure new contracts, to maintain good client relations, and to otherwise manage our business.

***Our employees or subcontractors may engage in misconduct or other improper activities, which could harm our ability to conduct business with the U.S. government.***

We are exposed to the risk that employee or subcontractor fraud or other misconduct could occur. Misconduct by employees or subcontractors could include intentional or unintentional failures to comply with U.S. government procurement regulations, engaging in other unauthorized activities, or falsifying time records. Employee or subcontractor misconduct could also involve the improper use of our clients' sensitive or classified information, or the inadvertent or intentional disclosure of our or our clients' sensitive information in violation of our contractual, statutory, or regulatory obligations. It is not always possible to deter employee or subcontractor misconduct, and the precautions we take to prevent and detect this activity may not be effective in controlling unknown or unmanaged risks or losses, which could materially harm our business. As a result of such misconduct, our employees could lose their security clearance and we could face fines and civil or criminal penalties, loss of facility clearance accreditation, and suspension, proposed debarment or debarment from bidding for or performing under contracts with the U.S. government, as well as reputational harm, which would materially and adversely affect our results of operations and financial condition.

***We face intense competition from many competitors, which could cause us to lose business, lower prices and suffer employee departures.***

Our business operates in a highly competitive industry, and we generally compete with a wide variety of U.S. government contractors, including large defense contractors, diversified service providers, and small businesses. We also face competition from entrants into our markets including companies divested by large prime contractors in response to increasing scrutiny of organizational conflicts of interest issues. There is also a significant industry trend towards consolidation, which may result in the emergence of companies that are better able to compete against us. Some of these companies possess greater financial resources and larger technical staffs, and others have smaller and more specialized staffs. These competitors could, among other things:

- divert sales from us by winning very large-scale government contracts, a risk that is enhanced by the recent trend in government procurement practices to bundle services into larger contracts;
- force us to charge lower prices in order to win or maintain contracts;
- seek to hire our employees; or
- adversely affect our relationships with current clients, including our ability to continue to win competitively awarded engagements where we are the incumbent.

If we lose business to our competitors or are forced to lower our prices or suffer employee departures, our revenue and our operating profits could decline. In addition, we may face competition from our subcontractors who, from time to time, seek to obtain prime contractor status on contracts for which they currently serve as a subcontractor to us. If one or more of our current subcontractors are awarded prime contractor status on such contracts in the future, it could divert sales from us and could force us to charge lower prices, which could have a material adverse effect on our revenue and profitability.

***Our failure to maintain strong relationships with other contractors, or the failure of contractors with which we have entered into a sub- or prime contractor relationship to meet their obligations to us or our clients, could have a material adverse effect on our business and results of operations.***

Maintaining strong relationships with other U.S. government contractors, who may also be our competitors, is important to our business and our failure to do so could have a material adverse effect on our business, prospects, financial condition, and operating results. To the extent that we fail to maintain good relations with our subcontractors or other prime contractors due to either perceived or actual performance failures or other conduct, they may refuse to hire us as a subcontractor in the future or to work with us as our subcontractor. In addition, other contractors may choose not to use us as a subcontractor or choose not to perform work for us as a subcontractor for any number of additional reasons, including because they choose to establish relationships with our competitors or because they choose to directly offer services that compete with our business.

As a prime contractor, we often rely on other companies to perform some of the work under a contract, and we expect to continue to depend on relationships with other contractors for portions of our delivery of services and revenue in the foreseeable future. If our subcontractors fail to perform their contractual obligations, our operating results and future growth prospects could be impaired. There is a risk that we may have disputes with our subcontractors arising from, among other things, the quality and timeliness of work performed by the subcontractor, client concerns about the subcontractor, our failure to extend existing task orders or issue new task orders under a subcontract, or our hiring of a subcontractor's personnel. In addition, if any of our subcontractors fail to deliver the agreed-upon supplies or perform the agreed-upon services on a timely basis, our ability to fulfill our obligations as a prime contractor may be jeopardized. Material losses could arise in future periods and subcontractor performance deficiencies could result in a client terminating a contract for default. A termination for default could expose us to liability and have an adverse effect on our ability to compete for future contracts and orders.

We estimate that revenue derived from contracts under which we acted as a subcontractor to other companies represented 9% of our revenue for fiscal 2018. As a subcontractor, we often lack control over fulfillment of a contract, and poor performance on the contract could tarnish our reputation, even when we perform as required, and could cause other contractors to choose not to hire us as a subcontractor in the future. If the U.S. government terminates or reduces other prime contractors' programs or does not award them new contracts, subcontracting opportunities available to us could decrease, which would have a material adverse effect on our financial condition and results of operations. In addition, as a subcontractor, we may be unable to collect payments owed to us by the prime contractor, even if we have performed our obligations under the contract, as a result of, among other things, the prime contractor's inability to fulfill the contract. Due to certain common provisions in subcontracts in certain countries, we could also experience delays in receiving payment if the prime contractor experiences payment delays, which could have an adverse effect on our financial condition and results of operations.

***Adverse judgments or settlements in legal disputes could result in materially adverse monetary damages or injunctive relief and damage our reputation.***

We are subject to, and may become a party to, a variety of litigation or other claims and suits that arise from time to time in the ordinary course of our business. For example, our performance under U.S. government contracts and compliance with the terms of those contracts and applicable laws and regulations are subject to continuous audit, review, and investigation by the U.S. government which may include such investigative techniques as subpoenas or civil investigative demands. As more fully described under "Item 3. Legal Proceedings", the U.S. Department of Justice (the "DOJ") is conducting a civil and criminal investigation of the Company, and the Company has also been in contact with other regulatory agencies and bodies, including the Securities and Exchange Commission, which notified the Company that it is conducting an investigation that the Company believes relates to matters that are also the subject of the DOJ's investigation. The Company may receive additional regulatory or governmental inquiries related to the matters that are the subject of the DOJ's investigation. In accordance with the Company's practice, the Company is cooperating with all relevant government parties. The total cost associated with these matters will depend on many factors, including the duration of these matters and any related finding. Given the nature of our business, these audits, reviews, and investigations may focus, among other areas, on various aspects of procurement integrity, labor time reporting, sensitive and/or classified information access and control, executive compensation, and post government employment restrictions. In addition, from time to time, we are also involved in legal proceedings and investigations arising in the ordinary course of business, including those relating to employment matters, relationships with clients and contractors, intellectual property disputes, and other business matters. Any such claims or investigations may be time-consuming, costly, divert management resources, or otherwise have a material adverse effect on our result of operations.

Additionally, over time, we have had disputes with current and former employees involving alleged violations of civil rights, wage and hour, and worker's compensation laws. Further, as more fully described under "Item 3. Legal Proceedings," six former officers and stockholders who had departed the company prior to the Carlyle Acquisition have filed a total of nine suits in various jurisdictions against us and certain of our current and former directors and officers. Each of the suits arises out of the acquisition and alleges that the former stockholders are entitled to certain payments that they would have received if they had held their stock at the time of the Carlyle Acquisition. Three of these suits have been dismissed with all appeals exhausted. Two suits were settled on April 16, 2015. One of the remaining suits had its Petition for Writ of Certiorari to the United States Supreme Court denied and the other three were consolidated and ultimately dismissed. The United States Court of Appeals for the Second Circuit affirmed dismissal of the suit on July 13, 2017, except for one plaintiff's securities fraud claim, which was remanded to give the plaintiff leave to file another amended complaint. On April 6, 2018, the plaintiff filed an amended complaint, alleging that the Company and certain former officers and directors violated Sections 10(b), 20(a) and 14(e) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). On April 25, 2018, the court entered an order postponing the deadline within which the defendants must answer or move to dismiss the amended complaint.

The results of litigation and other legal proceedings, including the other claims described under "Item 3. Legal Proceedings," are inherently uncertain and adverse judgments or settlements in some or all of these legal disputes may result in materially adverse monetary damages or injunctive relief against us. Any claims or litigation, even if fully indemnified or insured, could damage our reputation and make it more difficult to compete effectively or obtain adequate insurance in the future. The litigation and other legal proceedings described under "Item 3. Legal Proceedings" are subject to future developments and management's view of these matters may change in the future.

***We face certain significant risk exposures and potential liabilities that may not be adequately covered by indemnity or insurance.***

A significant portion of our business relates to designing, developing, and manufacturing advanced defense and technology systems and products, including cybersecurity products and services. New technologies may be untested or unproven. We maintain insurance policies that mitigate against risk and potential liabilities related to our operations. This insurance is maintained in amounts that we believe are reasonable. However, our insurance coverage may not be adequate to cover those claims or liabilities, and we may be forced to bear significant costs from an accident or incident. The amount of the insurance coverage we maintain or indemnification to which we may be contractually or otherwise entitled may not be adequate to cover all claims or liabilities. Accordingly, we may be forced to bear substantial costs resulting from risks and uncertainties of our business which would negatively impact our results of operations, financial condition or liquidity.

***Systems that we develop, integrate, maintain, or otherwise support could experience security breaches which may damage our reputation with our clients and hinder future contract win rates.***

We develop, integrate, maintain, or otherwise support systems and provide services that include managing and protecting information involved in intelligence, national security, and other sensitive or classified government functions. Our systems also store and process sensitive information for commercial clients. The cyber and security threats that our clients face have grown more frequent and sophisticated. A security breach in one of these systems could cause serious harm to our business, damage our reputation, and prevent us from being eligible for further work on sensitive systems for U.S. government or commercial

clients. Work for non-U.S. government and commercial clients involving the protection of information systems or that store clients' information could also be harmed due to associated security breaches. Damage to our reputation or limitations on our eligibility for additional work or any liability resulting from a security breach in one of the systems we develop, install, maintain, or otherwise support could have a material adverse effect on our results of operations.

***Certain services we provide and technologies we develop are designed to detect and monitor threats to our clients and may require our staff to travel to locations where their physical safety may be at risk.***

We help our clients detect, monitor and mitigate threats to their people, information and facilities. These threats may originate from nation states, terrorist or criminal actors, activist hackers or others who seek to harm our clients. Successful attacks on our clients may cause reputational harm to us and our clients, as well as liability to our clients or third parties. In addition, if we are associated with our clients in this regard, our staff, information and facilities may be targeted by a similar group of threat actors and may be at risk for loss, or physical or reputational harm.

***Internal system or service failures, or those of our vendors, including as a result of cyber or other security threats, could disrupt our business and impair our ability to effectively provide our services to our clients, which could damage our reputation and have a material adverse effect on our business and results of operations.***

We create, implement, and maintain information technology and engineering systems and also use vendors to provide services that are often critical to our clients' operations, some of which involve sensitive information and may be conducted in war zones or other hazardous environments, or include information whose confidentiality is protected by law. As a result, we are subject to systems or service failures, not only resulting from our own failures or the failures of third-party service providers, natural disasters, power shortages, or terrorist attacks, but also from continuous exposure to cyber and other security threats, including computer viruses and malware, attacks by computer hackers or physical break-ins. There has been an increase in the frequency and sophistication of the cyber and security threats we face, with attacks ranging from those common to businesses generally to those that are more advanced and persistent, which may target us because, as a cybersecurity services contractor, we hold classified, controlled unclassified and other sensitive information. As a result, we and our vendors face a heightened risk of a security breach or disruption resulting from an attack by computer hackers, foreign governments, and cyber terrorists. While we put in place policies, controls, and technologies to help detect and protect against such attacks, we cannot guarantee that future incidents will not occur, and if an incident does occur, we may not be able to successfully mitigate the impact. We have been the target of these types of attacks in the past and future attacks are likely to occur. If successful, these types of attacks on our network or other systems or service failures could have a material adverse effect on our business and results of operations, due to, among other things, the loss of client or proprietary data, interruptions or delays in our clients' businesses, and damage to our reputation. In addition, the failure or disruption of our systems, communications, vendors, or utilities could cause us to interrupt or suspend our operations, which could have a material adverse effect on our business and results of operations. In addition, if our employees inadvertently do not adhere to appropriate information security protocols, our protocols are inadequate, or our employees intentionally avoid these protocols, our or our clients' sensitive information may be released thereby causing significant negative impacts to our reputation and exposing us or our clients to liability.

If our or our vendors' systems, services, or other applications have significant defects or errors, are successfully attacked by cyber and other security threats, suffer delivery delays, or otherwise fail to meet our clients' expectations, we may:

- lose revenue due to adverse client reaction;
- be required to provide additional services to a client at no charge;
- incur additional costs related to remediation, monitoring and increasing our cybersecurity;
- lose revenue due to the deployment of internal staff for remediation efforts instead of client assignments;
- receive negative publicity, which could damage our reputation and adversely affect our ability to attract or retain clients;
- be unable to successfully market services that are reliant on the creation and maintaining of secure information technology systems to U.S. government, international, and commercial clients;
- suffer claims by clients or impacted third parties for substantial damages, particularly as a result of any successful network or systems breach and exfiltration of client and/or third party information; or
- incur significant costs, including fines from government regulators related to complying with applicable federal or state law, including laws pertaining to the security and protection of personal information.

In addition to any costs resulting from contract performance or required corrective action, these failures may result in increased costs or loss of revenue if they result in clients postponing subsequently scheduled work or canceling or failing to renew contracts.

The costs related to cyber or other security threats or disruptions may not be fully insured or indemnified by other means. Additionally, some cyber technologies and techniques that we utilize or develop may raise potential liabilities related to legal compliance intellectual property and civil liberties, including privacy concerns, which may not be fully insured or indemnified. We may not be able to obtain and maintain insurance coverage on reasonable terms or in sufficient amounts to cover one or more large claims, or the insurer may disclaim coverage as to some types of future claims. The successful assertion of any large claim against us could seriously harm our business. Even if not successful, these claims could result in significant legal and other costs, may be a distraction to our management, and may harm our client relationships. In certain new business areas, we may not be able to obtain sufficient insurance and may decide not to accept or solicit business in these areas.

As a contractor supporting defense and national security clients, we are also subject to regulatory compliance requirements under the Defense Federal Acquisition Regulation Supplement and other federal regulations requiring that our networks and IT systems comply with the security and privacy controls in National Institute of Standards and Technology Special Publications. To the extent that we do not comply with the applicable security and control requirements, unauthorized access or disclosure of sensitive information could potentially result in a contract termination that has a material adverse effect on our business and financial results and reputational harm.

***Failure to adequately protect, maintain, or enforce our rights in our intellectual property may adversely limit our competitive position.***

We rely upon a combination of nondisclosure agreements and other contractual arrangements, as well as copyright, trademark, patent, and trade secret laws to protect our proprietary information. We also enter into proprietary information and intellectual property agreements with employees, which require them to disclose any inventions created during employment, to convey such rights to inventions to us, and to restrict any disclosure of proprietary information. Trade secrets are generally difficult to protect. Although our employees are subject to confidentiality obligations, this protection may be inadequate to deter or prevent misappropriation of our confidential information and/or the infringement of our patents and copyrights. Further, we may be unable to detect unauthorized use of our intellectual property or otherwise take appropriate steps to enforce our rights. Failure to adequately protect, maintain, or enforce our intellectual property rights may adversely limit our competitive position.

***Assertions by third parties of infringement, misappropriation or other violations by us of their intellectual property rights could result in significant costs and substantially harm our business and operating results.***

In recent years, there has been significant litigation involving intellectual property rights in technology industries. We may face from time to time, allegations that we or a supplier or customer have violated the rights of third parties, including patent, trademark, and other intellectual property rights. If, with respect to any claim against us for violation of third-party intellectual property rights, we are unable to prevail in the litigation or retain or obtain sufficient rights or develop non-infringing intellectual property or otherwise alter our business practices on a timely or cost-efficient basis, our business and competitive position may be adversely affected.

Any infringement, misappropriation or related claims, whether or not meritorious, are time consuming, divert technical and management personnel, and are costly to resolve. As a result of any such dispute, we may have to develop non-infringing technology, pay damages, enter into royalty or licensing agreements, cease utilizing certain products or services, or take other actions to resolve the claims. These actions, if required, may be costly or unavailable on terms acceptable to us.

***Our focus on new growth areas for our business entails risks, including those associated with new relationships, clients, talent needs, capabilities, service offerings, and maintaining our collaborative culture and core values.***

We are focused on growing our presence in our addressable markets by: expanding our relationships with existing clients, developing new clients by leveraging our core competencies, further developing our existing capabilities and service offerings, creating new capabilities and service offerings to address our clients' emerging needs, and undertaking business development efforts focused on identifying near-term developments and long-term trends that may pose significant challenges for our clients. These efforts entail inherent risks associated with innovation and competition from other participants in those areas, potential failure to help our clients respond to the challenges they face, our ability to comply with uncertain evolving legal standards applicable to certain of our service offerings, including those in the cybersecurity area, and, with respect to potential international growth, risks associated with operating in foreign jurisdictions, such as compliance with applicable foreign and U.S. laws and regulations that may impose different and, occasionally, conflicting or contradictory requirements, and the economic, legal, and political conditions in the foreign jurisdictions in which we operate. As we attempt to develop new relationships, clients, capabilities, and service offerings, these efforts could harm our results of operations due to, among other things, a diversion of our focus and resources and actual costs, opportunity costs of pursuing these opportunities in lieu of others and a failure to reach a profitable return on our investments in new technologies, capabilities, and businesses, including expenses on research and development investments, and these efforts could ultimately be unsuccessful. Additionally, the possibility exists that our competitors might develop new capabilities or service offerings that might cause our existing capabilities and service offerings to become obsolete. If we fail in our new capabilities development efforts or our capabilities or services fail to achieve market acceptance more rapidly than our competitors, our ability to procure new contracts could be negatively impacted, which would negatively impact our results of operations and financial condition.

In addition, our ability to grow our business by leveraging our operating model to efficiently and effectively deploy our people across our client base is largely dependent on our ability to maintain our collaborative culture. To the extent that we are unable to maintain our culture for any reason, including our effort to focus on new growth areas or acquire new businesses with different corporate cultures, we may be unable to grow our business. Any such failure could have a material adverse effect on our business and results of operations.

In addition, with the growth of our U.S. and international operations, we are now providing client services and undertaking business development efforts in numerous and disparate geographic locations both domestically and internationally. Our ability to effectively serve our clients is dependent upon our ability to successfully leverage our operating model across all of these and any future locations, maintain effective management controls over all of our locations to ensure, among other things, compliance with applicable laws, rules and regulations, and instill our core values in all of our personnel at each of these and any future locations. Any inability to ensure any of the foregoing could have a material adverse effect on our business and results of operations.

***We are subject to risks associated with operating internationally.***

Our business operations are subject to a variety of risks associated with conducting business internationally, including:

- Changes in or interpretations of laws or policies that may adversely affect the performance of our services;
- Political instability in foreign countries;
- Imposition of inconsistent or contradictory laws or regulations;
- Reliance on the U.S. or other governments to authorize us to export products, technology, and services to clients and other business partners;
- Conducting business in places where laws, business practices, and customs are unfamiliar or unknown; and
- Imposition of limitations on or increase of withholding and other taxes on payments by foreign subsidiaries or joint ventures.

In addition, we are subject to the U.S. Foreign Corrupt Practices Act, or the FCPA, and other laws that prohibit improper payments or offers of payments to foreign governments and their officials and political parties by business entities for the purpose of obtaining or retaining business. We have operations and deal with governmental clients in countries known to experience corruption, including certain emerging countries in the Middle East and Southeast Asia. Our activities in these countries create the risk of unauthorized payments or offers of payments by one of our employees, consultants or contractors that could be in violation of various laws including the FCPA and other anti-corruption laws, even though these parties are not always subject to our control. Our international operations also involve activities involving the transmittal of information, which may include personal data, that may expose us to data privacy laws in the jurisdictions in which we operate. If our data protection practices become subject to new or different restrictions, and to the extent such practices are not compliant with the laws of the countries in which we process data, we could face increased compliance expenses and face penalties for violating such laws or be excluded from those markets altogether, in which case our operations could be adversely affected. We are also

subject to import-export control regulations restricting the use and dissemination of information classified for national security purposes and the export of certain products, services, and technical data, including requirements regarding any applicable licensing of our employees involved in such work.

If we were to fail to comply with the FCPA, other anti-corruption laws, applicable import-export control regulations, data privacy laws, or other applicable rules and regulations, we could be subject to substantial civil and criminal penalties, including fines for our company and incarceration for responsible employees and managers, suspension or debarment, and the possible loss of export or import privileges which could have a material adverse effect on our business and results of operations.

***Changes to our operating structure, capabilities or strategy intended to address our clients' needs, respond to developments in our markets and grow our business may not be successful.***

We routinely review our operating structure, capabilities and strategy to determine whether we are effectively meeting the needs of existing clients, effectively responding to developments in our markets and successfully building platforms intended to provide the foundation for the future growth of our business. The outcome of any such review is difficult to predict and the extent of changes to our business following such a review, if any, are dependent in part upon the nature and extent of the review.

The implementation of changes to our operating structure, capabilities, strategy or any other aspect of our business following an internal review, may materially alter various aspects of our business or our business model as an entirety and there can be no assurance that any such changes will be successful or that they will not ultimately have a negative effect on our business and results of operations.

***Many of our contracts with the U.S. government are classified or subject to other security restrictions, which may limit investor insight into portions of our business.***

We derive a substantial portion of our revenue from contracts with the U.S. government that are classified or subject to security restrictions that preclude the dissemination of certain information. In addition, a significant number of our employees have security clearances which preclude them from providing information regarding certain of our clients and services provided to such clients to other of our employees without security clearances and investors. Because we are limited in our ability to provide information about these contracts and services, the various risks associated with these contracts or services or any dispute or claims relating to such contracts or services, you may not have important information concerning our business, which will limit your insight into a substantial portion of our business and therefore may be less able to fully evaluate the risks related to that portion of our business.

***If we cannot collect our receivables or if payment is delayed, our business may be adversely affected by our inability to generate cash flow, provide working capital, or continue our business operations.***

We depend on the timely collection of our receivables to generate cash flow, provide working capital, and continue our business operations. If the U.S. government or any prime contractor for whom we are a subcontractor fails to pay or delays the payment of invoices for any reason, our business and financial condition may be materially and adversely affected. The U.S. government may delay or fail to pay invoices for a number of reasons, including lack of appropriated funds, lack of an approved budget, or as a result of audit findings by government regulatory agencies. Some prime contractors for whom we are a subcontractor have significantly fewer financial resources than we do, which may increase the risk that we may not be paid in full or that payment may be delayed.

***Recent efforts by the U.S. government to revise its organizational conflict of interest rules could limit our ability to successfully compete for new contracts or task orders, which would adversely affect our results of operations.***

Recent efforts by the U.S. government to reform its procurement practices have focused, among other areas, on the separation of certain types of work to facilitate objectivity and avoid or mitigate organizational conflicts of interest and the strengthening of regulations governing organizational conflicts of interest. Organizational conflicts of interest may arise from circumstances in which a contractor has:

- impaired objectivity during performance;
- unfair access to non-public information; or
- the ability to set the "ground rules" for another procurement for which the contractor competes.

A focus on organizational conflicts of interest issues has resulted in legislation and a proposed regulation aimed at increasing organizational conflicts of interest requirements, including, among other things, separating sellers of products and providers of advisory services in major defense acquisition programs. In addition, the U.S. government is working to adopt a FAR rule to address organizational conflicts of interest issues that will apply to all government contractors, including us, in Department of Defense and other procurements. A future FAR rule may also increase the restrictions in current organizational conflicts of interest regulations and rules. To the extent that proposed and future organizational conflicts of interest laws,

regulations, and rules, limit our ability to successfully compete for new contracts or task orders with the U.S. government, either because of organizational conflicts of interest issues arising from our business, or because companies with which we are affiliated, or with which we otherwise conduct business, create organizational conflicts of interest issues for us, our results of operations could be materially and adversely affected.

***We may consummate acquisitions, investments, joint ventures and divestitures, which involve numerous risks and uncertainties.***

As part of our operating strategy, we selectively pursue acquisitions, investments, partnerships and joint ventures. For example, in January 2017, we acquired eGov Holdings, Inc. (d/b/a Aquilent) and in October 2017, we acquired Morphick, Inc. These transactions pose many risks, including:

- we may not be able to identify suitable acquisition and investment candidates at prices we consider attractive;
- we may not be able to compete successfully for identified acquisition and investment candidates, complete acquisitions and investments, or accurately estimate the financial effect of acquisitions and investments on our business;
- future acquisitions and investments may require us to issue common stock or spend significant cash, resulting in dilution of ownership or additional debt leverage;
- we may have difficulty retaining an acquired company's key employees or clients;
- we may have difficulty integrating acquired businesses and investments, resulting in unforeseen difficulties, such as incompatible accounting, information management, or other control systems, and greater expenses than expected;
- acquisitions and investments may disrupt our business or distract our management from other responsibilities;
- as a result of an acquisition or investment, we may incur additional debt and we may need to record write-downs from future impairments of intangible assets, each of which could reduce our future reported earnings; we may have difficulty integrating personnel from the acquired company with our people and our core values; and
- we may not be able to effectively influence the operations of our joint ventures or partnerships, or we may be exposed to certain liabilities if our partners do not fulfill their obligations.

In connection with any acquisition or investment that we make, there may be liabilities that we fail to discover or that we inadequately assess, and we may fail to discover any failure of a target company to have fulfilled its contractual obligations to the U.S. government or other clients. Acquired entities and investments may not operate profitably or result in improved operating performance. Additionally, we may not realize anticipated synergies, business growth opportunities, cost savings, and other benefits, which could have a material adverse effect on our business and results of operations.

In addition, we may divest businesses, including businesses that are no longer a part of our ongoing strategic plan. These divestitures similarly require significant investment of time and resources, may disrupt our business, distract management from other responsibilities and may result in losses on disposal or continued financial involvement in the divested business, including through indemnification, guarantee or other financial arrangements, for a period of time, following the transaction, which could adversely affect our financial results. In addition, we may be unable to complete strategic divestitures on satisfactory terms and conditions, including non-competition arrangements, or within expected time frames.

***Goodwill represents a significant asset on our balance sheet, and changes in future business conditions could cause these investments to become impaired, requiring substantial write-downs that would reduce our operating income.***

As of March 31, 2018, the value of our goodwill was \$1.6 billion. The amount of our recorded goodwill may substantially increase in the future as a result of any acquisitions that we make. We evaluate the recoverability of recorded goodwill amounts annually, or when evidence of potential impairment exists. Impairment analysis is based on several factors requiring judgment and the use of estimates, which are inherently uncertain and based on assumptions that may prove to be inaccurate. Additionally, material changes in our financial outlook, as well as events outside of our control, such as deteriorating market conditions for companies in our industry, may indicate a potential impairment. When there is an impairment, we are required to write down the recorded amount of goodwill, which is reflected as a charge against operating income. Such non-cash impairment charges could have a material adverse effect on our results of operations in the period in which they are recognized.

***Changes in tax law, including the 2017 Tax Act, could adversely impact our results of operations.***

We may incur additional tax liabilities in the future as a result of changes in tax laws and regulations or as a result of the implementation of existing tax laws. In particular, we are continuing to analyze certain provisions of the 2017 Tax Act which was enacted on December 22, 2017. While the new law decreased the U.S. federal corporate tax rate to 21 percent, we do not yet know what all of the consequences of the 2017 Tax Act will be, which may result in volatility and/or an increase to our

effective tax rate. We have recorded in our consolidated financial statements provisional amounts based on current estimates of the effects of the 2017 Tax Act in accordance with our current understanding of the 2017 Tax Act and currently available guidance. We will continue to assess the effect of the 2017 Tax Act on our business as it relates to acceleration of depreciation, limitation on the deductibility of certain executive compensation, taxes on low taxed intangible foreign income as well as deduction for foreign derived intangible income. The final amounts may be significantly affected by regulations and interpretive guidance expected to be issued by the tax authorities, clarifications of the accounting treatment of various items, our additional analysis, and our refinement of our estimates of the effects of the 2017 Tax Act, and therefore, such final amounts may be materially different than our current provisional amounts, which could materially affect our tax obligations and effective tax rate. In addition, other countries may consider tax law changes in reaction to the 2017 Tax Act. Any changes in other taxing jurisdictions' administrative interpretations, decisions, policies and positions could also impact our tax liabilities. For additional information regarding the 2017 Tax Act and the provisional tax amounts recorded in our consolidated financial statements, see "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations -- Critical Accounting Estimates and Policies". For a description of our related accounting policies, refer to Note 2 and Note 13 to our accompanying consolidated financial statements.

## Risks Related to Our Industry

***Our U.S. government contracts may be terminated by the government at any time and may contain other provisions permitting the government to discontinue contract performance, and if lost contracts are not replaced, our operating results may differ materially and adversely from those anticipated.***

U.S. government contracts contain provisions and are subject to laws and regulations that provide government clients with rights and remedies not typically found in commercial contracts. These rights and remedies allow government clients, among other things, to:

- terminate existing contracts, with short notice, for convenience as well as for default;
- reduce orders under or otherwise modify contracts;
- for contracts subject to the Truth in Negotiations Act, reduce the contract price or cost where it was increased because a contractor or subcontractor furnished cost or pricing data during negotiations that was not complete, accurate, and current;
- for some contracts, (i) demand a refund, make a forward price adjustment, or terminate a contract for default if a contractor provided inaccurate or incomplete data during the contract negotiation process and (ii) reduce the contract price under certain triggering circumstances, including the revision of price lists or other documents upon which the contract award was predicated;
- terminate our facility security clearances and thereby prevent us from receiving classified contracts;
- cancel multi-year contracts and related orders if funds for contract performance for any subsequent year become unavailable;
- decline to exercise an option to renew a multi-year contract or issue task orders in connection with IDIQ contracts;
- claim rights in solutions, systems, and technology produced by us, appropriate such work-product for their continued use without continuing to contract for our services and disclose such work-product to third parties, including other U.S. government agencies and our competitors, which could harm our competitive position;
- prohibit future procurement awards with a particular agency due to a finding of organizational conflicts of interest based upon prior related work performed for the agency that would give a contractor an unfair advantage over competing contractors, or the existence of conflicting roles that might bias a contractor's judgment;
- subject the award of contracts to protest by competitors, which may require the contracting federal agency or department to suspend our performance pending the outcome of the protest and may also result in a requirement to resubmit offers for the contract or in the termination, reduction, or modification of the awarded contract;
- suspend or debar us from doing business with the U.S. government; and
- control or prohibit the export of our services.

Recent and potential future budget cuts, the impact of sequestration and recent efforts by the Office of Management and Budget to decrease federal awards for management support services, may cause agencies with which we currently have contracts to terminate, reduce the number of task orders under or fail to renew such contracts. If a U.S. government client were to unexpectedly terminate, cancel, or decline to exercise an option to renew with respect to one or more of our significant contracts, or suspend or debar us from doing business with the U.S. government, our revenue and operating results would be materially harmed.

***The U.S. government may revise its procurement, contract or other practices in a manner adverse to us.***

The U.S. government may:

- revise its procurement practices or adopt new contract laws, rules, and regulations, such as cost accounting standards, organizational conflicts of interest, and other rules governing inherently governmental functions at any time;
- reduce, delay, or cancel procurement programs resulting from U.S. government efforts to improve procurement practices and efficiency;
- limit the creation of new government-wide or agency-specific multiple award contracts;
- face restrictions or pressure from government employees and their unions regarding the amount of services the U.S. government may obtain from private contractors;
- award contracts on a technically acceptable/lowest cost basis in order to reduce expenditures, and we may not be the lowest cost provider of services;
- adopt new socio-economic requirements, including setting aside procurement opportunities to small, disadvantaged businesses;
- change the basis upon which it reimburses our compensation and other expenses or otherwise limit such reimbursements; and
- at its option, terminate or decline to renew our contracts.

In addition, any new contracting methods could be costly or administratively difficult for us to implement and could adversely affect our future revenue and profit margin. In addition, changes to the procurement system could cause delays in the procurement decision-making process. Any such changes to the U.S. government's procurement practices or the adoption of new contracting rules or practices could impair our ability to obtain new or re-compete contracts and any such changes or increased associated costs could materially and adversely affect our results of operations.

As part of its cost-cutting initiative, the Department of Defense has issued guidance regarding changes to the procurement process that is intended to control cost growth throughout the acquisition cycle by developing a competitive strategy for each program. Because this initiative may significantly change the way the U.S. government solicits, negotiates, and manages its contracts, it could result in an increase in competitive pressure and decreased profitability on contracts and have a material adverse effect on our results of operations.

***The U.S. government may prefer minority-owned, small and small disadvantaged businesses; therefore, we may have fewer opportunities to bid for.***

As a result of the Small Business Administration set-aside program, the U.S. government may decide to restrict certain procurements only to bidders that qualify as minority-owned, small, or small disadvantaged businesses. As a result, we would not be eligible to perform as a prime contractor on those programs and would be restricted to a maximum of 49% of the work as a subcontractor on those programs. An increase in the amount of procurements under the Small Business Administration set-aside program may impact our ability to bid on new procurements as a prime contractor or restrict our ability to re-compete on incumbent work that is placed in the set-aside program.

***Our contracts, performance, and administrative processes and systems are subject to audits, reviews, investigations, and cost adjustments by the U.S. government, which could reduce our revenue, disrupt our business, or otherwise materially adversely affect our results of operation.***

U.S. government agencies routinely audit, review, and investigate government contracts and government contractors' administrative processes and systems. These agencies review our performance on contracts, pricing practices, cost structure, and compliance with applicable laws, regulations and standards, including applicable government cost accounting standards. These agencies also review our compliance with government regulations and policies, and the DCAA audits, among other areas, the adequacy of our internal control systems and policies, including our purchasing, property, estimating, earned value and accounting systems. These internal control systems could focus on significant elements of costs, such as executive compensation. Determination of a significant internal control deficiency by a government agency could result in increased payment withholding that might materially increase our accounts receivable days sales outstanding and adversely affect our cash flow. In particular, over time the DCMA has increased and may continue to increase the proportion of executive compensation that it deems unallowable and the size of the executive population whose compensation is disallowed, which will continue to materially and adversely affect our results of operations or financial condition including the requirement to carry an increased level of reserves. Recent legislation and regulations implementing new limitations on the amount of allowable executive compensation costs contribute to increased regulatory scrutiny of the allowability of employee compensation costs, which can lead to greater amounts of employee compensation cost being disallowed. We recognize as revenue, net of reserves,

executive compensation that we determine, based on management's estimates, to be allowable; management's estimates in this regard are based on a number of factors that may change over time, including executive compensation survey data, our and other government contractors' experiences with the DCAA audit practices in our industry and relevant decisions of courts and boards of contract appeals. Any costs found to be unallowable under a contract will not be reimbursed, and any such costs already reimbursed must be refunded. Further, the amount of any such refund may exceed reserves established by management based on estimates and assumptions that are inherently uncertain. Moreover, if any of the administrative processes and business systems, some of which are currently certified as effective, are found not to comply with government imposed requirements, we may be subjected to increased government scrutiny and approval that could delay or otherwise adversely affect our ability to compete for or perform contracts or to be paid timely. Unfavorable U.S. government audit, review, or investigation results could subject us to civil or criminal penalties or administrative sanctions, and could harm our reputation and relationships with our clients and impair our ability to be awarded new contracts, which could affect our future sales and profitability by preventing us, by operation of law or in practice, from receiving new government contracts for some period of time. In addition, if our invoicing system were found to be inadequate following an audit by the DCAA, our ability to directly invoice U.S. government payment offices could be eliminated. As a result, we would be required to submit each invoice to the DCAA for approval prior to payment, which could materially increase our accounts receivable days sales outstanding and adversely affect our cash flow. In addition, proposed regulatory changes, if adopted, would require the Department of Defense's contracting officers to impose contractual withholdings at no less than certain minimum levels based on assessments of a contractor's business systems. An unfavorable outcome to an audit, review, or investigation by any U.S. government agency could materially and adversely affect our relationship with the U.S. government. If a government investigation uncovers improper or illegal activities, we may be subject to civil and criminal penalties and administrative sanctions, including termination of contracts, forfeitures of profits, withholding of payments, suspension of payments, fines, and suspension or debarment from doing business with the U.S. government. In addition, we could suffer serious reputational harm if allegations of impropriety were made against us. Provisions that we have recorded in our consolidated financial statements as a compliance reserve may not cover actual losses. Furthermore, the disallowance of any costs previously charged could directly and negatively affect our current results of operations for the relevant prior fiscal periods, and we could be required to repay any such disallowed amounts. Each of these results could materially and adversely affect our results of operations or financial condition.

***A delay in the completion of the U.S. government's budget process could result in a reduction in our backlog and have a material adverse effect on our revenue and operating results.***

On an annual basis, the U.S. Congress must approve budgets that govern spending by each of the federal agencies we support. When the U.S. Congress is unable to agree on budget priorities, and thus is unable to pass the annual budget on a timely basis, the U.S. Congress typically enacts a continuing resolution. A continuing resolution allows government agencies to operate at spending levels approved in the previous budget cycle. Under a continuing resolution, funding may not be available for new projects. In addition, when government agencies operate on the basis of a continuing resolution, they may delay funding we expect to receive on contracts we are already performing. Any such delays would likely result in new business initiatives being delayed or canceled and a reduction in our backlog, and could have a material adverse effect on our revenue and operating results. In addition, a failure to complete the budget process and fund government operations pursuant to a continuing resolution may result in a federal government shutdown (such as that which occurred during the government fiscal year 2014 and, to a lesser extent, government fiscal year 2018). A shutdown may result in us incurring substantial costs without reimbursement under our contracts and the delay or cancellation of key programs or the delay of contract payments, which could have a material adverse effect on our revenue and operating results. In addition, when supplemental appropriations are required to operate the U.S. government or fund specific programs and passage of legislation needed to approve any supplemental appropriation bill is delayed, the overall funding environment for our business could be adversely affected.

#### **Risks Related to Our Indebtedness**

***We have substantial indebtedness and may incur substantial additional indebtedness, which could adversely affect our financial health and our ability to obtain financing in the future as well as to react to changes in our business.***

As of March 31, 2018, we had total indebtedness of approximately \$1.8 billion and \$498.6 million of availability under our revolving credit facility (the "Revolving Credit Facility"). We are able to, and may, incur additional indebtedness in the future, subject to the limitations contained in the agreements governing our indebtedness. Our substantial indebtedness could have important consequences to holders of our common stock, including:

- making it more difficult for us to satisfy our obligations with respect to our Secured Credit Facility, consisting of a \$1,094 million term loan facility ("Term Loan A"), a \$395 million term loan facility ("Term Loan B" and, together with Term Loan A, the "Term Loans") and a \$500 million Revolving Credit Facility, with a sublimit for letters of credit of \$100 million, our \$350 million in aggregate principal amount of 5.125% Senior Notes due 2025 (the "Senior Notes") and our other debt;

- limiting our ability to obtain additional financing to fund future working capital, capital expenditures, acquisitions or other general corporate requirements;
- requiring a substantial portion of our cash flows to be dedicated to debt service payments instead of other purposes, thereby reducing the amount of cash flows available for working capital, capital expenditures, acquisitions and other general corporate purposes;
- increasing our vulnerability to general adverse economic and industry conditions
- exposing us to the risk of increased interest rates as certain of our borrowings, including under the Secured Credit Facility, are at variable rates of interest;
- limiting our flexibility in planning for and reacting to changes in the industry in which we compete;
- placing us at a disadvantage compared to other, less leveraged competitors or competitors with comparable debt and more favorable terms and thereby affecting our ability to compete; and
- increasing our cost of borrowing.

Although the Secured Credit Facility and the indenture governing the Senior Notes contain restrictions on the incurrence of additional indebtedness, these restrictions are subject to a number of qualifications and exceptions, and the additional indebtedness incurred in compliance with these restrictions could be substantial. These restrictions also will not prevent us from incurring obligations that do not constitute indebtedness. In addition, the Revolving Credit Facility provides for commitments of \$500 million, which as of March 31, 2018, had availability of \$498.6 million. Additionally, the used portion as it pertains to open standby letters of credit and bank guarantees totaled \$1.4 million. Furthermore, subject to specified conditions, without the consent of the then-existing lenders (but subject to the receipt of commitments), the indebtedness under the Secured Credit Facility may be increased by up to (x) \$400 million plus (y) an additional amount if, after giving pro forma effect to the incurrence of such additional amount and after giving effect to any acquisition consummated concurrently therewith and all other appropriate pro forma adjustment events, the consolidated net senior secured leverage ratio is equal to or less than 3.50:1.00. If new debt is added to our current debt levels, the related risks that we and the guarantors now face would increase and we may not be able to meet all our debt obligations, including the repayment of the Senior Notes.

***We may not be able to generate sufficient cash to service our indebtedness and may be forced to take other actions to satisfy our obligations under our indebtedness, which may not be successful.***

Our ability to make scheduled payments on or refinance our debt obligations will depend on our financial condition and operating performance, which are subject to prevailing economic and competitive conditions and to financial, business, legislative, regulatory and other factors beyond our control. We might not be able to maintain a level of cash flows from operating activities sufficient to permit us to pay the principal, premium, if any, and interest on our indebtedness. For information regarding the risks to our business that could impair our ability to satisfy our obligations under our indebtedness, see “— Risks Related to Our Business.”

If our cash flows and capital resources are insufficient to fund our debt service obligations, we could face substantial liquidity problems and could be forced to reduce or delay investments and capital expenditures or to dispose of material assets or operations, seek additional debt or equity capital or restructure or refinance our indebtedness. We may not be able to effect any such alternative measures on commercially reasonable terms or at all and, even if successful, those alternative actions may not allow us to meet our scheduled debt service obligations.

The agreements governing our indebtedness restrict our ability to dispose of assets and use the proceeds from those dispositions and also restrict our ability to raise debt to be used to repay other indebtedness when it becomes due.

We may not be able to consummate those dispositions or to obtain proceeds in an amount sufficient to meet any debt service obligations then due. In addition, under the Secured Credit Facility, we are subject to mandatory prepayments of our Term Loans from a portion of our excess cash flows, which may be stepped down upon the achievement of specified first lien leverage ratios. To the extent that we are required to prepay any amounts under our Term Loans, we may have insufficient cash to make required principal and interest payments on other indebtedness.

Our inability to generate sufficient cash flows to satisfy our debt obligations, or to refinance our indebtedness on commercially reasonable terms or at all, would materially and adversely affect our financial condition and results of operations and our ability to satisfy our obligations under our indebtedness.

If we cannot make scheduled payments on our debt, we will be in default and lenders under our Secured Credit Facility and holders of the Senior Notes could declare all outstanding principal and interest to be due and payable, the lenders under the Revolving Credit Facility could terminate their commitments to loan money, the lenders could foreclose against the assets securing their loans and we could be forced into bankruptcy or liquidation. All of these events could result in you losing some or all of the value of your investment.

***The terms of the agreements governing our indebtedness restrict our current and future operations, particularly our ability to respond to changes or to take certain actions, which could harm our long-term interests.***

The Secured Credit Facility and the indenture governing the Senior Notes contain covenants that, among other things, impose significant operating and financial restrictions on us and limit our ability to engage in actions that may be in our long-term best interest, including restrictions on our ability to:

- incur additional indebtedness, guarantee indebtedness or issue disqualified stock or preferred stock;
- pay dividends on or make other distributions in respect of, or repurchase or redeem, our capital stock;
- prepay, redeem or repurchase subordinated indebtedness;
- make loans and investments;
- sell or otherwise dispose of assets;
- incur liens securing indebtedness;
- enter into transactions with affiliates;
- enter into agreements restricting our subsidiaries' ability to pay dividends to us or the guarantors or make other intercompany transfers;
- consolidate, merge or sell all or substantially all of our or any guarantor's assets;
- designate our subsidiaries as unrestricted subsidiaries; and
- enter into certain lines of business.

These covenants are subject to a number of important exceptions and qualifications. In addition, the restrictive covenants in the Secured Credit Facility require us to maintain a consolidated net total leverage ratio and a consolidated net interest coverage ratio that will each be tested at the end of each fiscal quarter. Our ability to satisfy that financial ratio test may be affected by events beyond our control.

A breach of the covenants under the agreements governing our indebtedness could result in an event of default under those agreements. Such a default may allow certain creditors to accelerate the related debt and may result in the acceleration of any other debt to which a cross-acceleration or cross-default provision applies. In addition, an event of default under the Secured Credit Facility would also permit the lenders under the Revolving Credit Facility to terminate all other commitments to extend further credit under that facility. Furthermore, if we were unable to repay the amounts due and payable under the Secured Credit Facility, those lenders could proceed against the collateral granted to them to secure that indebtedness. In the event the lenders accelerate the repayment of our borrowings, we may not have sufficient assets to repay that indebtedness.

As a result of all of these restrictions, we may be:

- limited in how we conduct our business;
- unable to raise additional debt or equity financing to operate during general economic or business downturns; or
- unable to compete effectively or to take advantage of new business opportunities.

These restrictions might hinder our ability to grow in accordance with our strategy.

***Our variable rate indebtedness subjects us to interest rate risk, which could cause our debt service obligations to increase significantly.***

Borrowings under the Secured Credit Facility are at variable rates of interest and expose us to interest rate risk. Interest rates are currently at historically low levels. If interest rates increase, our debt service obligations on the variable rate indebtedness will increase even though the amount borrowed remains the same, and our net income and cash flows, including cash available for servicing our indebtedness, will correspondingly decrease.

Based on Term Loans outstanding as of March 31, 2018 and assuming all revolving loans are fully drawn, and after considering interest rate swaps that fixed the interest rate on \$450 million of principal of our variable rate debt, each quarter point change in interest rates would result in a \$3.8 million change in our projected annual interest expense on our

indebtedness under the Secured Credit Facility. We have entered into interest rate swaps and may in the future enter into additional interest rate swaps, that involve the exchange of floating for fixed rate interest payments in order to reduce future interest rate volatility of our variable rate indebtedness. However, due to risks for hedging gains and losses and cash settlement costs, we may not elect to maintain such interest rate swaps, and any swaps may not fully mitigate our interest rate risk.

***A downgrade, suspension or withdrawal of the rating assigned by a rating agency to us or our indebtedness could make it more difficult for us to obtain additional debt financing in the future.***

Our indebtedness has been rated by nationally recognized rating agencies and may in the future be rated by additional rating agencies. We cannot assure you that any rating assigned to us or our indebtedness will remain for any given period of time or that a rating will not be lowered or withdrawn entirely by a rating agency if, in that rating agency's judgment, circumstances relating to the basis of the rating, such as adverse changes in our business, so warrant. Any downgrade, suspension or withdrawal of a rating by a rating agency (or any anticipated downgrade, suspension or withdrawal) could make it more difficult or more expensive for us to obtain additional debt financing in the future.

#### **Risks Related to Our Common Stock**

***Booz Allen Holding is a holding company with no operations of its own, and it depends on its subsidiaries for cash to fund all of its operations and expenses, including to make future dividend payments, if any.***

The operations of Booz Allen Holding are conducted almost entirely through its subsidiaries and its ability to generate cash to meet its debt service obligations or to pay dividends is highly dependent on the earnings and the receipt of funds from its subsidiaries via dividends or intercompany loans. Further, the Secured Credit Facility and indenture governing the Senior Notes significantly restricts the ability of our subsidiaries to pay dividends or otherwise transfer assets to us. In addition, Delaware law may impose requirements that may restrict our ability to pay dividends to holders of our common stock.

***Our financial results may vary significantly from period to period as a result of a number of factors many of which are outside our control, which could cause the market price of our Class A Common Stock to fluctuate.***

Our financial results may vary significantly from period to period in the future as a result of many external factors that are outside of our control. Factors that may affect our financial results and that could cause the market price of our outstanding securities, including our Class A Common Stock, to fluctuate include those listed in this "Risk Factors" section and others such as:

- any cause of reduction or delay in U.S. government funding;
- fluctuations in revenue earned on existing contracts;
- commencement, completion, or termination of contracts during a particular period;
- a potential decline in our overall profit margins if our other direct costs and subcontract revenue grow at a faster rate than labor-related revenue;
- strategic decisions by us or our competitors, such as changes to business strategy, strategic investments, acquisitions, divestitures, spin offs, and joint ventures;
- a change in our contract mix to less profitable contracts;
- changes in policy or budgetary measures that adversely affect U.S. government contracts in general;
- variable purchasing patterns under U.S. government GSA schedules, blanket purchase agreements, which are agreements that fulfill repetitive needs under GSA schedules, and IDIQ contracts;
- changes in demand for our services and solutions;
- fluctuations in the degree to which we are able to utilize our professionals;
- seasonality associated with the U.S. government's fiscal year;
- an inability to utilize existing or future tax benefits for any reason, including a change in law;
- alterations to contract requirements; and
- adverse judgments or settlements in legal disputes.

***We cannot assure you that we will pay special or regular dividends on our stock in the future.***

The board of directors has authorized and declared a regular quarterly dividend for each quarter in the last several years. The board of directors has also authorized and declared special cash dividends from time to time. The declaration of any future

dividends and the establishment of the per share amount, record dates and payment dates for any such future dividends are subject to the discretion of the board of directors taking into account future earnings, cash flows, financial requirements and other factors. There can be no assurance that the board of directors will declare any dividends in the future. To the extent that expectations by market participants regarding the potential payment, or amount, of any special or regular dividend prove to be incorrect, the price of our common stock may be materially and negatively affected and investors that bought shares of our common stock based on those expectations may suffer a loss on their investment. Further, to the extent that we declare a regular or special dividend at a time when market participants hold no such expectations or the amount of any such dividend exceeds current expectations, the price of our common stock may increase and investors that sold shares of our common stock prior to the record date for any such dividend may forego potential gains on their investment.

***Fulfilling our obligations incident to being a public company, including with respect to the requirements of and related rules under the Sarbanes Oxley Act of 2002, is expensive and time consuming and any delays or difficulty in satisfying these obligations could have a material adverse effect on our future results of operations and our stock price.***

As a public company, the Sarbanes-Oxley Act of 2002 and the related rules and regulations of the SEC, as well as the New York Stock Exchange rules, require us to implement various corporate governance practices and adhere to a variety of reporting requirements and complex accounting rules. Compliance with these public company obligations requires us to devote significant management time and place significant additional demands on our finance and accounting staff and on our financial, accounting, and information systems. We have hired additional accounting and financial staff with appropriate public company reporting experience and technical accounting knowledge. Other expenses associated with being a public company include increased auditing, accounting, and legal fees and expenses, investor relations expenses, increased directors' fees and director and officer liability insurance costs, registrar and transfer agent fees, listing fees, as well as other expenses.

In particular, the Sarbanes-Oxley Act of 2002 requires us to document and test the effectiveness of our internal control over financial reporting in accordance with an established internal control framework, and to report on our conclusions as to the effectiveness of our internal controls. It also requires an independent registered public accounting firm to test our internal control over financial reporting and report on the effectiveness of such controls. In addition, we are required under the Exchange Act to maintain disclosure controls and procedures and internal control over financial reporting. Because of inherent limitations in any internal control environment, there can be no assurance that all control issues and instances of fraud, errors or misstatements, if any, within our company have been or will be detected on a timely basis. Such deficiencies could result in the correction or restatement of financial statements of one or more periods. Any failure to maintain effective controls or implement new or improved controls, or difficulties encountered in their implementation, could harm our operating results or cause us to fail to meet our reporting obligations. We also rely on third parties for certain calculations and other information that support our accounting and financial reporting, which includes reports from such organizations on their controls and systems that are used to generate this information. The calculations and other information that we receive from such third parties may not be accurate, and we may not receive adequate or timely information related to internal control failures occurring at these organizations. Any failure by such third parties to provide us with accurate information or implement and maintain effective controls may cause us to be unable to meet our reporting obligations as a publicly traded company. If we are unable to conclude that we have effective internal control over financial reporting, or if our independent registered public accounting firm is unable to provide us with an unqualified report regarding the effectiveness of our internal control over financial reporting, investors could lose confidence in the reliability of our consolidated financial statements, which could result in a decrease in the value of our common stock. Failure to comply with the Sarbanes-Oxley Act of 2002 could potentially subject us to sanctions or investigations by the SEC, the New York Stock Exchange, or other regulatory authorities.

***Provisions in our organizational documents and in the Delaware General Corporation Law may prevent takeover attempts that could be beneficial to our stockholders.***

Our amended and restated certificate of incorporation and amended and restated bylaws include a number of provisions that may have the effect of delaying, deterring, preventing, or rendering more difficult a change in control of Booz Allen Holding that our stockholders might consider in their best interests. These provisions include:

- establishment of a classified Board, with staggered terms;
- granting to the Board the sole power to set the number of directors and to fill any vacancy on the Board;
- limitations on the ability of stockholders to remove directors;
- granting to the Board the ability to designate and issue one or more series of preferred stock without stockholder approval, the terms of which may be determined at the sole discretion of the Board;
- a prohibition on stockholders from calling special meetings of stockholders;
- the establishment of advance notice requirements for stockholder proposals and nominations for election to the Board at stockholder meetings;

- requiring approval of two-thirds of stockholders to amend the bylaws; and
- prohibiting our stockholders from acting by written consent.

In addition, we are subject to the anti-takeover provisions of Section 203 of the Delaware General Corporation Law, which imposes additional requirements regarding mergers and other business combinations. These provisions may prevent our stockholders from receiving the benefit from any premium to the market price of our common stock offered by a bidder in a takeover context. Even in the absence of a takeover attempt, the existence of these provisions may adversely affect the prevailing market price of our common stock if the provisions are viewed as discouraging takeover attempts in the future.

Our amended and restated certificate of incorporation and amended and restated by-laws may also make it difficult for stockholders to replace or remove our management. These provisions may facilitate management entrenchment that may delay, deter, render more difficult, or prevent a change in our control, which may not be in the best interests of our stockholders.

***The market for our Class A Common Stock may be adversely affected by the performance of other companies in the government services market.***

In addition to factors that may affect our financial results and operations, the price of our Class A Common Stock may be impacted by the financial performance and outlook of other companies in the government services market. While certain factors may affect all participants in the markets in which we operate, such as U.S. government spending conditions and changes in rules and regulations applicable to government contractors, the market for our Class A Common Stock may be adversely affected by financial results or negative events only affecting other market participants or financial results of such participants. While such events or results may not impact or be indicative of our current or future performance, the price of our securities may nonetheless be adversely affected as a result thereof.

**Item 1B. *Unresolved Staff Comments***

None.

**Item 2. *Properties***

We do not own any facilities or real estate. Our corporate headquarters is located at 8283 Greensboro Drive, McLean, Virginia 22102. We lease other operating offices and facilities throughout North America, and a limited number of overseas locations. Our principal offices outside of McLean, Virginia include: Annapolis Junction, Maryland; Rockville, Maryland; Laurel, Maryland; San Diego, California; Herndon, Virginia; Charleston, South Carolina; Arlington, Virginia; Alexandria, Virginia; and Washington, D.C. We have a number of Sensitive Compartmented Information Facilities, which are enclosed areas within buildings that are used to perform classified work for the U.S. Intelligence Community. Many of our employees are located in facilities provided by the U.S. government. The total square footage of our leased offices and facilities is approximately 2.60 million square feet. We believe our facilities meet our current needs.

**Item 3. *Legal Proceedings***

Our performance under U.S. government contracts and compliance with the terms of those contracts and applicable laws and regulations are subject to continuous audit, review, and investigation by the U.S. government which may include such investigative techniques as subpoenas or civil investigative demands. Given the nature of our business, these audits, reviews, and investigations may focus, among other areas, on various aspects of procurement integrity, labor time reporting, sensitive and/or classified information access and control, executive compensation, and post government employment restrictions. We are not always aware of our status in such matters, but we are currently aware of certain pending audits and investigations involving labor time reporting, procurement integrity, and classified information access. In addition, from time to time, we are also involved in legal proceedings and investigations arising in the ordinary course of business, including those relating to employment matters, relationships with clients and contractors, intellectual property disputes, and other business matters. These legal proceedings seek various remedies, including claims for monetary damages in varying amounts, none of which are considered material, or are unspecified as to amount. Although the outcome of any such matter is inherently uncertain and may be materially adverse, based on current information, we do not expect any of the currently ongoing audits, reviews, investigations, or litigation to have a material adverse effect on our financial condition and results of operations. As of March 31, 2018 and 2017, there were no material amounts accrued in the consolidated financial statements related to these proceedings.

Six former officers and stockholders who had departed the company prior to the Carlyle Acquisition have filed a total of nine suits in various jurisdictions, with original filing dates ranging from July 3, 2008 through December 15, 2009, against us and certain of our current and former directors and officers. Three of these suits were amended on July 2, 2010 and then further amended into one consolidated complaint on September 7, 2010. Another two of the original nine suits were consolidated into

one complaint on September 24, 2014. Each of the suits arises out of the Carlyle Acquisition and alleges that the former stockholders are entitled to certain payments that they would have received if they had held their stock at the time of the Carlyle Acquisition. Some of the suits also allege that the acquisition price paid to stockholders was insufficient. The various suits assert claims for breach of contract, tortious interference with contract, breach of fiduciary duty, civil Racketeer Influenced and Corrupt Organizations Act, or RICO, violations, violations of the Employee Retirement Income Security Act, or ERISA, and/or securities and common law fraud. Three of these suits have been dismissed with all appeals exhausted. The two suits that were consolidated into one action on September 24, 2014 were settled on April 16, 2015. One of the remaining suits has been dismissed by the United States District Court for the Southern District of California and such dismissal was upheld by the United States Court of Appeals for the Ninth Circuit. The plaintiff in this suit subsequently filed a Petition for Writ of Certiorari to the United States Supreme Court, which was denied by the United States Supreme Court on January 9, 2017. The other three remaining suits that were previously consolidated on September 7, 2010 have been dismissed by the United States District Court for the Southern District of New York and were on appeal before the United States Court of Appeals for the Second Circuit. On July 13, 2017, the United States Court of Appeals for the Second Circuit affirmed the ruling of the United States District Court for the Southern District of New York, except for one plaintiff's securities fraud claim, which was remanded to the United States District Court for the Southern District of New York to give the plaintiff, Paul Kocourek, leave to file another amended complaint to attempt to plead a securities fraud claim. On April 6, 2018, the plaintiff filed an amended complaint in which Mr. Kocourek, individually, as Trustee of the Paul Kocourek Trust and on behalf of a putative class, alleges that the Company and certain former officers and directors violated Sections 10(b), 20(a) and 14(e) of the Exchange Act. On April 25, 2018, the court entered an order postponing the deadline within which the defendants must answer or move to dismiss the amended complaint. A lead plaintiff has not been appointed.

As of March 31, 2018, the aggregate alleged damages that will be sought in the remaining suit is unknown. As of March 31, 2018, although the outcome of any of these cases is inherently uncertain and may be materially adverse, based on current information, we do not expect them to have a material adverse effect on our financial condition and results of operations.

On June 7, 2017, Booz Allen Hamilton Inc. was informed that the U.S. Department of Justice (DOJ) is conducting a civil and criminal investigation of the Company. In connection with the investigation, the DOJ has requested information from the Company relating to certain elements of the Company's cost accounting and indirect cost charging practices with the U.S. government. Since learning of the investigation, the Company has engaged a law firm experienced in these matters to represent the Company in connection with this matter and respond to the government's requests. As is commonly the case with this type of matter, the Company has also been in contact with other regulatory agencies and bodies, including the SEC, which notified the Company that it is conducting an investigation that the Company believes relates to the matters that are also the subject of the DOJ's investigation. The Company may receive additional regulatory or governmental inquiries related to the matters that are subject of the DOJ's investigation. In accordance with the Company's practice, the Company is cooperating with all relevant government parties. The total cost associated with these matters will depend on many factors, including the duration of these matters and any related findings. At this stage, the Company is not able to reasonably estimate the expected amount or range of cost or any loss associated with these matters.

On June 19, 2017, a purported stockholder of the Company filed a putative class action lawsuit in the United States District Court for the Eastern District of Virginia styled *Langley v. Booz Allen Hamilton Holding Corp.*, No. 17-cv-00696 naming the Company, its Chief Executive Officer and its Chief Financial Officer as defendants purportedly on behalf of all purchases of the Company's securities from May 19, 2016 through June 15, 2017. On September 5, 2017, the court named two lead plaintiffs, and on October 20, 2017, the lead plaintiffs filed a consolidated amended complaint. The complaint asserts claims under Sections 10(b) and 20(a) of the Exchange Act and Rule 10b-5 promulgated thereunder, alleging misrepresentations or omissions by the Company purporting to relate to matters that are the subject of the DOJ investigation described above. The plaintiffs seek to recover from the Company and the individual defendants an unspecified amount of damages. The Company believes the suit lacks merit and intends to defend against the lawsuit. Motions to dismiss were argued on January 12, 2018, and on February 8, 2018, the court dismissed the amended complaint in its entirety without prejudice. At this stage of the lawsuit, the Company is not able to reasonably estimate the expected amount or range of cost or any loss associated with the lawsuit.

On November 13, 2017, a Verified Shareholder Derivative Complaint was filed in the United States District Court for the District of Delaware styled *Celine Thum v. Rozanski et al.*, C.A. No. 17-cv-01638, naming the Company as a nominal defendant and numerous current and former officers and directors as defendants. The complaint asserts claims for breach of fiduciary duties, unjust enrichment, waste of corporate assets, abuse of control, gross mismanagements, and violations of Sections 14(a), 10(b), and 20(a) of the Exchange Act, purportedly relating to matters that are the subject of the DOJ investigation described above. The parties have stipulated to a stay of the proceedings pending the outcome of the securities litigation (described above), which the court ordered on January 24, 2018. At this stage of the lawsuit, the Company is not able to reasonably estimate the expected amount or range of cost or any loss associated with the lawsuit.

**Item 4. Mine Safety Disclosures**

None.

**Executive Officers of the Registrant**

The following table sets forth information about our executive officers as of the date hereof:

<b>Name</b>	<b>Age</b>	<b>Position</b>
Horacio D. Rozanski	50	President and Chief Executive Officer
Lloyd W. Howell, Jr.	51	Executive Vice President, Chief Financial Officer and Treasurer
Kristine Martin Anderson	49	Executive Vice President
Karen M. Dahut	54	Executive Vice President
Nancy J. Laben	56	Executive Vice President, Chief Legal Officer and Secretary
Gary D. Labovich	58	Executive Vice President
Christopher Ling	53	Executive Vice President
Joseph Logue	53	Executive Vice President
Joseph W. Mahaffee	60	Executive Vice President and Chief Administrative Officer
Angela M. Messer	54	Executive Vice President and Chief Transformation Officer
Susan L. Penfield	56	Executive Vice President
Elizabeth M. Thompson	63	Executive Vice President and Chief People Officer
Laura S. Adams	45	Vice President, Corporate Controller and Chief Accounting Officer

*Horacio D. Rozanski* is our President and Chief Executive Officer and served as our Chief Operating Officer until January 1, 2015. Mr. Rozanski served as the Chief Strategy and Talent Officer in 2010 and, prior to that, Chief Personnel Officer of our company from 2002 through 2010. Mr. Rozanski joined our company in 1992 and became an Executive Vice President in 2009, our President on January 1, 2014 and our Chief Executive Officer on January 1, 2015. He serves on the board of trustees of the Jewish Primary Day School of the Nation's Capital and the board of directors of The Center for Talent Innovation and the United States Holocaust Memorial Museum's Committee on Conscience and as Vice Chair of the Corporate Fund for the John F. Kennedy Center for the Performing Arts.

*Lloyd W. Howell, Jr.* is an Executive Vice President of our company and our Chief Financial Officer and Treasurer since July 1, 2016. Mr. Howell previously served as the group leader for our Civil Commercial Group. Mr. Howell joined our company in 1988, left in 1991, rejoined in 1995 and became an Executive Vice President in 2005. He served as chairman of our Ethics & Compliance Committee for over seven years, until April 2014. Mr. Howell serves on the boards of directors of Integra Life Sciences, Partnership for Public Service and Capital Partners for Education. Mr. Howell also serves on the board of overseers for the School of Engineering and Applied Science and as a Trustee at the University of Pennsylvania.

*Kristine Martin Anderson* is an Executive Vice President and is the group leader for the company's Civil Group after leading the company's civil health business since April 2015. Prior to joining Booz Allen in 2006, she was vice president for operations and strategy at CareScience, a software solutions company. Ms. Anderson currently serves on the eHealth Initiative's board of directors. In addition, she serves on the Cost and Resource Use Standing Committee of the National Quality Forum and the Quality and Safety Committee for the Healthcare Information and Management Systems Society.

*Karen M. Dahut* is an Executive Vice President and is the group leader for the company's Defense Group and Commercial Group. Ms. Dahut joined our company in 2002 and became a Senior Vice President in 2004. Ms. Dahut led the company's Strategic Innovations Group from 2012 to April 2016 and the Civil Commercial Group from 2016 to March 2018. Previously, she also led the company's Analytics business and its US Navy and Marine Corps business. Ms. Dahut is a board member of the Tech Data Corporation and Northern Virginia Technology Council.

*Nancy J. Laben* is an Executive Vice President of our company and our Chief Legal Officer and Secretary. Ms. Laben joined our company in September 2013. She oversees the Legal functions, Ethics & Compliance and Corporate Affairs. Before joining our company, Ms. Laben served as General Counsel of AECOM Technology Corporation from June 2010 to August 2013, where she was responsible for all legal support. Prior to June 2010, Ms. Laben served as Deputy General Counsel at Accenture plc beginning in 1989. Prior to Accenture, Ms. Laben served in the law department at IBM Corporation.

*Gary Labovich* is an Executive Vice President and leads the modernization of our management systems. He joined Booz Allen in July 2004. Mr. Labovich has led the company's systems delivery and digital businesses as well as the delivery of the company's financial services capabilities and service offerings to both federal and private sector clients. Prior to joining the

company, Mr. Labovich spent 18 years at American Management Systems in key roles as an entrepreneur and a senior executive specializing in systems development and strategic consulting for federal, state, local and commercial organizations. Mr. Labovich is a former chair and a member of the board of trustees for the Greater DC Maryland Chapter of the National Multiple Sclerosis and serves on the board of trustees for Clark University.

*Christopher Ling* is an Executive Vice President and leads the company's National Security Group. Mr. Ling joined the company in 1991 and has over 25 years of experience in management consulting, analytics, missions operations, technology, cybersecurity, engineering, and innovation to design, develop and implement solutions. Prior to becoming the group lead for the National Security Group, Mr. Ling led the company's International business from April 2016 through March 2018, where he provided a range of general management consulting, defense, counter terrorism, cyber and data analytics to public and commercial/private sector clients primarily in the Middle East. Mr. Ling was also responsible for leading the company's cyber business from April 2014 through March 2016 and the Defense/Military Intel business prior to April 2014. Mr. Ling is a member of the Business Executives for National Security.

*Joseph Logue* is an Executive Vice President of our company and was the group leader for our Defense Intelligence Group until March 2018. Mr. Logue joined our company in 1997 and became an Executive Vice President in 2009. Previously, he led our former commercial Information Technology practice. As previously disclosed, Mr. Logue will retire from the company effective June 30, 2018.

*Joseph W. Mahaffee* is an Executive Vice President, our Chief Administrative Officer (CAO) and was our Chief Information Security Officer (CISO) until April 2018. Mr. Mahaffee joined the company in 1981. Prior to his CAO and CISO roles, Mr. Mahaffee served in a variety of client/market-facing leadership roles, including Client Service Officer for our NSA account, Assurance and Resilience Capability Leader and the Northeast Region Leader. Mr. Mahaffee has primarily focused his career serving clients in the Defense and Intelligence Community markets. Altogether, he has more than 38 years of professional experience in Cybersecurity, systems engineering, communications, information assurance and signals intelligence. Prior to joining our company, Mr. Mahaffee was an information security engineer with the National Security Agency.

*Angela Messer* is an Executive Vice President and our Chief Transformation Officer (CTO) since April 2018. Ms. Messer joined our company in 1996, left and rejoined in 2001 and became Executive Vice President in 2013. Previously she led the company's Cyber capability, guiding teams of cyber forensics engineers, data scientists, and threat intelligence experts who focus on cyber malware, cyber next gen operations and incident response. Previously, she led the company's Army business, which is a global, multi-functional business in the defense and intelligence sector. Prior to joining the company, she was a U.S. Army officer, managed two commercial businesses and launched a startup software development company.

*Susan L. Penfield* is an Executive Vice President of our company and is the group leader for our Strategic Innovation Group. Ms. Penfield joined the company in 1994. She has over 25 years of strategy, technology, marketing and solutions delivery experience. Prior to joining the Strategic Innovation Group, Ms. Penfield led the company's Health business, where she drove technology and transformation initiatives across the Federal, commercial and non-profit health space. She serves on the board of directors of the Children's Inn at the National Institutes of Health and Seedspot. Ms. Penfield is a member of the the National Association for Female Executives (NAFE), and was recognized by the NAFE as its 2015 Digital Trailblazer.

*Elizabeth M. Thompson* is an Executive Vice President of our company and serves as our Chief People Officer. Ms. Thompson joined our company in 2008. Ms. Thompson served as Vice President of Human Resources for Fannie Mae from 2000 to 2008. Ms. Thompson holds an M.S. in Human Resources and Personnel Management from American University. Ms. Thompson is also a member of the board of directors of the Thurgood Marshall College Fund.

*Laura S. Adams* is a Vice President of our company and our Corporate Controller and Chief Accounting Officer. Ms. Adams joined Booz Allen in January 2009 and has served as the company's Contoller since July 2014 and Chief Accounting Officer since 2016. Ms. Adams brings more than 25 years of finance and accounting specialty and industry experience, primarily in aerospace and defense and government and commercial IT management consulting services. Before joining Booz Allen, Ms. Adams was a senior manager in the audit and assurance practice of Ernst & Young from 1995 through 2008.

## PART II

### Item 5. Market for Registrant's Common Equity, Related Stockholder Matters and Issuer Purchases of Equity Securities

#### Market Information

Our Class A Common Stock began trading on the New York Stock Exchange on November 17, 2010. At the annual meeting of stockholders held on July 31, 2014, the stockholders approved a proposal to amend and restate the certificate of incorporation, which had the effect of converting all issued and outstanding shares of Class B Non-Voting Common Stock and Class C Restricted Common Stock into shares of Class A Common Stock on a one-for-one basis. The conversion was effected on August 13, 2014 when the Company filed its third amended and restated certificate of incorporation with the Secretary of State of the State of Delaware. As a result of the conversion, there were no shares of Class B Non-Voting Common Stock and Class C Restricted Common Stock outstanding at such time. On September 30, 2015, the Company purchased, at par value, all issued and outstanding shares of Class E special voting common stock in connection with the exercise of the final tranche of rollover options during the second quarter of fiscal 2016. There is no established trading market for each of our Class B Non-Voting Common Stock, Class C Restricted Common Stock, or Class E Special Voting Common Stock. On May 22, 2018, there were 75,571 beneficial holders of our Class A Common Stock. The following table sets forth, for the periods indicated, the high and low sales price per share of our Class A Common Stock as reported by the New York Stock Exchange:

	High	Low
Fiscal 2018		
1 <sup>st</sup> Quarter	\$ 39.67	\$ 31.06
2 <sup>nd</sup> Quarter	37.82	31.56
3 <sup>rd</sup> Quarter	39.38	35.71
4 <sup>th</sup> Quarter	40.25	35.21
Fiscal 2017		
1 <sup>st</sup> Quarter	\$ 30.64	\$ 27.02
2 <sup>nd</sup> Quarter	31.94	29.03
3 <sup>rd</sup> Quarter	38.54	29.55
4 <sup>th</sup> Quarter	37.69	32.75

#### Dividends

During fiscal 2018, the Company's Board of Directors authorized and declared three regular quarterly cash dividends of \$0.17 per share and one quarterly cash dividend of \$0.19 per share. During fiscal 2017, the Company's Board of Directors authorized and declared three regular quarterly cash dividends of \$0.15 per share and one quarterly cash dividend of \$0.17 per share. The Company plans to continue paying recurring dividends in the future and assessing its excess cash resources to determine the best way to utilize its excess cash flow to meet its objectives. Any future dividends declared will be at the discretion of the Company's Board of Directors and will depend, among other factors, upon our earnings, liquidity, financial condition, alternate capital allocation opportunities, or any other factors our Board of Directors deems relevant. On May 29, 2018, the Company announced that its Board of Directors had declared a quarterly cash dividend of \$0.19 per share. Payment of the dividend will be made on June 29, 2018 to stockholders of record at the close of business on June 14, 2018.

#### Recent Sales of Unregistered Securities

None.

## Issuer Purchases of Equity Securities

The following table shows the share repurchase activity for each of the three months in the quarter ended March 31, 2018:

Period	Total Number of Shares Purchased	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Approximate Dollar Value of Shares that May Yet Be Purchased Under the Plans or Programs (1)
January 2018	—	\$—	—	\$ 270,902,584
February 2018	1,067,857	\$37.46	1,067,857	\$ 230,902,601
March 2018	857,351	\$38.55	857,351	\$ 197,855,040
Total	1,925,208		1,925,208	

- (1) On December 12, 2011, the Board of Directors approved a \$30.0 million share repurchase program. On January 27, 2015, the Board of Directors approved an increase to our share repurchase authorization from \$30.0 million to up to \$180.0 million. On January 25, 2017, the Board of Directors approved an increase to our share repurchase authorization from \$180.0 million to up to \$410.0 million. On November 2, 2017, the Board of Directors approved an increase to our share repurchase authorization from \$410.0 million to up to \$610.0 million. On May 24, 2018, the Board of Directors approved an increase to our share repurchase authorization from \$610.0 million to up to \$910.0 million. As of May 24, 2018, taking into effect the increase in the share repurchase authorization, the Company may repurchase up to approximately \$493.7 million of additional shares of common stock under its share repurchase program. A special committee of the Board of Directors was appointed to evaluate market conditions and other relevant factors and initiate repurchases under the program from time to time. The share repurchase program may be suspended, modified or discontinued at any time at the Company's discretion without prior notice.

## Use of Proceeds from Registered Securities

None.

## Performance

The graph set forth below compares the cumulative shareholder return on our Class A Common Stock between March 31, 2013 and March 31, 2018, to the cumulative return of (i) the Russell 1000 Index and (ii) S&P Software & Services Select Industry Index over the same period. The Russell 1000 and S&P Software & Services Select Industry Indices represent comparator groups for relative cumulative return performance to Booz Allen Hamilton. This graph assumes an initial investment of \$100 on March 31, 2013 in our Class A Common Stock, the Russell 1000 Index, and the S&P Software & Services Select Industry Index and assumes the reinvestment of dividends, if any. The stock price performance included in this graph is not necessarily indicative of future stock price performance.

### COMPARISON OF CUMULATIVE TOTAL RETURNS



ASSUMES \$100 INVESTED ON MARCH 31, 2013  
ASSUMES DIVIDEND REINVESTED

Company/Market/Peer Group	3/31/2013	3/31/2014	3/31/2015	3/31/2016	3/31/2017	3/31/2018
Booz Allen Hamilton Holding Corp.	\$ 100.00	\$ 186.31	\$ 261.62	\$ 279.33	\$ 332.97	\$ 371.42
Russell 1000 Index	\$ 100.00	\$ 122.41	\$ 138.00	\$ 138.69	\$ 162.87	\$ 185.63
S&P Software & Services Select Industry Index	\$ 100.00	\$ 129.16	\$ 146.39	\$ 142.24	\$ 176.82	\$ 228.48

This performance graph and other information furnished under this Part II Item 5 of this Annual Report shall not be deemed to be “soliciting material” or to be “filed” with the SEC or subject to Regulation 14A or 14C, or to the liabilities of Section 18 of the Exchange Act.

## Item 6. Selected Financial Data

The selected consolidated statements of operations data for fiscal 2018, fiscal 2017, and fiscal 2016 and the selected consolidated balance sheet data as of March 31, 2018 and 2017 have been derived from our audited consolidated financial statements included elsewhere in this Annual Report. The selected consolidated statement of operations data for fiscal 2015 and fiscal 2014 and the selected consolidated balance sheet data as of March 31, 2016, 2015 and 2014 have been derived from audited consolidated financial statements which are not included in this Annual Report. Our historical results are not

necessarily indicative of the results that may be expected for any future period. The selected financial data should be read in conjunction with “Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations” and our consolidated financial statements and related notes included elsewhere in this Annual Report.

(In thousands, except share and per share data)	Fiscal Year Ended March 31,				
	2018	2017	2016	2015	2014
<b>Consolidated Statements of Operations:</b>					
Revenue	\$ 6,171,853	\$ 5,804,284	\$ 5,405,738	\$ 5,274,770	\$ 5,478,693
Operating costs and expenses:					
Cost of revenue	2,867,103	2,691,982	2,580,026	2,593,849	2,716,113
Billable expenses	1,861,312	1,751,077	1,513,083	1,406,527	1,487,115
General and administrative expenses	858,597	817,434	806,509	752,912	742,527
Depreciation and amortization	64,756	59,544	61,536	62,660	72,327
Total operating costs and expenses	5,651,768	5,320,037	4,961,154	4,815,948	5,018,082
Operating income	520,085	484,247	444,584	458,822	460,611
Interest expense	(82,269)	(62,298)	(70,815)	(71,832)	(78,030)
Other income (expense), net	188	(10,049)	5,693	(1,072)	(1,794)
Income before income taxes	438,004	411,900	379,462	385,918	380,787
Income tax expense	132,893	159,410	85,368	153,349	148,599
Net income	\$ 305,111	\$ 252,490	\$ 294,094	\$ 232,569	\$ 232,188
Earnings per common share (1):					
Basic	\$ 2.08	\$ 1.69	\$ 1.98	\$ 1.58	\$ 1.62
Diluted	\$ 2.05	\$ 1.67	\$ 1.94	\$ 1.52	\$ 1.54
Weighted average common shares outstanding (1):					
Basic	145,964,574	148,218,968	146,494,407	145,414,120	141,314,544
Diluted	147,750,022	150,274,640	149,719,137	150,375,531	148,681,074
Dividends declared per share	\$ 0.70	\$ 0.62	\$ 0.54	\$ 1.46	\$ 2.40

(In thousands)	As of March 31,				
	2018	2017	2016	2015	2014
<b>Consolidated Balance Sheets:</b>					
Cash and cash equivalents	\$ 286,958	\$ 217,417	\$ 187,529	\$ 207,217	\$ 259,994
Working capital	452,553	193,079	249,858	299,675	309,186
Total assets	3,603,366	3,373,105	3,010,171	2,863,982	2,915,229
Long-term debt, net of current portion	1,755,479	1,470,174	1,484,448	1,555,761	1,567,893
Stockholders’ equity	554,628	573,591	408,488	186,498	171,636

(1) Basic earnings per share for the Company has been computed using the weighted average number of shares of Class A Common Stock, Class B Non-Voting Common Stock, and Class C Restricted Common Stock outstanding during the period. The Company’s diluted earnings per share has been computed using the weighted average number of shares of Class A Common Stock, Class B Non-Voting Common Stock, and Class C Restricted Common Stock including the dilutive effect of outstanding common stock options and other stock-based awards. For the purposes of calculating basic and diluted earnings per share, the Company has utilized the two class method, given non-forfeitable dividends declared on unvested Class A Restricted Common Stock. The weighted average number of Class E Special Voting Common Stock has not been included in the calculation of either basic earnings per share or diluted earnings per share due to the terms of such common stock.

## Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations

The following discussion and analysis is intended to help the reader understand our business, financial condition, results of operations, and liquidity and capital resources. You should read this discussion in conjunction with “Item 6. Selected Financial Data,” and our consolidated financial statements and the related notes contained elsewhere in this Annual Report.

The statements in this discussion regarding industry outlook, our expectations regarding our future performance, liquidity and capital resources, and other non-historical statements in this discussion are forward-looking statements. These forward-looking statements are subject to numerous risks and uncertainties, including, but not limited to, the risks and uncertainties described in “Item 1A. Risk Factors” and “Introductory Note — Cautionary Note Regarding Forward-Looking Statements”. Our actual results may differ materially from those contained in or implied by any forward-looking statements.

*Our fiscal year ends March 31 and, unless otherwise noted, references to years or fiscal are for fiscal years ended March 31. See “— Results of Operations.”*

## **Overview**

We are a leading provider of management and technology consulting, engineering, analytics, digital solutions, mission operations, and cyber expertise to U.S. and international governments, major corporations, and not-for-profit organizations. Our ability to deliver value to our clients has always been, and continues to be, a product of the strong character, expertise and tremendous passion of our people. Our approximately 24,600 employees work to solve hard problems by making clients' missions their own, combining decades of consulting and domain expertise with functional expertise in areas such as analytics, digital solutions, engineering, and cyber, all fostered by a culture of innovation that extends to all reaches of the company.

Through our dedication to our clients' missions, and a commitment to evolving our business to address their client needs, we have longstanding relationships with our clients, some more than 75 years. We support critical missions for a diverse base of federal government clients, including nearly all of the U.S. government's cabinet-level departments, as well as increasingly for top-tier commercial and international clients. We support our federal government clients by helping them tackle their most complex and pressing challenges such as protecting soldiers in combat and supporting their families, advancing cyber capabilities, keeping our national infrastructure secure, enabling and enhancing digital services, transforming the healthcare system, and improving government efficiency to achieve better outcomes. We serve commercial clients across industries including financial services, health and life sciences, energy, and transportation to solve the hardest and most consequential challenges, including through our cybersecurity products and services. Our international clients are primarily in the Middle East, and we have a growing presence in Southeast Asia.

## Financial and Other Highlights

During fiscal 2018, the Company generated its highest annual revenue since its initial public offering and reported increases in headcount and backlog for the year. Revenue increased 6.3% from fiscal 2017 to fiscal 2018 primarily driven by increased client demand, which led to increased client staff headcount, and an increase in client staff labor. Revenue also benefited from higher billable expenses as compared to the prior year.

Operating income increased 7.4% to \$520.1 million in fiscal 2018 from \$484.2 million in fiscal 2017, which reflects an increase in operating margin to 8.4% from 8.3% in the comparable period. The increase in operating income was primarily driven by the same factors driving revenue growth as well as improved contract profitability. The increase in operating income was partially offset by an increase in the Company's provisions for the potential recovery of allowable expenses recorded during fiscal 2018 as compared to fiscal 2017. The Company also incurred incremental legal costs during fiscal 2018 in response to the U.S. Department of Justice investigation and matters which purport to relate to the investigation, a portion of which was offset by the receipt of insurance reimbursements. We expect to incur additional costs in the future. Based on the information currently available, the Company is not able to reasonably estimate the expected long-term incremental legal costs or amounts that may be reimbursed associated with this investigation and these related matters.

## Non-GAAP Measures

We publicly disclose certain non-GAAP financial measurements, including Revenue, Excluding Billable Expenses, Adjusted Operating Income, Adjusted EBITDA, Adjusted EBITDA Margin on Revenue, Adjusted EBITDA Margin on Revenue, Excluding Billable Expenses, Adjusted Net Income, and Adjusted Diluted Earnings Per Share, or Adjusted Diluted EPS, because management uses these measures for business planning purposes, including to manage our business against internal projected results of operations and measure our performance. We view Adjusted Operating Income, Adjusted EBITDA, Adjusted EBITDA Margin on Revenue, Adjusted EBITDA Margin on Revenue, Excluding Billable Expenses, Adjusted Net Income, and Adjusted Diluted EPS as measures of our core operating business, which exclude the impact of the items detailed below, as these items are generally not operational in nature. These non-GAAP measures also provide another basis for comparing period to period results by excluding potential differences caused by non-operational and unusual or non-recurring items. In addition, we use Revenue, Excluding Billable Expenses because it provides management useful information about the Company's operating performance by excluding the impact of costs that are not indicative of the level of productivity of our consulting staff headcount and our overall direct labor, which management believes provides useful information to our investors about our core operations. We also utilize and discuss Free Cash Flow, because management uses this measure for business planning purposes, measuring the cash generating ability of the operating business, and measuring liquidity generally. We present these supplemental measures because we believe that these measures provide investors and securities analysts with important supplemental information with which to evaluate our performance, long-term earnings potential, or liquidity, as applicable, and to enable them to assess our performance on the same basis as management. These supplemental performance measurements may vary from and may not be comparable to similarly titled measures by other companies in our industry. Revenue, Excluding Billable Expenses, Adjusted Operating Income, Adjusted EBITDA, Adjusted EBITDA Margin on Revenue, Adjusted EBITDA Margin on Revenue, Excluding Billable Expenses, Adjusted Net Income, Adjusted Diluted EPS, and Free Cash Flow are not recognized measurements under accounting principles generally accepted in the United States, or GAAP, and when analyzing our performance or liquidity, as applicable, investors should (i) evaluate each adjustment in our reconciliation of revenue to Revenue, Excluding Billable Expenses, operating income to Adjusted Operating Income, net income to Adjusted EBITDA, Adjusted EBITDA Margin on Revenue, Adjusted EBITDA Margin on Revenue, Excluding Billable Expenses, Adjusted Net Income and Adjusted Diluted Earnings Per Share, and net cash provided by operating activities to Free Cash Flow, (ii) use Revenue, Excluding Billable Expenses, Adjusted Operating Income, Adjusted EBITDA, Adjusted EBITDA Margin on Revenue, Adjusted EBITDA Margin on Revenue, Excluding Billable Expenses, Adjusted Net Income, and Adjusted Diluted EPS in addition to, and not as an alternative to, revenue, operating income, net income or diluted EPS, as measures of operating results, each as defined under GAAP and (iii) use Free Cash Flow in addition to, and not as an alternative to, net cash provided by operating activities as a measure of liquidity, each as defined under GAAP. We have defined the aforementioned non-GAAP measures as follows:

- "Revenue, Excluding Billable Expenses" represents revenue less billable expenses. We use Revenue, Excluding Billable Expenses because it provides management useful information about the Company's operating performance by excluding the impact of costs that are not indicative of the level of productivity of our consulting staff headcount and our overall direct labor, which management believes provides useful information to our investors about our core operations.
- "Adjusted Operating Income" represents operating income before: (i) adjustments related to the amortization of intangible assets resulting from the acquisition of our Company by The Carlyle Group (the "Carlyle Acquisition"), and (ii) transaction costs, fees, losses, and expenses, including fees associated with debt prepayments. We prepare Adjusted Operating Income to eliminate the impact of items we do not consider indicative of ongoing operating performance due to their inherent unusual, extraordinary, or non-recurring nature or because they result from an event of a similar nature.
- "Adjusted EBITDA" represents net income before income taxes, net interest and other expense and depreciation and amortization before certain other items, including transaction costs, fees, losses, and expenses, including fees associated with debt prepayments. "Adjusted EBITDA Margin on Revenue" is calculated as Adjusted EBITDA divided by revenue. "Adjusted EBITDA Margin on Revenue, Excluding Billable Expenses" is calculated as Adjusted EBITDA divided by Revenue, Excluding Billable Expenses. The Company prepares Adjusted EBITDA, Adjusted EBITDA Margin on Revenue, and Adjusted EBITDA Margin on Revenue, Excluding Billable Expenses to eliminate the impact of items it does not consider indicative of ongoing operating performance due to their inherent unusual, extraordinary or non-recurring nature or because they result from an event of a similar nature.
- "Adjusted Net Income" represents net income before: (i) adjustments related to the amortization of intangible assets resulting from the Carlyle Acquisition, (ii) transaction costs, fees, losses, and expenses, including fees associated with debt prepayments, (iii) amortization or write-off of debt issuance costs and write-off of original issue discount, (iv) release of income tax reserves, and (v) re-measurement of deferred tax assets and

liabilities as a result of the 2017 Tax Act in each case net of the tax effect where appropriate calculated using an assumed effective tax rate. We prepare Adjusted Net Income to eliminate the impact of items, net of tax, we do not consider indicative of ongoing operating performance due to their inherent unusual, extraordinary, or non-recurring nature or because they result from an event of a similar nature. We view net income excluding the impact of the re-measurement of the Company's deferred tax assets and liabilities as a result of the 2017 Tax Act as an important indicator of performance consistent with the manner in which management measures and forecasts the Company's performance and the way in which management is incentivized to perform.

- "Adjusted Diluted EPS" represents diluted EPS calculated using Adjusted Net Income as opposed to net income. Additionally, Adjusted Diluted EPS does not contemplate any adjustments to net income as required under the two-class method as disclosed in the footnotes to the consolidated financial statements.
- "Free Cash Flow" represents the net cash generated from operating activities less the impact of purchases of property and equipment.

Below is a reconciliation of Revenue, Excluding Billable Expenses, Adjusted Operating Income, Adjusted EBITDA, Adjusted EBITDA Margin, Adjusted Net Income, Adjusted Diluted EPS, and Free Cash Flow to the most directly comparable financial measure calculated and presented in accordance with GAAP.

(Amounts in thousands, except share and per share data)	Fiscal Year Ended March 31,		
	2018	2017	2016
	(Unaudited)		
<b>Revenue, Excluding Billable Expenses</b>			
Revenue	\$ 6,171,853	\$ 5,804,284	\$ 5,405,738
Billable expenses	1,861,312	1,751,077	1,513,083
Revenue, Excluding Billable Expenses	\$ 4,310,541	\$ 4,053,207	\$ 3,892,655
<b>Adjusted Operating Income</b>			
Operating Income	\$ 520,085	\$ 484,247	\$ 444,584
Amortization of intangible assets (a)	—	4,225	4,225
Transaction expenses (b)	—	3,354	—
Adjusted Operating Income	\$ 520,085	\$ 491,826	\$ 448,809
<b>EBITDA, Adjusted EBITDA, Adjusted EBITDA Margin on Revenue &amp; Adjusted EBITDA Margin on Revenue, Excluding Billable Expenses</b>			
Net income	\$ 305,111	\$ 252,490	\$ 294,094
Income tax expense	132,893	159,410	85,368
Interest and other, net (c)	82,081	72,347	65,122
Depreciation and amortization	64,756	59,544	61,536
EBITDA	584,841	543,791	506,120
Transaction expenses (b)	—	3,354	—
Adjusted EBITDA	\$ 584,841	\$ 547,145	\$ 506,120
Adjusted EBITDA Margin on Revenue	9.5%	9.4%	9.4%
Adjusted EBITDA Margin on Revenue, Excluding Billable Expenses	13.6%	13.5%	13.0%
<b>Adjusted Net Income</b>			
Net income	\$ 305,111	\$ 252,490	\$ 294,094
Amortization of intangible assets (a)	—	4,225	4,225
Transaction expenses (b)	—	3,354	—
Release of income tax reserves (d)	—	—	(53,301)
Re-measurement of deferred tax assets/liabilities (e)	(9,107)	—	—
Amortization or write-off of debt issuance costs and write-off of original issue discount	2,655	8,866	5,201
Adjustments for tax effect (f)	(969)	(6,578)	(3,770)
Adjusted Net Income	\$ 297,690	\$ 262,357	\$ 246,449
<b>Adjusted Diluted Earnings Per Share</b>			
Weighted-average number of diluted shares outstanding	147,750,022	150,274,640	149,719,137
Adjusted Net Income Per Diluted Share (g)	\$ 2.01	\$ 1.75	\$ 1.65
<b>Free Cash Flow</b>			
Net cash provided by operating activities	\$ 369,143	\$ 382,277	\$ 249,234
Less: Purchases of property and equipment	(78,437)	(53,919)	(66,635)
Free Cash Flow	\$ 290,706	\$ 328,358	\$ 182,599

(a) Reflects amortization of intangible assets resulting from the Carlyle Acquisition.

(b) Reflects debt refinancing costs incurred in connection with the refinancing transaction consummated on July 13, 2016.

- (c) Reflects the combination of Interest expense and Other income (expense), net from the consolidated statement of operations.
- (d) Release of pre-acquisition income tax reserves assumed by the Company in connection with the Carlyle Acquisition.
- (e) Reflects the provisional income tax benefit associated with the re-measurement of the Company's deferred tax assets and liabilities as a result of the 2017 Tax Act.
- (f) Fiscal 2017 and 2016 reflect the tax effect of adjustments at an assumed effective tax rate of 40%. Beginning in the third quarter of fiscal 2018 with the enactment of the 2017 Tax Act, adjustments are reflected using an assumed effective tax rate of 36.5%, which approximates a blended federal and state tax rate for fiscal 2018, and consistently excludes the impact of other tax credits and incentive benefits realized.
- (g) Excludes an adjustment of approximately \$1.9 million, \$2.3 million, and \$3.5 million of net earnings for fiscal 2018, 2017, and 2016, respectively, associated with the application of the two-class method for computing diluted earnings per share.

## **Factors and Trends Affecting Our Results of Operations**

Our results of operations have been, and we expect them to continue to be, affected by the following factors, which may cause our future results of operations to differ from our historical results of operations discussed under “— Results of Operations.”

### ***Business Environment and Key Trends in Our Markets***

We believe that the following trends and developments in the U.S. government services industry and our markets may influence our future results of operations:

- uncertainty around the timing, extent, nature and effect of Congressional and other U.S. government actions to approve funding of the U.S. government, address budgetary constraints, including caps on the discretionary budget for defense and non-defense departments and agencies, as established by the Bipartisan Budget Control Act of 2011 and subsequently adjusted by the American Tax Payer Relief Act of 2012, the Bipartisan Budget Act of 2013 and the Bipartisan Budget Act of 2015, and address the ability of Congress to determine how to allocate the available budget authority and pass appropriations bills to fund both U.S. government departments and agencies that are, and those that are not, subject to the caps;
- budget deficits and the growing U.S. national debt increasing pressure on the U.S. government to reduce federal spending across all federal agencies together with associated uncertainty about the size and timing of those reductions;
- cost-cutting and efficiency initiatives, current and future budget restrictions, continued implementation of Congressionally mandated automatic spending cuts and other efforts to reduce U.S. government spending could cause clients to reduce or delay funding for orders for services or invest appropriated funds on a less consistent or rapid basis or not at all, particularly when considering long-term initiatives and in light of uncertainty around Congressional efforts to approve funding of the U.S. government and to craft a long-term agreement on the U.S. government's ability to incur indebtedness in excess of its current limits and generally in the current political environment, there is a risk that clients will not issue task orders in sufficient volume to reach current contract ceilings, alter historical patterns of contract awards, including the typical increase in the award of task orders or completion of other contract actions by the U.S. government in the period before the end of the U.S. government's fiscal year on September 30, delay requests for new proposals and contract awards, rely on short-term extensions and funding of current contracts, or reduce staffing levels and hours of operation;
- delays in the completion of future U.S. government's budget processes, which have in the past and could in the future delay procurement of the products, services, and solutions we provide;
- changes in the relative mix of overall U.S. government spending and areas of spending growth, with shifts in priorities on homeland security, intelligence, defense-related programs, and healthcare, and continued increased spending on technology and innovation including cybersecurity, Command, Control, Communications, Computers, Intelligence, Surveillance, and Reconnaissance (C4ISR), advanced analytics, systems modernization and integration;
- legislative and regulatory changes to limitations on the amount of allowable executive compensation permitted under flexibly priced contracts following adoption of interim rules adopted by federal agencies implementing a section of the Bipartisan Budget Act of 2013, which substantially further reduce the amount of allowable executive compensation under these contracts and extend these limitations to a larger segment of our executives and our entire contract base;

- efforts by the U.S. government to address organizational conflicts of interest and related issues and the impact of those efforts on us and our competitors;
- increased audit, review, investigation and general scrutiny by U.S. government agencies of government contractors' performance under U.S. government contracts and compliance with the terms of those contracts and applicable laws;
- the federal focus on refining the definition of “inherently governmental” work, including proposals to limit contractor access to sensitive or classified information and work assignments, which will continue to drive pockets of insourcing in various agencies, particularly in the intelligence market;
- negative publicity and increased scrutiny of government contractors in general, including us, relating to U.S. government expenditures for contractor services and incidents involving the mishandling of sensitive or classified information, data breaches and cybersecurity;
- U.S. government agencies awarding contracts on a technically acceptable/lowest cost basis, which could have a negative impact on our ability to win certain contracts;
- increased competition from other government contractors and market entrants seeking to take advantage of certain of the trends identified above, and industry trend towards consolidation, which may result in the emergence of companies that are better able to compete against us;
- cost-cutting and efficiency and effectiveness efforts by U.S. civilian agencies with a focus on increased use of performance measurement, “program integrity” efforts to reduce waste, fraud and abuse in entitlement programs, and renewed focus on improving procurement practices for and interagency use of IT services, including through the use of cloud based options and data center consolidation;
- restrictions by the U.S. government on the ability of federal agencies to use lead system integrators, in response to cost, schedule and performance problems with large defense acquisition programs where contractors were performing the lead system integrator role;
- increasingly complex requirements of the Department of Defense and the U.S. intelligence community, including cybersecurity, managing federal health care cost growth and focus on reforming existing government regulation of various sectors of the economy, such as financial regulation and healthcare; and
- increasing small business regulations across the Department of Defense and civilian agency clients continue to gain traction, agencies are required to meet high small business set aside targets, and large business prime contractors are required to subcontract in accordance with considerable small business participation goals necessary for contract award.

#### ***Sources of Revenue***

Substantially all of our revenue is derived from services provided under contracts and task orders with the U.S. government, primarily by our consulting staff and, to a lesser extent, our subcontractors. Funding for our contracts and task orders is generally linked to trends in budgets and spending across various U.S. government agencies and departments. We provide services under a large portfolio of contracts and contract vehicles to a broad client base, and we believe that our diversified contract and client base lessens potential volatility in our business; however, a reduction in the amount of services that we are contracted to provide to the U.S. government or any of our significant U.S. government clients could have a material adverse effect on our business and results of operations. In particular, the Department of Defense is one of our significant clients, and the Budget Control Act (BCA) of 2011 (as amended by the American Taxpayer Relief Act of 2012, the Bipartisan Budget Act of 2013, the Bipartisan Budget Act of 2015, and the Bipartisan Act of 2018), provides for automatic spending cuts (referred to as sequestration) totaling approximately \$1.2 trillion between 2013 and 2021, including an estimated \$500 billion in federal defense spending cuts over this time period. The Bipartisan Budget Act of 2018 raised BCA spending caps on defense spending by \$80 billion for fiscal 2018, and \$85 billion for fiscal 2019. For non-defense funding, the Bipartisan Budget Act of 2018 raised BCA spending caps by \$63 billion for fiscal 2018 and \$67 billion for fiscal 2019. While the American Taxpayer Relief Act of 2012, the Bipartisan Budget Act of 2013, the Bipartisan Budget Act of 2015, and the Bipartisan Budget Act of 2018 all negated and raised budget limits put in place by the BCA for both defense and non-defense spending, those spending limits are due to return in fiscal 2020, and absent another budget deal, could result in significant cuts to the budget levels allowed by the Bipartisan Budget Act of 2018. This could result in a commensurate reduction in the amount of services that we are contracted to provide to the Department of Defense and could have a material adverse effect on our business and results of operations, and given the uncertainty of when and how these automatic reductions required by the BCA may return and/or be applied, we are unable to predict the nature or magnitude of the potential adverse effect.

#### ***Contract Types***

We generate revenue under the following three basic types of contracts:

- *Cost-Reimbursable Contracts.* Cost-reimbursable contracts provide for the payment of allowable costs incurred during performance of the contract, up to a ceiling based on the amount that has been funded, plus a fee. As we increase or decrease our spending on allowable costs, our revenue generated on cost-reimbursable contracts will increase, up to the ceiling and funded amounts, or decrease, respectively. We generate revenue under two general types of cost-reimbursable contracts: cost-plus-fixed-fee and cost-plus-award-fee, both of which reimburse allowable costs and provide for a fee. The fee under each type of cost-reimbursable contract is generally payable upon completion of services in accordance with the terms of the contract. Cost-plus-fixed-fee contracts offer no opportunity for payment beyond the fixed fee. Cost-plus-award-fee contracts also provide for an award fee that varies within specified limits based upon the client’s assessment of our performance against a predetermined set of criteria, such as targets for factors like cost, quality, schedule, and performance.
- *Time-and-Materials Contracts.* Under a time-and-materials contract, we are paid a fixed hourly rate for each direct labor hour expended, and we are reimbursed for billable material costs and billable out-of-pocket expenses inclusive of allocable indirect costs. To the extent our actual direct labor including allocated indirect costs, and associated billable expenses decrease or increase in relation to the fixed hourly billing rates provided in the contract, we will generate more or less profit, respectively, or could incur a loss.
- *Fixed-Price Contracts.* Under a fixed-price contract, we agree to perform the specified work for a predetermined price. To the extent our actual direct and allocated indirect costs decrease or increase from the estimates upon which the price was negotiated, we will generate more or less profit, respectively, or could incur a loss. Some fixed-price contracts have a performance-based component, pursuant to which we can earn incentive payments or incur financial penalties based on our performance. Fixed-price level of effort contracts require us to provide a specified level of effort (i.e., labor hours), over a stated period of time, for a fixed price.

The amount of risk and potential reward varies under each type of contract. Under cost-reimbursable contracts, there is limited financial risk, because we are reimbursed for all allowable costs up to a ceiling. However, profit margins on this type of contract tend to be lower than on time-and-materials and fixed-price contracts. Under time-and-materials contracts, we are reimbursed for the hours worked using the predetermined hourly rates for each labor category. In addition, we are typically reimbursed for other contract direct costs and expenses at cost. We assume financial risk on time-and-materials contracts because our labor costs may exceed the negotiated billing rates. Profit margins on well-managed time-and-materials contracts tend to be higher than profit margins on cost-reimbursable contracts as long as we are able to staff those contracts with people who have an appropriate skill set. Under fixed-price contracts, we are required to deliver the objectives under the contract for a predetermined price. Compared to time-and-materials and cost-reimbursable contracts, fixed-price contracts generally offer higher profit margin opportunities because we receive the full benefit of any cost savings but generally involve greater financial risk because we bear the impact of any cost overruns. In the aggregate, the contract type mix in our revenue for any given period will affect that period’s profitability. Changes in contract type as a result of re-competes and new business could influence the percentage/mix in unanticipated ways.

The table below presents the percentage of total revenue for each type of contract:

	Fiscal Year Ended March 31,		
	2018	2017	2016
Cost-reimbursable (1)	51%	50%	51%
Time-and-materials	25%	26%	26%
Fixed-price (2)	24%	24%	23%

(1) Includes both cost-plus-fixed-fee and cost-plus-award-fee contracts.

(2) Includes fixed-price level of effort contracts.

#### *Contract Diversity and Revenue Mix*

We provide services to our clients through a large number of single award contracts, contract vehicles, and multiple award contract vehicles. Most of our revenue is generated under indefinite delivery/indefinite quantity, or IDIQ, contract vehicles, which include multiple award government wide acquisition contract vehicles, or GWACs, and General Services Administration Multiple Award Schedule Contracts, or GSA schedules, and certain single award contracts. GWACs and GSA schedules are

available to all U.S. government agencies. Any number of contractors typically compete under multiple award IDIQ contract vehicles for task orders to provide particular services, and we earn revenue under these contract vehicles only to the extent that we are successful in the bidding process for task orders. No single task order under any IDIQ contract represented more than 2.7% of our revenue in fiscal 2018. No single definite contract accounted for more than 2.2% of our revenue in fiscal 2018.

We generate revenue under our contracts and task orders through our provision of services as both a prime contractor and subcontractor, as well as from the provision of services by subcontractors under contracts and task orders for which we act as the prime contractor. For fiscal 2018, 2017, and 2016, 91%, 91%, and 90%, respectively, of our revenue was generated by contracts and task orders for which we served as a prime contractor; 9%, 9%, and 10%, respectively, of our revenue was generated by contracts and task orders for which we served as a subcontractor; and 25%, 25%, and 24%, respectively, of our revenue was generated by services provided by our subcontractors. The mix of these types of revenue affects our operating margin. Substantially all of our operating margin is derived from direct consulting staff labor as the portion of our operating margin derived from fees we earn on services provided by our subcontractors is not significant. We view growth in direct consulting staff labor as the primary driver of earnings growth. Direct consulting staff labor growth is driven by consulting staff headcount growth, after attrition, and total backlog growth.

#### Our People

Revenue from our contracts is derived from services delivered by consulting staff and, to a lesser extent, from our subcontractors. Our ability to hire, retain, and deploy talent with skills appropriately aligned with client needs is critical to our ability to grow our revenue. We continuously evaluate whether our talent base is properly sized and appropriately compensated and contains an optimal mix of skills to be cost competitive and meet the rapidly evolving needs of our clients. We seek to achieve that result through recruitment and management of capacity and compensation. As of March 31, 2018, 2017, and 2016, we employed approximately 24,600, 23,300, and 22,600 people, respectively, of which approximately 22,100, 21,000, and 20,300, respectively, were consulting staff.

#### Contract Backlog

We define backlog to include the following three components:

- *Funded Backlog.* Funded backlog represents the revenue value of orders for services under existing contracts for which funding is appropriated or otherwise authorized less revenue previously recognized on these contracts.
- *Unfunded Backlog.* Unfunded backlog represents the revenue value of orders (including optional orders) for services under existing contracts for which funding has not been appropriated or otherwise authorized.
- *Priced Options.* Priced contract options represent 100% of the revenue value of all future contract option periods under existing contracts that may be exercised at our clients' option and for which funding has not been appropriated or otherwise authorized.

Backlog does not include any task orders under IDIQ contracts, except to the extent that task orders have been awarded to us under those contracts.

The following table summarizes the value of our contract backlog at the respective dates presented:

	Fiscal Year Ended March 31,		
	2018	2017	2016
	(In millions)		
Backlog:			
Funded	\$ 2,685	\$ 2,815	\$ 2,673
Unfunded	4,161	3,098	2,546
Priced options	9,174	7,679	6,595
Total backlog	<u>\$ 16,020</u>	<u>\$ 13,592</u>	<u>\$ 11,814</u>

Our backlog includes orders under contracts that in some cases extend for several years. The U.S. Congress generally appropriates funds for our clients on a yearly basis, even though their contracts with us may call for performance that is expected to take a number of years to complete. As a result, contracts typically are only partially funded at any point during their term and all or some of the work to be performed under the contracts may remain unfunded unless and until the U.S. Congress makes subsequent appropriations and the procuring agency allocates funding to the contract.

We view growth in total backlog and consulting staff headcount as the two key measures of our potential business growth. Growing and deploying consulting staff is the primary means by which we are able to achieve profitable revenue growth. To the extent that we are able to hire additional consulting staff and deploy them against funded backlog, we generally recognize increased revenue. Total backlog increased by 17.9% from March 31, 2017 to March 31, 2018 and increased by 15.1% from March 31, 2016 to March 31, 2017. Additions to funded backlog, during fiscal 2018 and 2017 totaled \$6.0 billion and \$5.9 billion, respectively, with the increase from fiscal 2017 to fiscal 2018 due to the conversion of unfunded backlog to funded backlog, the award of new contracts and task orders under which funding was appropriated, and the subsequent funding of priced options. We report internally on our backlog on a monthly basis and review backlog upon occurrence of certain events to determine if any adjustments are necessary.

We cannot predict with any certainty the portion of our backlog that we expect to recognize as revenue in any future period and we cannot guarantee that we will recognize any revenue from our backlog. The primary risks that could affect our ability to recognize such revenue on a timely basis or at all are: program schedule changes, contract modifications, and our ability to assimilate and deploy new consulting staff against funded backlog; cost-cutting initiatives and other efforts to reduce U.S. government spending, which could reduce or delay funding for orders for services; and delayed funding of our contracts due to delays in the completion of the U.S. government's budgeting process and the use of continuing resolutions by the U.S. government to fund its operations. The amount of our funded backlog is also subject to change, due to, among other factors: changes in congressional appropriations that reflect changes in U.S. government policies or priorities resulting from various military, political, economic or international developments; changes in the use of U.S. government contracting vehicles, and the provisions therein used to procure our services and adjustments to the scope of services, or cancellation of contracts, by the U.S. government at any time. In our recent experience, none of the following additional risks have had a material negative effect on our ability to realize revenue from our funded backlog: the unilateral right of the U.S. government to cancel multi-year contracts and related orders or to terminate existing contracts for convenience or default; in the case of unfunded backlog, the potential that funding will not be made available; and, in the case of priced options, the risk that our clients will not exercise their options.

In addition, funded backlog includes orders under contracts for which the period of performance has expired, and we may not recognize revenue on the funded backlog that includes such orders due to, among other reasons, the tardy submission of invoices by our subcontractors and the expiration of the relevant appropriated funding in accordance with a predetermined expiration date such as the end of the U.S. government's fiscal year. The revenue value of orders included in funded backlog that has not been recognized as revenue due to period of performance expirations has not exceeded approximately 7.9% of funded backlog as of the end of any of the four fiscal quarters preceding the fiscal quarter ended March 31, 2018.

We expect to recognize revenue from a substantial portion of funded backlog as of March 31, 2018 within the next twelve months. However, given the uncertainties discussed above, as well as the risks described in "Item 1A. Risk Factors", we can give no assurance that we will be able to convert our backlog into revenue in any particular period, if at all.

### ***Operating Costs and Expenses***

Costs associated with compensation and related expenses for our people are the most significant component of our operating costs and expenses. The principal factors that affect our costs are additional people as we grow our business and are awarded new contracts, task orders, and additional work under our existing contracts, and the hiring of people with specific skill sets and security clearances as required by our additional work.

Our most significant operating costs and expenses are described below.

- *Cost of Revenue.* Cost of revenue includes direct labor, related employee benefits, and overhead. Overhead consists of indirect costs, including indirect labor relating to infrastructure, management and administration, and other expenses.
- *Billable Expenses.* Billable expenses include direct subcontractor expenses, travel expenses, and other expenses incurred to perform on contracts.
- *General and Administrative Expenses.* General and administrative expenses include indirect labor of executive management and corporate administrative functions, marketing and bid and proposal costs, and other discretionary spending.
- *Depreciation and Amortization.* Depreciation and amortization includes the depreciation of computers, leasehold improvements, furniture and other equipment, and the amortization of internally developed software, as well as third-party software that we use internally, and of identifiable long-lived intangible assets over their estimated useful lives.

## ***Seasonality***

The U.S. government's fiscal year ends on September 30 of each year. While not certain, it is not uncommon for U.S. government agencies to award extra tasks or complete other contract actions in the weeks before the end of its fiscal year in order to avoid the loss of unexpended fiscal year funds. In addition, we also have historically experienced higher bid and proposal costs in the months leading up to the U.S. government's fiscal year end as we pursue new contract opportunities being awarded shortly after the U.S. government fiscal year end as new opportunities are expected to have funding appropriated in the U.S. government's subsequent fiscal year. We may continue to experience this seasonality in future periods, and our future periods may be affected by it. While not certain, changes in the government's funding and spending patterns have altered historical seasonality trends, supporting our approach to managing the business on an annual basis.

Seasonality is just one of a number of factors, many of which are outside of our control, which may affect our results in any period. See "Item 1A. Risk Factors."

## **Critical Accounting Estimates and Policies**

Our discussion and analysis of our financial condition and results of operations are based on our consolidated financial statements, which have been prepared in accordance with GAAP. The preparation of these consolidated financial statements in accordance with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and the disclosure of contingencies at the date of the consolidated financial statements as well as the reported amounts of revenue and expenses during the reporting period. Management evaluates these estimates and assumptions on an ongoing basis. Our estimates and assumptions have been prepared on the basis of the most current reasonably available information. Actual results may differ from these estimates under different assumptions or conditions.

Our significant accounting policies, including the critical policies and practices listed below, are more fully described and discussed in the notes to the consolidated financial statements. We consider the following accounting policies to be critical to an understanding of our financial condition and results of operations because these policies require the most difficult, subjective or complex judgments on the part of our management in their application, often as a result of the need to make estimates about the effect of matters that are inherently uncertain.

### ***Revenue Recognition and Cost Estimation***

Substantially all of our revenue is derived from contracts to provide professional services to the U.S. government and its agencies. In most cases, we recognize revenue as work is performed. We recognize revenue for cost-reimbursable-plus-fixed-fee contracts with the U.S. government as hours are worked based on reimbursable and allowable costs, recoverable indirect costs and an accrual for the fixed fee component of these contracts. Executive compensation that we determine to be allowable for cost reimbursement based on management's estimates is recognized as revenue, net of reserves. Management's estimates in this regard are based on a number of factors that may change over time, including executive compensation survey data, our and other government contractors' experiences with the DCAA audit practices in our industry, and relevant decisions of courts and boards of contract appeals. Many of our U.S. government contracts include award fees, which are earned based on the client's evaluation of our performance. We have significant history with the client for the majority of contracts on which we earn award fees. That history and management's evaluation and monitoring of performance form the basis for our ability to estimate such fees over the life of the contract. Based on these estimates, we recognize award fees as work on the contracts is performed. Revisions to these estimates may result in increases or decreases to revenue and income, and are reflected in the consolidated financial statements in periods in which they are identified. Historically, revisions to these estimates have not had a material effect on our results of operations.

Revenue for time-and-materials contracts is recognized as services are performed, generally on the basis of contract allowable labor hours worked multiplied by the contract-defined billing rates, plus allowable direct costs and indirect cost allocations associated with materials used and other direct expenses incurred in connection with the performance of the contract.

For fixed-price contracts, we primarily recognize revenue on the percentage-of-completion basis with progress toward completion of a particular contract based on actual costs incurred relative to total estimated costs to be incurred over the life of the contract. On some fixed-price contracts we may use an alternative input method to calculate the percent complete, such as labor hours or labor dollars. This method is used when a contract contains significant, up-front material purchases resulting in costs incurred that are not representative of the actual progress on the contract. Profits on fixed-price contracts result from the difference between the incurred costs used to calculate the percentage of completion and the revenue earned. These methods are followed where reasonably dependable estimates of revenue and costs under the contract can be made. If we are unable to reasonably estimate revenue or cost, the completed contract method is used. Historically, we have been able to reasonably estimate total contract revenue and costs and such estimates are regularly reviewed. Recorded revenue and costs are subject to revision as the contract progresses. Such revisions may result in increases or decreases to revenue and income, and are reflected in the consolidated financial statements in the periods in which they are first identified. If our estimates indicate that a contract

loss will occur, a loss provision is recorded in the period in which the loss first becomes probable and reasonably estimable. Estimating costs under our long-term contracts is complex and involves significant judgment. Factors that must be considered in making estimates include labor productivity and availability, the nature and technical complexity of the work to be performed, potential performance delays, warranty obligations, availability and timing of funding from the client, progress toward completion, and recoverability of claims. Adjustments to original estimates are often required as work progresses and additional information becomes known, even though the scope of the work required under the contract may not change. Any adjustment as a result of a change in estimates is made when facts develop, events become known, or an adjustment is otherwise warranted, such as in the case of a contract modification. We have procedures and processes in place to monitor the actual progress of a project against estimates and our estimates are updated if circumstances are warranted. Historically, revisions to our estimates have not had a material effect on our results of operations.

### ***Business Combinations***

The accounting for the Company's business combinations consists of allocating the purchase price to tangible and intangible assets acquired and liabilities assumed based on their fair values, with the excess recorded as goodwill. Certain fair value measurements include inputs that are unobservable, requiring management to make judgments and estimates that can be affected by contract performance and other factors that may cause final amounts to differ materially from original estimates. We have up to one year from the acquisition date to use additional information obtained to adjust the fair value of the acquired assets and liabilities which may result in changes to the recorded values with an offsetting adjustment to goodwill.

### ***Goodwill and Intangible Assets Impairment***

We test goodwill and trade name for impairment at least annually as of January 1 of each year and more frequently if interim indicators of impairment exist. We perform our impairment testing of goodwill at the reporting level. As our business is highly integrated and all of our components have similar economic characteristics, we conclude that we have one reporting unit at the consolidated entity level, which is the same as our single operating segment. We test goodwill for impairment using the quantitative method (primarily based on market capitalization). We test the trade name for impairment using the relief from royalty method that requires management to make significant amount of judgments and estimates in the valuation.

Amortizable intangible assets are tested for impairment when an event occurs or circumstances change indicating that the carrying amount of the asset may not be recoverable. A significant amount of management judgment is required to determine if an event representing an impairment indicator has occurred during the year, including but not limited to: a decline in forecasted cash flows; a sustained, material decline in the stock price and market capitalization; a significant adverse change in the business climate or economy; or unanticipated competition. An adverse change in any of these factors could have a significant impact on the recoverability of other intangible assets.

During the fiscal years ended March 31, 2018 and 2016, the Company did not record any impairment of intangible assets. During the fiscal year ended March 31, 2017, the Company recorded impairment charges of \$3.8 million related to intangible assets acquired in a historical acquisition. We do not consider goodwill, trade name, or any other amortizable intangible assets at risk of impairment.

### ***Share-Based Payments***

We use the Black-Scholes option-pricing model to estimate the fair value for stock options. Critical inputs into the Black-Scholes option-pricing model include the following: option exercise price, fair value of the stock price, expected life of the option, annualized volatility of the stock, annual rate of quarterly dividends on the stock, and the risk-free interest rate.

During fiscal 2018, the Company's Board of Directors authorized and declared recurring cash dividends in the amount of \$0.17 per share (declared in the first three quarters) and \$0.19 per share (declared in the fourth quarter) to holders of Booz Allen Holding's Class A Common Stock. Therefore, an annualized dividend yield between 1.89% and 2.00% was used in the Black-Scholes option-pricing model for all grants made during the fiscal year. Implied volatility is calculated as of each grant date based on our historical volatility. Other than the expected life of the option, volatility is the most sensitive input to our option grants. The expected term is estimated using historical exercise patterns of our equity award recipients.

The risk-free interest rate used in the Black-Scholes option-pricing model is determined by referencing the U.S. Treasury yield curve rates with the remaining term equal to the expected life assumed at the date of grant.

Forfeitures for our stock option awards are estimated based on our historical analysis of attrition levels and updated annually. We do not expect this assumption to change materially, as attrition levels associated with new option grants have not materially changed.

As a public company, we use the closing price of our Class A Common Stock on the grant date for valuation purposes.

## ***Accounting for Income Taxes***

Provisions for federal, state, and foreign income taxes are calculated from the income reported on our consolidated financial statements based on current tax law and also include the cumulative effect of any changes in tax rates from those previously used in determining deferred tax assets and liabilities. Such provisions differ from the amounts currently receivable or payable because certain items of income and expense are recognized in different time periods for purposes of preparing consolidated financial statements than for income tax purposes.

Significant judgment is required in determining income tax provisions and evaluating tax positions. We establish reserves for uncertain tax positions when, despite the belief that our tax positions are supportable, there remains uncertainty in a tax position taken in our previously filed income tax returns. For tax positions where it is more likely than not that a tax benefit will be sustained, we record the largest amount of tax benefit with a greater than 50% likelihood of being realized upon settlement with a taxing authority that has full knowledge of all relevant information. To the extent we prevail in matters for which accruals have been established or are required to pay amounts in excess of reserves, our effective tax rate in a given consolidated financial statement period may be materially impacted.

The carrying value of our net deferred tax assets assumes that we will be able to generate sufficient future taxable income in certain tax jurisdictions to realize the value of these assets. If we are unable to generate sufficient future taxable income in these jurisdictions, a valuation allowance is recorded when it is more likely than not that the value of the deferred tax assets is not realizable.

The 2017 Tax Act significantly changes how the Company is taxed, requiring complex computations to be performed and significant judgments to be made in interpretation of the provisions. Subsequent to the enactment of the 2017 Tax Act, the SEC staff issued Staff Accounting Bulletin No. 118, Income Tax Accounting Implications of the Tax Cuts and Jobs Act ("SAB 118"), which provides guidance on accounting for the tax effects of the 2017 Tax Act. SAB 118 provides a measurement period that should not extend beyond one year from the 2017 Tax Act enactment date for companies to complete the accounting under Accounting Standards Codification No. 740, "Income Taxes" (ASC 740). In accordance with SAB 118, the Company must reflect the income tax effects of those aspects of the 2017 Tax Act for which the accounting under ASC 740 is complete. To the extent the Company is accounting for certain income tax effects of the 2017 Tax Act which are incomplete but a reasonable estimate can be determined, the company must record a provisional estimate in the financial statements. As noted in "Item 1A. Risk Factors-Risks Related to Our Business--Changes in tax law, including the 2017 Tax Act, could adversely impact our results of operations", our assessment of the 2017 Tax Act may be significantly affected by regulations and interpretive guidance expected to be issued by the tax authorities, clarifications of the accounting treatment of various items, our additional analysis, and our refinement of our estimates of the effects of the 2017 Tax Act, and therefore, such final amounts may be materially different than our current provisional amounts, which could materially affect our tax obligations and effective tax rate. For a description of our related accounting policies, refer to Note 2 and Note 13 to our accompanying consolidated financial statements.

### ***Recent Accounting Pronouncements***

See Note 2 to our accompanying audited consolidated financial statements for information related to our adoption of new accounting standards and for information on our anticipated adoption of recently issued accounting standards.

### **Segment Reporting**

We report operating results and financial data in one operating and reportable segment. We manage our business as a single profit center in order to promote collaboration, provide comprehensive functional service offerings across our entire client base, and provide incentives to employees based on the success of the organization as a whole. Although certain information regarding served markets and functional capabilities is discussed for purposes of promoting an understanding of our complex business, we manage our business and allocate resources at the consolidated level of a single operating segment.

### **Basis of Presentation**

The accompanying consolidated financial statements include the accounts of the Company and its wholly-owned subsidiaries, and have been prepared in accordance with GAAP, and the rules and regulations of the U.S. Securities and Exchange Commission, or SEC. All intercompany balances and transactions have been eliminated in consolidation.

The accompanying consolidated financial statements and notes of the Company include its subsidiaries, and the joint ventures and partnerships over which the Company has a controlling financial interest. The Company uses the equity method to account for investments in entities that it does not control if it is otherwise able to exert significant influence over the entities' operating and financial policies.

The Company's fiscal year ends on March 31 and unless otherwise noted, references to fiscal year or fiscal are for fiscal years ended March 31. The accompanying consolidated financial statements present the financial position of the Company as of March 31, 2018 and 2017 and the Company's results of operations for fiscal 2018, fiscal 2017, and fiscal 2016.

Certain amounts reported in the Company's prior year consolidated financial statements have been reclassified to conform to the current year presentation.

## Results of Operations

The following table sets forth items from our consolidated statements of operations for the periods indicated:

	Fiscal Year Ended March 31,			Fiscal 2018 Versus Fiscal 2017	Fiscal 2017 Versus Fiscal 2016
	2018	2017	2016		
	(In thousands)				
Revenue	\$ 6,171,853	\$ 5,804,284	\$ 5,405,738	6.3 %	7.4 %
Operating costs and expenses:					
Cost of revenue	2,867,103	2,691,982	2,580,026	6.5 %	4.3 %
Billable expenses	1,861,312	1,751,077	1,513,083	6.3 %	15.7 %
General and administrative expenses	858,597	817,434	806,509	5.0 %	1.4 %
Depreciation and amortization	64,756	59,544	61,536	8.8 %	(3.2)%
Total operating costs and expenses	5,651,768	5,320,037	4,961,154	6.2 %	7.2 %
Operating income	520,085	484,247	444,584	7.4 %	8.9 %
Interest expense	(82,269)	(62,298)	(70,815)	32.1 %	(12.0)%
Other income (expense), net	188	(10,049)	5,693	NM	NM
Income before income taxes	438,004	411,900	379,462	6.3 %	8.5 %
Income tax expense	132,893	159,410	85,368	(16.6)%	86.7 %
Net income	\$ 305,111	\$ 252,490	\$ 294,094	20.8 %	(14.1)%

NM - Not meaningful

### Fiscal 2018 Compared to Fiscal 2017

#### Revenue

Revenue increased to \$6,171.9 million from \$5,804.3 million, or a 6.3% increase, primarily due to increased client demand which led to increased client staff headcount, and an increase in client staff labor, as well as increases in billable expenses.

#### Cost of Revenue

Cost of revenue increased to \$2,867.1 million from \$2,692.0 million, or a 6.5% increase. This increase was primarily due to an increase in salaries and salary-related benefits of \$168.8 million, higher incentive compensation of \$9.6 million, and an increase in employer retirement plan contributions of \$9.5 million. The increase in salaries and salary-related benefits was driven by an increase in headcount growth and annual base salary increases. Cost of revenue as a percentage of revenue was 46.5% and 46.4% in fiscal 2018 and fiscal 2017, respectively.

#### Billable Expenses

Billable expenses increased to \$1,861.3 million from \$1,751.1 million, or a 6.3% increase. The overall increase was primarily attributable to an increase in use of subcontractors in the current year driven by client demand. In addition, contracts which require the Company to incur travel expenses on behalf of clients increased over the prior year period. Billable expenses as a percentage of revenue were 30.2% for both fiscal 2018 and fiscal 2017.

#### General and Administrative Expenses

General and administrative expenses increased to \$858.6 million from \$817.4 million, or a 5.0% increase. The increase was primarily due to salaries and salary-related benefits of \$43.0 million, driven by headcount growth as well as annual base salary increases, and occupancy costs of \$5.1 million, partially offset by lower incentive compensation of \$9.9 million. General and administrative expenses as a percentage of revenue were 13.9% and 14.1% for fiscal 2018 and fiscal 2017, respectively.

#### *Depreciation and Amortization Expense*

Depreciation and amortization expense increased to \$64.8 million from \$59.5 million, or an 8.8% increase, primarily due to increases in intangible asset amortization related to the Company's acquisition of Aquilent in fiscal 2017, partially offset by a decrease in amortization of other amortizable intangible assets that fully amortized in fiscal 2017.

#### *Interest Expense*

Interest expense increased to \$82.3 million from \$62.3 million, or a 32.1% increase, primarily as a result of interest expense related to the issuance of the Senior Notes in April 2017.

#### *Income Tax Expense*

Income tax expense decreased to \$132.9 million from \$159.4 million, or a 16.6% decrease. The effective tax rate decreased to 30.3% in fiscal 2018 from 38.7% in fiscal 2017 primarily due to the blended federal tax rate benefit of the 2017 Tax Act and provisional estimates for the re-measurement of the existing deferred tax balances. See Note 13 to our consolidated financial statements for additional information. The effective tax rate also decreased with the recognition of excess tax benefits of \$14.5 million being reflected in earnings as a reduction to income tax expense for fiscal 2018. This was driven by the Company's initial adoption of new accounting guidance in the first quarter of fiscal 2018 whereby excess tax benefits on employee share-based payment awards are now recognized in earnings as a reduction to income tax expense instead of as an adjustment to additional paid-in-capital, as was the case historically. See Notes 2 to our consolidated financial statements for additional information on how this accounting change could impact earnings in future periods.

### ***Fiscal 2017 Compared to Fiscal 2016***

#### *Revenue*

Revenue increased to \$5,804.3 million from \$5,405.7 million, or a 7.4% increase, primarily driven by stronger client demand, as evidenced by our backlog growth. The increase in client demand coupled with our increased client staff headcount and client billability, resulted in increases in our direct labor and corresponding generation of revenue growth. Revenue growth was also driven by an increase in billable expenses, including subcontractors and direct material and other direct cost purchases for clients. Conversions to funded backlog during fiscal 2017 totaled \$5.9 billion in comparison to \$5.4 billion for the comparable year with the increase from fiscal 2016 to fiscal 2017 due to the conversion of unfunded backlog to funded backlog, the award of new contracts and task orders under which funding was appropriated, and the subsequent funding of priced options.

#### *Cost of Revenue*

Cost of revenue decreased to \$2,692.0 million from \$2,580.0 million, or a 4.3% decrease. This increase was primarily due to an increase in salaries and salary-related benefits of \$98.4 million and an increase in incentive compensation of \$5.4 million. The increase in salaries and salary-related benefits was driven by an increase in headcount growth, annual base salary increases and consulting staff spending more time on direct contract activities. Cost of revenue as a percentage of revenue was 46.4% and 47.7% in fiscal 2017 and fiscal 2016, respectively.

#### *Billable Expenses*

Billable expenses increased to \$1,751.1 million from \$1,513.1 million, or a 15.7% increase. The overall increase was primarily attributable to an increase in use of subcontractors in fiscal 2017 driven by client demand. In addition, contracts which require the Company to incur direct expenses on behalf of our clients have increased over the prior year period. Billable expenses as a percentage of revenue were 30.2% and 28.0% in fiscal 2017 and fiscal 2016, respectively.

#### *General and Administrative Expenses*

General and administrative expenses increased to \$817.4 million from \$806.5 million, or a 1.4% increase, primarily due to the correction of an immaterial misstatement. In addition, the Company recorded an impairment charge of \$3.8 million for the technologies, customer relationships and other intangible assets related to a business acquisition. These increases were partially offset by decreases in occupancy costs and other business expenses of approximately \$11.6 million. General and administrative expenses as a percentage of revenue were 14.1% and 14.9% for fiscal 2017 and fiscal 2016, respectively.

#### *Depreciation and Amortization Expense*

Depreciation and amortization expense decreased to \$59.5 million from \$61.5 million, or a 3.2% decrease, primarily due to a decrease in depreciation expense resulting from the effect of lower capital expenditures in prior years.

### Interest Expense

Interest expense decreased to \$62.3 million from \$70.8 million, or a 12.0% decrease, primarily as a result of the Third Amendment to the Credit Agreement consummated in July 2016, which reduced interest expense for fiscal 2017 as compared to fiscal 2016.

### Income Tax Expense

Income tax expense increased to \$159.4 million from \$85.4 million, or a 86.7% increase. The effective tax rate increased to 38.7% in fiscal 2017 from 22.5% in fiscal 2016, primarily due to the release of uncertain tax position reserves in fiscal 2016.

### Liquidity and Capital Resources

As of March 31, 2018, our total liquidity was \$787.0 million, consisting of \$287.0 million of cash and cash equivalents and \$500.0 million available under the Revolving Credit Facility. In the opinion of management, we will be able to meet our liquidity and cash needs through a combination of cash flows from operating activities, available cash balances, and available borrowing under the Revolving Credit Facility. If these resources need to be augmented, additional cash requirements would likely be financed through the issuance of debt or equity securities.

The following table presents selected financial information for the periods presented:

	Fiscal Year Ended March 31,		
	2018	2017	2016
	(In thousands)		
Cash and cash equivalents	\$ 286,958	\$ 217,417	\$ 187,529
Total debt	\$ 1,818,579	\$ 1,663,324	\$ 1,597,261
Net cash provided by operating activities	\$ 369,143	\$ 382,277	\$ 249,234
Net cash used in investing activities	(96,453)	(300,896)	(117,753)
Net cash used in financing activities	(203,149)	(51,493)	(151,169)
Total increase (decrease) in cash and cash equivalents	\$ 69,541	\$ 29,888	\$ (19,688)

From time to time we evaluate alternative uses for excess cash resources once our operating cash flow and required debt servicing needs have been met. Some of the possible uses of our remaining excess cash at any point in time may include funding strategic acquisitions, further investment in our business, and returning value to shareholders through share repurchases, recurring dividends, and special dividends. While the timing and financial magnitude of these possible actions are currently indeterminable, the Company expects to be able to manage and adjust its capital structure in the future to meet its liquidity needs.

Historically, we have been able to generate sufficient cash to fund our operations, mandatory debt and interest payments, capital expenditures, and discretionary funding needs. However, due to fluctuations in cash flows, including as a result of the trends and developments described above under "— Factors and Trends Affecting Our Results of Operations" relating to U.S. government cost-cutting, reductions or delays in the U.S. government appropriations and spending process and other budgetary matters, it may be necessary from time-to-time in the future to borrow under our Secured Credit Facility to meet cash demands. While the timing and financial magnitude of these possible actions are currently indeterminable, we expect to be able to manage and adjust our capital structure to meet our liquidity needs. Our expected liquidity and capital structure may also be impacted by discretionary investments and acquisitions that we could pursue. We anticipate that cash provided by operating activities, existing cash and cash equivalents, and borrowing capacity under our Revolving Credit Facility will be sufficient to meet our anticipated cash requirements for the next twelve months, which primarily include:

- operating expenses, including salaries;
- working capital requirements to fund the growth of our business;
- capital expenditures which primarily relate to the purchase of computers, business systems, furniture and leasehold improvements to support our operations;
- commitments and other discretionary investments;
- debt service requirements for borrowings under our Secured Credit Facility and interest payments for the Senior Notes; and
- cash taxes to be paid.

Our ability to fund our operating needs depends, in part, on our ability to continue to generate positive cash flows from operations or, if necessary, raise cash in the capital markets.

### **Cash Flows**

Cash received from clients, either from the payment of invoices for work performed or for advances in excess of costs incurred, is our primary source of cash. We generally do not begin work on contracts until funding is appropriated by the client. Billing timetables and payment terms on our contracts vary based on a number of factors, including whether the contract type is cost-reimbursable, time-and-materials, or fixed-price. We generally bill and collect cash more frequently under cost-reimbursable and time-and-materials contracts, as we are authorized to bill as the costs are incurred or work is performed. In contrast, we may be limited to bill certain fixed-price contracts only when specified milestones, including deliveries, are achieved. In addition, a number of our contracts may provide for performance-based payments, which allow us to bill and collect cash prior to completing the work.

Accounts receivable is the principal component of our working capital and is generally driven by revenue growth with other short-term fluctuations related to the payment practices of our clients. Our accounts receivable reflects amounts billed to our clients as of each balance sheet date. Our clients generally pay our invoices within 30 days of the invoice date. At any month-end, we also include in accounts receivable the revenue that was recognized in the preceding month, which is generally billed early in the following month. Finally, we include in accounts receivable amounts related to revenue accrued in excess of amounts billed, primarily on our fixed-price and cost-reimbursable-plus-award-fee contracts. The total amount of our accounts receivable can vary significantly over time, but is generally sensitive to revenue levels. Total accounts receivable (billed and unbilled combined, net of allowance for doubtful accounts) days sales outstanding, or DSO, which we calculate by dividing total accounts receivable by revenue per day during the relevant fiscal quarter, was 65 as of March 31, 2018 and 60 as of March 31, 2017. DSO increased as a result of sustained revenue growth and the timing of billings and collections associated with that growth.

#### *Operating Cash Flow*

Net cash provided by operations is primarily affected by the overall profitability of our contracts, our ability to invoice and collect cash from clients in a timely manner, and our ability to manage our vendor payments. Continued uncertainty in global economic conditions may also affect our business as customers and suppliers may decide to downsize, defer, or cancel contracts, which could negatively affect the operating cash flows. Net cash provided by operations was \$369.1 million in fiscal 2018 compared to \$382.3 million in the prior year, or a 3.4% decrease. The decrease was primarily the result of higher cash taxes paid during fiscal 2018 and an increase in working capital needs, including an increase in accounts receivable that is consistent with our growth.

#### *Investing Cash Flow*

Net cash used in investing activities was \$96.5 million in fiscal 2018 compared to \$300.9 million in the prior year period, or a 67.9% decrease. The decrease in net cash used in investing activities was due to the Company's acquisition of eGov Holdings, Inc. (d/b/a Aquilent) in fiscal 2017, partially offset by an increase in capital expenditures over the prior year primarily related to the timing of the leasehold improvements to update existing office space.

#### *Financing Cash Flow*

Net cash used in financing activities was \$203.1 million in fiscal 2018 compared to \$51.5 million in the prior year period. The increase in net cash used in financing activities was primarily due to the following:

- An increase in share repurchases over the prior year period of \$223.8 million. In fiscal 2018, the Company repurchased a total of 7.3 million shares of Class A Common Stock, including those related to shares withheld to cover Restricted Stock vesting, for \$260.4 million and also paid \$9.9 million for shares of Class A Common Stock repurchased in fiscal 2017 that settled in fiscal 2018. In fiscal 2017, the Company repurchased a total of 1.3 million shares of Class A Common Stock for \$46.5 million.
- Net borrowings on the Revolving Credit Facility decreased \$225.0 million as compared to the prior year period.
- The above was offset by net proceeds received of \$343.3 million from the issuance of the Senior Notes.

#### **Dividends and Share Repurchases**

The Company paid \$0.70 in dividends per share to shareholders of record in fiscal 2018. On May 29, 2018, the Company announced a regular quarterly cash dividend in the amount of \$0.19 per share. The quarterly dividend is payable on June 29, 2018 to stockholders of record on June 14, 2018.

The following table summarizes the cash distributions recognized in the consolidated statement of cash flows:

	Fiscal Year Ended March 31,		
	2018	2017	2016
	(In thousands)		
Recurring dividends (1)	\$ 103,411	\$ 92,925	\$ 80,015
Dividend equivalents (2)	951	2,254	31,802
Total distributions	<u>\$ 104,362</u>	<u>\$ 95,179</u>	<u>\$ 111,817</u>

(1) Amounts represent recurring dividends that were declared and paid for during each quarter of fiscal 2018, 2017, and 2016, respectively.

(2) Dividend equivalents are distributions made to option holders equal to the previously declared special dividends.

On December 12, 2011, the Board of Directors authorized the repurchase of up to \$30.0 million of our shares. On January 27, 2015, the share repurchase authorization was increased to \$180.0 million. On January 25, 2017, the Board of Directors approved an increase to share repurchase authorization from \$180.0 million to \$410.0 million. On November 2, 2017, the Board of Directors approved an increase to our share repurchase authorization from \$410.0 million to up to \$610.0 million. During fiscal 2018 and 2017, the Company purchased 7.2 million and 1.3 million shares of the Company's Class A Common Stock for an aggregate of \$257.6 million and \$46.4 million, respectively. Following the aforementioned repurchases as of March 31, 2018, the Company had \$197.9 million remaining under the repurchase program.

On May 24, 2018, the Board of Directors approved an increase to our share repurchase authorization from \$610.0 million to up to \$910.0 million. As of May 24, 2018, taking into effect the increase in the share repurchase authorization, the Company may repurchase up to approximately \$493.7 million of additional shares of common stock under its share repurchase program.

Any determination to pursue one or more of the above alternative uses for excess cash is subject to the discretion of our Board of Directors, and will depend upon various factors, including our results of operations, financial condition, liquidity requirements, restrictions that may be imposed by applicable law, our contracts, and our Credit Agreement, as amended, and other factors deemed relevant by our Board of Directors.

#### **Indebtedness**

Our debt totaled \$1,818.6 million and \$1,663.3 million as of March 31, 2018 and 2017, respectively. Our debt bears interest at specified rates and is held by a syndicate of lenders (see Note 11 to our consolidated financial statements).

On March 7, 2018, Booz Allen Hamilton and Booz Allen Investor, and certain wholly-owned subsidiaries of Booz Allen Hamilton, entered into the Fifth Amendment (the "Fifth Amendment") to the Credit Agreement (the "Credit Agreement"), dated as of July 31, 2012 among Booz Allen Hamilton, Booz Allen Investor, certain wholly owned subsidiaries of Booz Allen Hamilton and Bank of America, N.A., as Administrative Agent, Collateral Agent and Issuing Lender (as previously amended by the First Amendment to Credit Agreement, dated as of August 16, 2013, the Second Amendment to Credit Agreement, date as of May 7, 2014, the Third Amendment to the Credit Agreement, dated as of July 13, 2016 and the Fourth Amendment to the Credit Agreement, dated as of February 6, 2017). Pursuant to the Fifth Amendment, the Company reduced the interest rate spread applicable to Term Loan B ("Term Loan B" and, together with Term Loan A, the "Term Loans"). The interest rate applicable to the Term Loan A ("Term Loan A") is unchanged.

Prior to the Fifth Amendment, approximately \$395 million were outstanding under the Term Loan B. Pursuant to the Fifth Amendment, certain lenders converted their existing Term Loan B loans into a new tranche of Term Loan B loans in an aggregate amount, along with Term Loan B loans advances by certain new lenders, of approximately \$395 million. The proceeds from the new lenders were used to prepay in full all of the existing Term B Loans that were not converted into the Term Loan B tranche.

As of March 31, 2018, the Credit Agreement, as amended, provided the Company with a \$1,094 million Term Loan A and a \$395 million Term Loan B, and a \$500.0 million Revolving Credit Facility, with a sublimit for letters of credit of \$100.0 million. As of March 31, 2018, the maturity date of Term Loan A and the termination date for the Revolving Credit Facility was June 30, 2021 and the maturity date of Term Loan B was June 30, 2023. Booz Allen Hamilton's obligations and the guarantors' guarantees under the Credit Agreement, as amended, are secured by a first priority lien on substantially all of the assets (including capital stock of subsidiaries) of Booz Allen Hamilton, Investor and the subsidiary guarantors, subject to certain exceptions set forth in the Credit Agreement, as amended, and related documentation. Subject to specified conditions, without the consent of the then-existing lenders (but subject to the receipt of commitments), the Term Loans or Revolving Credit Facility may be expanded (or a new term loan facility or revolving credit facility added to the existing facilities) by up to (i)

\$400 million plus (ii) the aggregate principal amount under which pro forma consolidated net secured leverage remains less than or equal to 3.50:1.00.

At Booz Allen Hamilton's option, borrowings under Term Loan A and Revolving Credit Facility bear interest based either on LIBOR (adjusted for maximum reserves, and subject to a floor of zero) for the applicable interest period or a base rate (equal to the highest of (x) the administrative agent's prime corporate rate, (y) the overnight federal funds rate plus 0.50% and (z) three-month LIBOR (adjusted for maximum reserves, and subject to a floor of zero) plus 1.00%), in each case plus an applicable margin, payable at the end of the applicable interest period and in any event at least quarterly. The applicable margin for Term Loan A and borrowings under the Revolving Credit Facility ranges from 1.50% to 2.25% for LIBOR loans and 0.50% to 1.25% for base rate loans, in each case based on Booz Allen Hamilton's consolidated total net leverage ratio. Unused commitments under the Revolving Credit Facility are subject to a quarterly fee ranging from 0.30% to 0.40% based on Booz Allen Hamilton's consolidated total net leverage ratio.

Under the Fifth Amendment, the rate at which Term Loan B bears interest is based on LIBOR (adjusted for maximum reserves and subject to a floor of zero plus 2.00% for the applicable interest period) or a base rate (equal to the highest of (x) the corporate base rate established by the administrative agent, (y) the overnight federal funds rate plus 0.50%, (z) three-month LIBOR (adjusted for maximum reserves) plus 1.00%, plus, in each case, 1.25%, payable at the end of the applicable interest period; provided, that if such rate shall be less than zero, such rate shall be deemed to be zero.

Booz Allen Hamilton occasionally borrows under the Revolving Credit Facility in anticipation of cash demands. During fiscal 2018 and 2017, Booz Allen Hamilton accessed a total of \$125.0 million and \$575.0 million, respectively of its \$500.0 million Revolving Credit Facility. As of March 31, 2018, there was no outstanding balance on the Revolving Credit Facility. As of March 31, 2017, \$130.0 million was outstanding on the Revolving Credit Facility.

The Credit Agreement, as amended, requires quarterly principal payments of 1.25% of the stated principal amount of Term Loan A until maturity, and quarterly principal payments of 0.25% of the stated principal amount of Term Loan B until maturity.

We also have agreed to pay customary letter of credit and agency fees. As of March 31, 2018 and 2017, we were contingently liable under open standby letters of credit and bank guarantees issued by our banks in favor of third parties that totaled \$6.3 million and \$8.6 million, respectively. These letters of credit and bank guarantees primarily support insurance and bid and performance obligations. At March 31, 2018 and 2017, approximately \$1.4 million and \$1.7 million of these instruments reduce our available borrowings under the Revolving Credit Facility. The remainder is guaranteed under a separate \$15.0 million facility established in fiscal 2015, of which \$10.1 million and \$3.1 million, respectively, was available to us at March 31, 2018 and 2017. As of March 31, 2018, we had \$498.6 million of capacity available for additional borrowings under the Revolving Credit Facility.

The Credit Agreement, as amended, contains customary representations and warranties and customary affirmative and negative covenants. The negative covenants include limitations on the following, in each case subject to certain exceptions: (i) indebtedness and liens; (ii) mergers, consolidations or amalgamations, liquidations, wind-ups or dissolutions, and disposition of all or substantially all assets; (iii) dispositions of property; (iv) restricted payments; (v) investments; (vi) transactions with affiliates; (vii) sale and lease back transactions; (viii) change in fiscal periods; (ix) negative pledges; (x) restrictive agreements; (xi) line of business; and (xii) speculative hedging. The events of default include the following, in each case subject to certain exceptions: (a) failure to make required payments under the Secured Credit Facility; (b) material breaches of representations or warranties under the Secured Credit Facility; (c) failure to observe covenants or agreements under the Secured Credit Facility; (d) failure to pay or default under certain other material indebtedness; (e) bankruptcy or insolvency; (f) certain ERISA events; (g) certain material judgments; (h) actual or asserted invalidity of the Guarantee and Collateral Agreements or the other security documents or failure of the guarantees or perfected liens thereunder; and (i) a change of control. In addition, we are required to meet certain financial covenants at each quarter end, namely Consolidated Net Total Leverage and Consolidated Net Interest Coverage Ratios. As of March 31, 2018, we were compliant with these covenants.

During fiscal 2018, interest payments of \$38.1 million and \$14.9 million were made for the Term Loan A and Term Loan B facilities, respectively. During fiscal 2017, interest payments of \$28.8 million and \$19.5 million were made for the Term Loan A and Term Loan B facilities, respectively.

The total outstanding debt balance is recorded in the accompanying consolidated balance sheets net of unamortized discount and debt issuance costs of \$20.7 million and \$18.1 million as of March 31, 2018 and 2017, respectively.

On April 25, 2017, Booz Allen Hamilton issued \$350 million aggregate principal amount of its 5.125% Senior Notes due 2025 under an Indenture, dated April 25, 2017, among Booz Allen Hamilton, certain subsidiaries of Booz Allen Hamilton, as guarantors (the "Subsidiary Guarantors"), and Wilmington Trust, National Association, as trustee (the "Trustee"), as supplemented by the First Supplemental Indenture, dated as of April 25, 2017, among Booz Allen Hamilton, the Subsidiary Guarantors and the Trustee. A portion of the proceeds was used to repay all outstanding loans under the Revolving Credit

Facility. We intend to use the remaining proceeds for working capital and other general corporate purposes, which may include the repayment of a portion or all of the outstanding DPO. During fiscal 2018, interest payments of \$9.3 million were made for the Senior Notes. There were no similar payments made or required in fiscal 2017. (see Note 11 to our consolidated financial statements).

Borrowings under our Term Loans, and if used, our Revolving Credit Facility, incur interest at a variable rate. In accordance with our risk management strategy between April 6, 2017 and May 24, 2017, Booz Allen Hamilton executed a series of interest rate swaps. As of March 31, 2018, we had interest rate swaps with an aggregate notional amount of \$450 million. These instruments hedge the variability of cash outflows for interest payments on the floating portion of our debt. The Company's objectives in using cash flow hedges are to reduce volatility due to interest rate movements and to add stability to interest expense (see Note 12 in our consolidated financial statements).

### Capital Structure and Resources

Our stockholders' equity amounted to \$554.6 million as of March 31, 2018, a decrease of \$19.0 million compared to stockholders' equity of \$573.6 million as of March 31, 2017. The decrease was primarily due to a \$269.6 million increase in treasury stock resulting from the repurchase of shares of our Class A Common Stock and \$103.4 million in dividend payments during fiscal 2018. These were partially offset by net income of \$305.1 million, stock-based compensation expense of \$23.3 million, and stock option exercises of \$12.1 million in fiscal 2018.

### Off-Balance Sheet Arrangements

As of March 31, 2018, we did not have any material off-balance sheet arrangements.

### Contractual Obligations

The following table summarizes our contractual obligations that require us to make future cash payments as of March 31, 2018. For contractual obligations, we included payments that we have an unconditional obligation to make.

	Payments Due by Fiscal Periods				
	Total	Less Than 1 Year	1 to 3 Years	3 to 5 Years	More Than 5 years
	(In thousands)				
Long-term debt (a)	\$ 1,839,275	\$ 63,100	\$ 126,200	\$ 924,725	\$ 725,250
Operating lease obligations	423,507	71,013	123,032	87,573	141,889
Interest on indebtedness	342,586	75,549	143,806	74,710	48,521
Deferred payment obligation (b)	83,333	83,333	—	—	—
Payments to the Booz Allen Foundation (c)	3,333	3,333	—	—	—
Liability to option holders (d)	280	280	—	—	—
Tax liabilities for uncertain tax positions (e)	11,787	519	11,268	—	—
Total contractual obligations	<u>\$ 2,704,101</u>	<u>\$ 297,127</u>	<u>\$ 404,306</u>	<u>\$ 924,725</u>	<u>\$ 915,660</u>

(a) See Note 11 to our consolidated financial statements for additional information regarding debt and related matters.

(b) Includes \$80 million deferred payment obligation balance plus interest due within the next year.

(c) See Note 20 to our consolidated financial statements for a discussion of the Company's binding and irrevocable pledge to the Booz Allen Foundation.

(d) Reflects liabilities to holders of stock options issued under the Equity Incentive Plan, as amended, as a result of special dividends paid in November 2013, and February and August 2014.

(e) Reflects a reserve of \$10.2 million for income tax uncertainties created with the acquisition discussed in Note 4 to our consolidated financial statements.

In the normal course of business, we enter into agreements with subcontractors and vendors to provide products and services that we consume in our operations or that are delivered to our clients. These products and services are not considered unconditional obligations until the products and services are actually delivered, at which time we record a liability for our obligation.

## **Capital Expenditures**

Since we do not own any of our facilities, our capital expenditure requirements primarily relate to the purchase of computers, business systems, furniture, and leasehold improvements to support our operations. Direct facility and equipment costs billed to clients are not treated as capital expenses. Our capital expenditures for fiscal 2018 and 2017 were \$78.4 million and \$53.9 million, respectively, and the majority of such capital expenditures related to facilities infrastructure, equipment, and information technology. The increase in capital expenditures over the prior year primarily related to the timing of the leasehold improvements to update existing office space. Expenditures for facilities infrastructure and equipment are generally incurred to support new and existing programs across our business. We also incur capital expenditures for information technology to support programs and general enterprise information technology infrastructure. We expect capital expenditures for fiscal 2019 to increase from fiscal 2018 as a result of increased investments in our facilities, infrastructure, systems, and technology to support our continued growth.

## **Commitments and Contingencies**

We are subject to a number of reviews, investigations, claims, lawsuits, and other uncertainties related to our business. For a discussion of these items, refer to Note 21 to our consolidated financial statements.

**Item 7A. Quantitative and Qualitative Disclosures About Market Risk**

Market risk is the potential loss arising from adverse changes in market rates and market prices such as those related to interest rates. We actively monitor these exposures and manage such risks through our regular operating and financing activities or through the use of derivative financial instruments.

Our exposure to market risk for changes in interest rates relates primarily to our outstanding debt and cash equivalents, which consist primarily of funds invested in U.S. government money-market funds, and our cash flow hedges. As of March 31, 2018 and 2017, we had \$287.0 million and \$217.4 million, respectively, in cash and cash equivalents. The interest expense associated with our term loans and any loans under our revolving credit facility will vary with market rates.

Our exposure to market risk for changes in interest rates related to our outstanding debt will impact our Secured Credit Facility. A hypothetical interest rate increase of 1% would have increased interest expense related to the term facilities under our Secured Credit Facility by approximately \$14.9 million in fiscal 2018 and \$15.5 million in fiscal 2017, and likewise decreased our income and cash flows. As the Company's interest rate swaps are forward starting in nature, with a start date of April 30, 2018, they will not reduce interest expense until fiscal 2019. The year over year increase in interest expense is primarily due to the April 2017 issuance of the Senior Notes. Additionally, 1 Month LIBOR, the benchmark interest rate attached to our floating rate debt, rose approximately 90 basis points throughout fiscal 2018, further contributing to the Company's increased interest expense. This increase in LIBOR was partially offset with a 25 basis point reduction in our Term Loan B credit spread as part of the Fifth Amendment on March 7, 2018.

The return on our cash and cash equivalents balance as of March 31, 2018 and 2017 was less than 2%. Therefore, the corresponding impact to our interest income, and likewise to our income and cash flow, was not material.

Pursuant to our interest rate risk management strategies, we began using interest rate cash flow hedges in April 2017 to add stability to our incurrence of interest rate expense and to manage our exposure to related interest rate movement. See Note 12 to our consolidated financial statements for further discussion. As of March 31, 2018, we had interest rate swaps with an aggregate notional amount of \$450 million. These derivative instruments hedge the variability of cash outflows for interest payments on our variable rate debt and are recorded at fair value on our consolidated balance sheet. As of March 31, 2018, a 25 basis point increase in interest rates would increase the fair value of our interest rate swaps by approximately \$3.7 million and a 25 basis point decrease in interest rates would decrease the fair value of our interest rate swaps by approximately \$3.7 million.

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**Report of Ernst & Young LLP,  
Independent Registered Public Accounting Firm**

To the Shareholders and Board of Directors of  
Booz Allen Hamilton Holding Corporation

**Opinion on the Financial Statements**

We have audited the accompanying consolidated balance sheets of Booz Allen Hamilton Holding Corporation (the Company) as of March 31, 2018 and 2017, the related consolidated statements of operations, comprehensive income, stockholders' equity and cash flows for each of the three years in the period ended March 31, 2018 and the related notes (collectively referred to as the "consolidated financial statements"). In our opinion, the consolidated financial statements present fairly, in all material respects, the consolidated financial position of the Company at March 31, 2018 and 2017, and the consolidated results of its operations and its cash flows for each of the three years in the period ended March 31, 2018, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the Company's internal control over financial reporting as of March 31, 2018, based on criteria established in Internal Control-Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) and our report dated May 29, 2018 expressed an unqualified opinion thereon.

**Basis for Opinion**

These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audits in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement, whether due to error or fraud. Our audits included performing procedures to assess the risks of material misstatement of the financial statements, whether due to error or fraud, and performing procedures that respond to those risks. Such procedures included examining, on a test basis, evidence regarding the amounts and disclosures in the financial statements. Our audits also included evaluating the accounting principles used and significant estimates made by management, as well as evaluating the overall presentation of the financial statements. We believe that our audits provide a reasonable basis for our opinion.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2006  
Tysons, Virginia  
May 29, 2018

**BOOZ ALLEN HAMILTON HOLDING CORPORATION**  
**CONSOLIDATED BALANCE SHEETS**

	March 31, 2018	March 31, 2017
	(Amounts in thousands, except share and per share data)	
<b>ASSETS</b>		
Current assets:		
Cash and cash equivalents	\$ 286,958	\$ 217,417
Accounts receivable, net of allowance	1,130,452	991,810
Prepaid expenses and other current assets	71,309	85,253
Total current assets	1,488,719	1,294,480
Property and equipment, net of accumulated depreciation	169,896	139,167
Deferred tax assets	—	10,825
Intangible assets, net of accumulated amortization	260,972	271,880
Goodwill	1,581,146	1,571,190
Other long-term assets	102,633	85,563
Total assets	<u>\$ 3,603,366</u>	<u>\$ 3,373,105</u>
<b>LIABILITIES AND STOCKHOLDERS' EQUITY</b>		
Current liabilities:		
Current portion of long-term debt	\$ 63,100	\$ 193,150
Accounts payable and other accrued expenses	557,559	504,117
Accrued compensation and benefits	282,750	263,816
Other current liabilities	132,757	140,318
Total current liabilities	1,036,166	1,101,401
Long-term debt, net of current portion	1,755,479	1,470,174
Income tax reserves	11,787	11,647
Deferred tax liabilities	4,485	—
Other long-term liabilities	240,821	216,292
Total liabilities	3,048,738	2,799,514
Commitments and contingencies (Note 21)		
Stockholders' equity:		
Common stock, Class A — \$0.01 par value — authorized, 600,000,000 shares; issued, 158,028,673 shares at March 31, 2018 and 155,901,485 shares at March 31, 2017; outstanding, 143,446,539 shares at March 31, 2018 and 148,887,708 shares at March 31, 2017	1,580	1,559
Treasury stock, at cost — 14,582,134 shares at March 31, 2018 and 7,013,777 shares at March 31, 2017	(461,457)	(191,900)
Additional paid-in capital	346,958	302,907
Retained earnings	682,653	478,102
Accumulated other comprehensive loss	(15,106)	(17,077)
Total stockholders' equity	554,628	573,591
Total liabilities and stockholders' equity	<u>\$ 3,603,366</u>	<u>\$ 3,373,105</u>

The accompanying notes are an integral part of these Consolidated Financial Statements.

**BOOZ ALLEN HAMILTON HOLDING CORPORATION**  
**CONSOLIDATED STATEMENTS OF OPERATIONS**

	Fiscal Year Ended March 31,		
	2018	2017	2016
	(Amounts in thousands, except per share data)		
Revenue	\$ 6,171,853	\$ 5,804,284	\$ 5,405,738
Operating costs and expenses:			
Cost of revenue	2,867,103	2,691,982	2,580,026
Billable expenses	1,861,312	1,751,077	1,513,083
General and administrative expenses	858,597	817,434	806,509
Depreciation and amortization	64,756	59,544	61,536
Total operating costs and expenses	5,651,768	5,320,037	4,961,154
Operating income	520,085	484,247	444,584
Interest expense	(82,269)	(62,298)	(70,815)
Other income (expense), net	188	(10,049)	5,693
Income before income taxes	438,004	411,900	379,462
Income tax expense	132,893	159,410	85,368
Net income	\$ 305,111	\$ 252,490	\$ 294,094
Earnings per common share (Note 3):			
Basic	\$ 2.08	\$ 1.69	\$ 1.98
Diluted	\$ 2.05	\$ 1.67	\$ 1.94

The accompanying notes are an integral part of these Consolidated Financial Statements.

**BOOZ ALLEN HAMILTON HOLDING CORPORATION**  
**CONSOLIDATED STATEMENTS OF COMPREHENSIVE INCOME**

	Fiscal Year Ended March 31,		
	2018	2017	2016
	(Amounts in thousands)		
Net income	\$ 305,111	\$ 252,490	\$ 294,094
Other comprehensive income, net of tax:			
Unrealized gain on derivatives designated as cash flow hedges	4,993	—	
Change in postretirement plan costs	(171)	2,536	2,546
Total other comprehensive (loss) income, net of tax	\$ 4,822	\$ 2,536	\$ 2,546
Comprehensive income	\$ 309,933	\$ 255,026	\$ 296,640

The accompanying notes are an integral part of these Consolidated Financial Statements.

**BOOZ ALLEN HAMILTON HOLDING CORPORATION**  
**CONSOLIDATED STATEMENTS OF CASH FLOWS**

	Fiscal Year Ended March 31,		
	2018	2017	2016
(Amounts in thousands)			
<b>Cash flows from operating activities</b>			
Net income	\$ 305,111	\$ 252,490	\$ 294,094
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	64,756	59,544	61,536
Stock-based compensation expense	23,318	21,249	24,992
Deferred income taxes	13,505	15,536	3,549
Excess tax benefits from stock-based compensation	(14,457)	(18,175)	(31,924)
Amortization of debt issuance costs and loss on extinguishment	5,974	15,566	8,359
Losses (gains) on dispositions and impairments	(246)	4,673	547
Changes in assets and liabilities:			
Accounts receivable	(135,870)	(87,154)	(31,229)
Income taxes receivable / payable	9,636	54,564	(4,170)
Prepaid expenses and other current assets	14,119	(115)	24,873
Other long-term assets	(12,394)	(10,146)	(49,060)
Accrued compensation and benefits	11,296	21,535	(8,409)
Accounts payable and other accrued expenses	47,316	14,846	4,911
Accrued interest	6,218	(806)	(2,829)
Income tax reserves	140	(91)	(56,927)
Other current liabilities	6,461	13,256	66,031
Other long-term liabilities	24,260	25,505	(55,110)
Net cash provided by operating activities	369,143	382,277	249,234
<b>Cash flows from investing activities</b>			
Purchases of property and equipment	(78,437)	(53,919)	(66,635)
Payments for business acquisitions, net of cash acquired	(19,113)	(247,627)	(51,118)
Insurance proceeds received for damage to equipment	1,097	650	—
Net cash used in investing activities	(96,453)	(300,896)	(117,753)
<b>Cash flows from financing activities</b>			
Proceeds from issuance of common stock	8,907	6,314	5,977
Stock option exercises	12,095	14,687	7,962
Excess tax benefits from stock-based compensation	—	18,175	31,924
Repurchases of common stock	(270,318)	(46,548)	(63,152)
Cash dividends paid	(103,411)	(92,925)	(80,015)
Dividend equivalents paid to option holders	(951)	(2,254)	(31,802)
Repayment of debt	(317,149)	(968,325)	(295,063)
Proceeds from debt issuance	467,678	1,019,383	273,000
Net cash used in financing activities	(203,149)	(51,493)	(151,169)
Net increase (decrease) in cash and cash equivalents	69,541	29,888	(19,688)
Cash and cash equivalents—beginning of year	217,417	187,529	207,217
Cash and cash equivalents—end of year	\$ 286,958	\$ 217,417	\$ 187,529
<b>Supplemental disclosures of cash flow information</b>			
Cash paid during the period for:			
Interest	\$ 62,498	\$ 49,062	\$ 57,068
Income taxes	\$ 128,416	\$ 89,556	\$ 143,083
<b>Supplemental disclosures of non-cash investing and financing activities</b>			
Share repurchases transacted but not settled and paid	\$ 9,146	\$ 9,907	\$ —
Contingent consideration arising from businesses acquired	\$ —	\$ 3,576	\$ —

The accompanying notes are an integral part of these Consolidated Financial Statements.

**BOOZ ALLEN HAMILTON HOLDING CORPORATION**  
**CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY**

(Amounts in thousands, except share data)	Class A Common Stock		Class E Special Voting Common Stock		Treasury Stock		Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Stockholders' Equity
	Shares	Amount	Shares	Amount	Shares	Amount				
<b>Balance at March 31, 2015</b>	150,237,675	\$ 1,502	1,851,589	\$ 6	(2,999,393)	\$ (72,293)	\$174,985	\$ 104,457	\$ (22,159)	\$ 186,498
Issuance of common stock	443,813	4	0	—	0	—	5,973	—	—	5,977
Stock options exercised	2,709,570	28	(1,851,589)	(6)	0	—	7,940	—	—	7,962
Excess tax benefits from the exercise of stock options	0	—	0	—	0	—	31,924	—	—	31,924
Repurchase of common stock	0	—	0	—	(2,399,203)	(63,152)	—	—	—	(63,152)
Recognition of liability related to future stock option exercises (Note 18)	0	—	0	—	0	—	(2,339)	—	—	(2,339)
Net income	0	—	0	—	0	—	—	294,094	—	294,094
Other comprehensive income, net of tax	0	—	0	—	0	—	—	—	2,546	2,546
Dividends paid (Note 17)	0	—	0	—	0	—	—	(80,014)	—	(80,014)
Stock-based compensation expense	0	—	0	—	0	—	24,992	—	—	24,992
<b>Balance at March 31, 2016</b>	153,391,058	\$ 1,534	0	\$ —	(5,398,596)	\$ (135,445)	\$243,475	\$ 318,537	\$ (19,613)	\$ 408,488
Issuance of common stock	578,932	6	0	—	0	—	6,308	—	—	6,314
Stock options exercised	1,931,495	19	0	—	0	—	14,668	—	—	14,687
Excess tax benefits from the exercise of stock options	0	—	0	—	0	—	18,175	—	—	18,175
Repurchase of common stock	0	—	0	—	(1,615,181)	(56,455)	—	—	—	(56,455)
Recognition of liability related to future stock option exercises (Note 18)	0	—	0	—	0	—	(968)	—	—	(968)
Net income	0	—	0	—	0	—	—	252,490	—	252,490
Other comprehensive income, net of tax	0	—	0	—	0	—	—	—	2,536	2,536
Dividends paid (Note 17)	0	—	0	—	0	—	—	(92,925)	—	(92,925)
Stock-based compensation expense	0	—	0	—	0	—	21,249	—	—	21,249
<b>Balance at March 31, 2017</b>	155,901,485	\$ 1,559	0	\$ —	(7,013,777)	\$ (191,900)	\$302,907	\$ 478,102	\$ (17,077)	\$ 573,591
Issuance of common stock	866,099	8	0	—	0	—	8,899	—	—	8,907
Stock options exercised	1,261,089	13	0	—	0	—	12,082	—	—	12,095
Excess tax benefits from the exercise of stock options	0	—	0	—	0	—	—	—	—	—
Repurchase of common stock	0	—	0	—	(7,568,357)	(269,557)	—	—	—	(269,557)
Recognition of liability related to future stock option exercises (Note 18)	0	—	0	—	0	—	(248)	—	—	(248)
Net income	0	—	0	—	0	—	—	305,111	—	305,111
Reclassification of AOCI due to the Act (Note 2)	0	—	0	—	0	—	—	2,851	(2,851)	—
Other comprehensive (loss) income, net of tax	0	—	0	—	0	—	—	—	4,822	4,822
Dividends paid (Note 17)	0	—	0	—	0	—	—	(103,411)	—	(103,411)
Stock-based compensation expense	0	—	0	—	0	—	23,318	—	—	23,318
<b>Balance at March 31, 2018</b>	158,028,673	\$ 1,580	0	\$ —	(14,582,134)	\$ (461,457)	\$346,958	\$ 682,653	\$ (15,106)	\$ 554,628

The accompanying notes are an integral part of these Consolidated Financial Statements.

**BOOZ ALLEN HAMILTON HOLDING CORPORATION**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
(Amounts in tables in thousands, except share and per share data or unless otherwise noted)

**BOOZ ALLEN HAMILTON HOLDING CORPORATION**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
(Amounts in tables in thousands, except share and per share data or unless otherwise noted)  
March 31, 2018

## 1. BUSINESS OVERVIEW

### *Our Business*

Booz Allen Hamilton Holding Corporation, including its wholly owned subsidiaries, or Holding, the Company or we, us, and our, was incorporated in Delaware in May 2008. The Company provides management and technology consulting, engineering, analytics, digital solutions, mission operations, and cyber expertise to U.S. and international governments, major corporations, and not-for-profit organizations. The Company reports operating results and financial data in one reportable segment. The Company is headquartered in McLean, Virginia, with approximately 24,600 employees as of March 31, 2018.

## 2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

### *Basis of Presentation*

The accompanying consolidated financial statements include the accounts of the Company and its wholly owned subsidiaries, and have been prepared in accordance with accounting principles generally accepted in the United States, or U.S. GAAP, and the rules and regulations of the U.S. Securities and Exchange Commission, or SEC. All intercompany balances and transactions have been eliminated in consolidation.

The consolidated financial statements and notes of the Company include its subsidiaries, and the joint ventures and partnerships over which the Company has a controlling financial interest. The Company uses the equity method to account for investments in entities that it does not control if it is otherwise able to exert significant influence over the entities' operating and financial policies.

The Company's fiscal year ends on March 31 and unless otherwise noted, references to fiscal year or fiscal are for fiscal years ended March 31. The accompanying consolidated financial statements present the financial position of the Company as of March 31, 2018 and 2017 and the Company's results of operations for fiscal 2018, fiscal 2017, and fiscal 2016.

Certain amounts reported in the Company's prior year consolidated financial statements have been reclassified to conform to the current year presentation.

### *Use of Estimates*

The preparation of consolidated financial statements in conformity with U.S. GAAP requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the consolidated financial statements, and the reported amounts of revenue and expenses during the reporting periods. Areas of the consolidated financial statements where estimates may have the most significant effect include contractual and regulatory reserves, valuation and lives of tangible and intangible assets, contingent consideration related to business acquisitions, impairment of long-lived assets, accrued liabilities, revenue recognition and costs to complete fixed-price contracts, bonus and other incentive compensation, stock-based compensation, reserves for tax benefits and valuation allowances on deferred tax assets, provisions for income taxes, postretirement obligations, certain deferred costs, collectability of receivables, and loss accruals for litigation. Actual results experienced by the Company may differ materially from management's estimates.

### *Revenue Recognition*

Substantially all of the Company's revenue is derived from services and solutions provided to the U.S. government and its agencies, primarily by the Company's consulting staff and, to a lesser extent, subcontractors. The Company generates its revenue from the following types of contractual arrangements: cost-reimbursable-plus-fee contracts, time-and-materials contracts, and fixed-price contracts.

Revenue on cost-reimbursable-plus-fee contracts is recognized as services are performed, generally based on the allowable costs incurred during the period plus any recognizable earned fee. The Company considers fixed fees under cost-reimbursable-plus-fee contracts to be earned in proportion to the allowable costs incurred in performance of the contract. For cost-reimbursable-plus-fee contracts that include performance-based fee incentives, which are principally award fee arrangements, the Company recognizes income when such fees are probable and estimable. Estimates of the total fee to be earned are made based on contract provisions, prior experience with similar contracts or clients, and management's evaluation of the performance on such contracts. Revisions to these estimates may result in increases or decreases to revenue and income, and are reflected in the consolidated financial statements in periods in which they are identified. Historically, revisions to these

**BOOZ ALLEN HAMILTON HOLDING CORPORATION**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**(Amounts in tables in thousands, except share and per share data or unless otherwise noted)**

estimates have not had a material effect on our results of operations. Contract costs, including indirect expenses, are subject to audit by the Defense Contract Audit Agency, or DCAA, and, accordingly, are subject to possible cost disallowances. Executive compensation that we determine to be allowable for cost reimbursement based on management's estimates is recognized as revenue, net of reserves. Management's estimates in this regard are based on a number of factors that may change over time, including executive compensation survey data, our and other government contractors' experiences with the DCAA audit practices in our industry, and relevant decisions of courts and boards of contract appeals.

Revenue earned under time-and-materials contracts is recognized as hours are worked based on contractually billable rates to the client. Costs on time-and-materials contracts are expensed as incurred.

Revenue on fixed-price contracts is primarily recognized using the percentage of completion method based on actual costs incurred relative to total estimated costs for the contract. On some fixed-price contracts the Company may use an alternative input method to calculate the percent complete, such as labor hours or labor dollars. This method is used when a contract contains significant, up-front material purchases resulting in costs incurred that are not representative of the actual progress on the contract. In either method, these estimated costs are updated during the term of the contract, and may result in revision by the Company of recognized revenue and estimated costs in the period in which the changes in estimated costs are identified. Historically, revisions to these estimates have not had a material effect on our results of operations. Profits on fixed-price contracts result from the difference between incurred costs used to calculate the percentage of completion and revenue earned.

Contract accounting requires significant judgment relative to assessing risks, estimating contract revenue and costs, and making assumptions for schedule and technical issues. Due to the size and nature of many of the Company's contracts, developing total revenue and cost at completion estimates requires the use of significant judgment. Contract costs include direct labor and billable expenses and an allocation of allowable indirect costs. Billable expenses is comprised of subcontracting costs and other "out-of-pocket" costs that often include, but are not limited to, travel-related costs and telecommunications charges. The Company typically recognizes revenue and billable expenses from these transactions on a gross basis when it is the primary obligor on our contracts with customers. Assumptions regarding the length of time to complete the contract also include expected increases in wages and prices for materials. Estimates of total contract revenue and costs are monitored during the term of the contract and are subject to revision as the contract progresses. Anticipated losses on contracts are recognized in the period they are deemed probable and can be reasonably estimated.

The Company's contracts may include the delivery of a combination of one or more of the Company's service offerings. In these situations, the Company determines whether such arrangements with multiple service offerings should be treated as separate units of accounting based on how the elements are bid or negotiated, whether the customer can accept separate elements of the arrangement, and the relationship between the pricing on the elements individually and combined. All other revenues are recognized when persuasive evidence of an arrangement exists, services or products have been provided to the customer, the sales price is fixed or determinable and collectability is reasonably assured.

***Cash and Cash Equivalents***

Cash and cash equivalents include operating cash on hand and highly liquid investments having a weighted average maturity of 60 days or less and a weighted average life of 120 days or less. The Company's cash equivalents consist primarily of institutional and government money market funds and money market deposit accounts. The Company maintains its cash and cash equivalents in bank accounts that, at times, exceed the federally insured FDIC limits. The Company has not experienced any losses in such accounts.

***Valuation of Accounts Receivable***

The Company maintains allowances for doubtful accounts against certain billed and unbilled receivables based upon the latest information regarding whether specific charges are recoverable or invoices are ultimately collectible. Assessing the recoverability of charges and collectability of customer receivables requires management judgment. The Company determines its allowance for doubtful accounts by specifically analyzing individual accounts receivable, historical bad debts, customer credit-worthiness, current economic conditions, accounts receivable aging trends for billed receivables, availability of funding, compliance with contractual terms and conditions, client satisfaction with work performed, and other factors impacting unbilled receivables. Valuation reserves are periodically re-evaluated and adjusted as more information about the ultimate recoverability and collectability of accounts receivable becomes available. Upon determination that a receivable is uncollectible, the receivable balance and any associated reserve are written off.

**BOOZ ALLEN HAMILTON HOLDING CORPORATION**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
**(Amounts in tables in thousands, except share and per share data or unless otherwise noted)**

***Concentrations of Credit Risk***

Financial instruments that potentially subject the Company to concentrations of credit risk consist primarily of cash equivalents and accounts receivable. The Company's cash equivalents are generally invested in U.S. government money market funds and money market deposit accounts. The Company believes that credit risk for accounts receivable is limited as the receivables are primarily with the U.S. government.

***Property and Equipment***

Property and equipment are recorded at cost, and the balances are presented net of accumulated depreciation. The cost of software purchased or internally developed is capitalized, as appropriate. Depreciation is calculated using the straight-line method over the estimated useful lives of the assets. Furniture and equipment is depreciated over five to ten years, computer equipment is depreciated over four years, and software purchased or developed for internal use is depreciated over three to five years. Leasehold improvements are amortized over the shorter of the useful life of the asset or the lease term. Maintenance and repairs are charged to expense as incurred.

Rent expense is recorded on a straight-line basis over the life of the respective lease. The difference between the cash payment and rent expense is recorded as deferred rent in either accounts payable and other accrued expenses or other long-term liabilities in the consolidated balance sheets, depending on when the amounts will be recognized. The Company receives incentives for tenant improvements on certain of its leases. The cash expended on such improvements is recorded as property and equipment and amortized over the life of the associated asset, or lease term, whichever is shorter. Incentives for tenant improvements are recorded as deferred rent in either accounts payable and other accrued expenses or other long-term liabilities in the consolidated balance sheets depending on when the amounts will be recognized. Incentives for tenant improvements are amortized on a straight-line basis over the lease term.

***Business Combinations***

The accounting for the Company's business combinations consists of allocating the purchase price to tangible and intangible assets acquired and liabilities assumed based on their estimated fair values, with the excess recorded as goodwill. The Company has up to one year from the acquisition date to use information as of each acquisition date to adjust the fair value of the acquired assets and liabilities which may result in material changes to their recorded values with an offsetting adjustment to goodwill.

We have a contingent consideration arrangement in connection with a business acquisition which requires a fair value measurement determined using probability-weighted cash flows. See Note 19 to our consolidated financial statements for further information about the valuation of the contingent consideration liability and the inputs used in the fair value measurement.

***Intangible Assets***

Intangible assets primarily consist of the Company's trade name, customer relationships, and other amortizable intangible assets. Customer relationships are generally amortized on an accelerated basis over the expected life based on projected future cash flows of approximately three to twelve years. The Company's trade name is not amortized, but is tested for impairment on at least an annual basis as of January 1 and more frequently if interim indicators of impairment exist. The trade name is considered to be impaired if the carrying value exceeds its estimated fair value. The Company used the relief from royalty method to estimate the fair value. The fair value of the asset is the present value of the license fees avoided by owning the asset, or the royalty savings. During the fiscal year ended March 31, 2017, the Company recorded impairment charges related to intangible assets acquired in an acquisition. During the fiscal year ended March 31, 2018, and 2016, the Company did not record any impairment of intangible assets.

***Goodwill***

The Company assesses goodwill for impairment on at least an annual basis on January 1 unless interim indicators of impairment exist. Goodwill is considered to be impaired when the net book value of a reporting unit exceeds its estimated fair value. The Company operates as a single operating segment and as a single reporting unit for the purpose of evaluating goodwill. As of January 1, 2018, the Company performed its annual impairment test of goodwill by comparing the fair value of the Company (based on market capitalization) to the carrying value of the Company's net equity, and concluded that the fair value of the reporting unit was significantly greater than the carrying amount. During the fiscal years ended March 31, 2018, 2017, and 2016, the Company did not record any impairment of goodwill.

**BOOZ ALLEN HAMILTON HOLDING CORPORATION**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
(Amounts in tables in thousands, except share and per share data or unless otherwise noted)

***Long-Lived Assets***

The Company reviews its long-lived assets, including property and equipment and amortizable intangible assets, for impairment whenever events or changes in circumstances indicate that the carrying amounts of the assets may not be fully recoverable. If the total of the expected undiscounted future net cash flows is less than the carrying amount of the asset, a loss is recognized for any excess of the carrying amount over the fair value of the asset. During the fiscal years ended March 31, 2018, 2017, and 2016, the Company did not record any material impairment charges.

***Income Taxes***

The Company provides for income taxes as a “C” corporation on income earned from operations. The Company is subject to federal, state, and foreign taxation in various jurisdictions.

Deferred tax assets and liabilities are recorded to recognize the expected future tax benefits or costs of events that have been, or will be, reported in different years for financial statement purposes than for tax purposes. Deferred tax assets and liabilities are computed based on the difference between the consolidated financial statement carrying amount and tax basis of assets and liabilities using enacted tax rates and laws for the years in which these items are expected to reverse. If management determines that some portion or all of a deferred tax asset is not “more likely than not” to be realized, a valuation allowance is recorded as a component of the income tax provision to reduce the deferred tax asset to an appropriate level in that period. In determining the need for a valuation allowance, management considers all positive and negative evidence, including historical earnings, projected future taxable income, future reversals of existing taxable temporary differences, taxable income in prior carryback periods, and prudent, feasible tax-planning strategies.

The Company periodically assesses its tax positions for all periods open to examination by tax authorities based on the latest available information. Where it is not more likely than not that the Company’s tax position will be sustained, the Company records its best estimate of the resulting tax liability, penalties, and interest in the consolidated financial statements. These uncertain tax positions are recorded as a component of income tax expense. As uncertain tax positions in periods open to examination are closed out, or as new information becomes available, the resulting change is reflected in the recorded liability and income tax expense. Penalties and interest recognized related to the reserves for uncertain tax positions are recorded as a component of income tax expense.

See Note 13 to our consolidated financial statements for further information regarding the effects of U.S. tax law changes enacted during the third fiscal quarter of 2018 and financial reporting guidance issued by the SEC.

***Comprehensive Income***

Comprehensive income is the change in equity of a business enterprise during a period from transactions and other events and circumstances from non-owner sources, and is presented in the consolidated statements of comprehensive income. Accumulated other comprehensive loss as of March 31, 2018 and 2017 consisted of net unrealized losses on the Company’s defined and postretirement benefit plans and unrealized gains or losses on interest rate swaps designated as cash flow hedges.

***Share-Based Payments***

Share-based payments to employees are recognized in the consolidated statements of operations based on their grant date fair values with the expense for time vested awards recognized on an accelerated basis over the vesting period. The expense for performance awards is recognized straight line over the vesting period. The Company uses the Black-Scholes option-pricing model to determine the fair value of its option awards at the time of grant.

***Defined Benefit Plan and Other Postretirement Benefits***

The Company recognizes the underfunded status of defined benefit plans on the consolidated balance sheets within other long-term liabilities. Gains and losses, and prior service costs and credits that have not yet been recognized through net periodic benefit cost are recognized in accumulated other comprehensive income (loss), net of tax effects, and will be amortized as a component of net periodic cost in future periods. The measurement date, the date at which the benefit obligations are measured, is the Company’s fiscal year-end.

The Company also offers medical and dental benefits to inactive employees (and their eligible dependents) on long-term disability. The Company accrues the costs of the benefits at the date the inactive employee becomes disability eligible and elects to participate in the benefit. The accrued cost for such benefits is calculated using an actuarial estimate of the present value of all future benefit payments for obligations at the end of the fiscal year.

**BOOZ ALLEN HAMILTON HOLDING CORPORATION**  
**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS**  
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***Self-Funded Medical Plans***

The Company maintains self-funded medical insurance. Self-funded plans include Consumer Driven Health Plans with a Health Savings Account option and traditional choice plans. Further, self-funded plans also include prescription drug and dental benefits. The Company records an incurred but unreported claim liability in the accrued compensation and benefits line of the consolidated balance sheets for self-funded plans based on an actuarial valuation. The estimate of the incurred but unreported claim liability was provided by a third-party valuation firm, primarily based on claims and participant data for the medical, dental, and pharmacy related costs.

***Fair Value Measurements***

Fair value is the price that would be received to sell an asset or paid to transfer a liability in an orderly transaction between market participants at the measurement date. In determining fair value, we consider the principal or most advantageous market in which the asset or liability would transact, and if necessary, consider assumptions that market participants would use when pricing the asset or liability.

The accounting guidance for fair value measurements establishes a three-level fair value hierarchy that prioritizes the inputs used in measuring fair value as follows: observable inputs such as quoted prices in active markets (Level 1); inputs other than quoted prices in active markets that are observable either directly or indirectly (Level 2); and unobservable inputs in which there is little or no market data, which requires the Company to develop its own assumptions (Level 3). Assets and liabilities are classified in their entirety within the fair value hierarchy based on the lowest level input that is significant to the fair value measurement. See Note 19 to our consolidated financial statements for additional information on the Company's fair value measurements.

***Recent Accounting Pronouncements***

On February 14, 2018, the Financial Accounting Standards Board, or FASB, issued Accounting Standards Update, or ASU 2018-02, *Income Statement, Reporting Comprehensive Income (Topic 220): Reclassification of Certain Tax Effects from Accumulated Other Comprehensive Income*. This guidance permits entities to reclassify the effect of the change in the U.S. federal corporate income tax rate on the gross deferred tax amounts related to items remaining in accumulated other comprehensive income to retained earnings as a result of the Tax Cuts and Jobs Act (the "2017 Tax Act") enacted by the U.S. federal government on December 22, 2017. The updated guidance is effective for interim and annual reporting periods beginning after December 15, 2018, with early adoption permitted. Although immaterial, the Company early adopted ASU 2018-02 and made an election to reclassify \$2.9 million from accumulated other comprehensive income to retained earnings in the fourth quarter of fiscal 2018.

On December 22, 2017, the Staff of the SEC issued Staff Accounting Bulletin No. 118, *Income Tax Accounting Implications of the Tax Cuts and Jobs Act*, or SAB 118, which addresses situations where the accounting under FASB Accounting Standards Codification No. 740, *Income Taxes*, or ASC 740 is incomplete for certain income tax effects of Public Law No. 115-97, commonly referred to as the 2017 Tax Act, by the time an entity issues its financial statements for the fiscal period that includes the date that the 2017 Tax Act was enacted.

Under ASC 740, entities are required to adjust current and deferred tax liabilities and assets for the effects of changes in tax laws or rates at their date of enactment. However, pursuant to SAB 118, if an entity does not have the necessary information available, prepared, or analyzed for certain income tax effects of the 2017 Tax Act at the time an entity's financial statements are issued, an entity shall apply ASC 740 based on the provisions of the tax laws that were in effect immediately prior to the enactment of the 2017 Tax Act. If the accounting for certain income tax effects of the 2017 Tax Act is incomplete, but an entity can determine a reasonable estimate for those effects, an entity can record provisional amounts and adjust such amounts as necessary during a measurement period, which ends on the earlier of when an entity has obtained, prepared, and analyzed the information necessary to complete the accounting requirements of ASC 740 and December 22, 2018.

As discussed further in Note 13, the Company is a fiscal year-end taxpayer and is required to use a blended statutory federal tax rate, inclusive of the federal rate change enacted on December 22, 2017, to compute its effective tax rate from the third quarter of fiscal 2018. These effects contributed to an overall decrease in the Company's effective tax rate. Based on ASC 740, comparative prior period amounts were not adjusted for the rate change effects of the 2017 Tax Act.

Further, the Company recognized provisional tax effects of the 2017 Tax Act in the year ended March 31, 2018 and recorded \$9.1 million in income tax benefit which relates entirely to the re-measurement of deferred tax assets and liabilities using the new 21% tax rate. Upon completion of its on-going assessment of the implications of the 2017 Tax Act during the measurement period, the Company may identify additional re-measurement adjustments to the recorded deferred tax balances

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resulting from the 2017 Tax Act given its complexity and pending further interpretive guidance that may be issued by the Internal Revenue Service (IRS). In addition, a tax accounting method change was filed as of March 31, 2018 associated with the Company's unbilled receivables that is currently pending IRS approval. As a non-automatic method change, the Company can not yet adjust for this in the deferred re-measurement process. The Company will continue to assess its provision for income taxes as future guidance is issued. Any such revisions will be treated in accordance with the measurement period guidance outlined in SAB 118.

In August 2017, the FASB issued ASU 2017-12, *Targeted Improvements to Accounting for Hedging Activities*. This guidance eliminates the requirement to separately measure and report hedge ineffectiveness and generally requires, for qualifying hedges, the entire change in the fair value of a hedging instrument to be presented in the same income statement line as the hedged item. Additionally, the guidance also expands an entity's ability to apply hedge accounting for nonfinancial and financial risk components, simplifies the hedge documentation and hedge effectiveness assessment requirements, and modifies certain disclosure requirements. ASU 2017-12 is effective for reporting periods beginning after December 15, 2018, with early adoption permitted. The Company does not expect the adoption of this standard to have a material impact on its consolidated financial statements.

In March 2017, the FASB issued ASU 2017-07, *Improving the Presentation of Net Periodic Pension Cost and Net Periodic Postretirement Benefit Cost*, which will change the presentation of net periodic benefit cost components on the consolidated statement of operations. Under this guidance, the service cost component of net periodic benefit cost will continue to be presented in the same line items as other employee compensation costs, while the remaining components of net periodic benefit costs are to be presented outside operating income. ASU 2017-07 is effective for annual reporting periods beginning after December 15, 2017 and is to be applied retrospectively, with early adoption permitted. The Company will adopt the new standard in the first quarter of fiscal 2019 on a retrospective basis. For the Officer Medical Plan, the adoption of ASU 2017-07 will result in a reclassification of \$7.3 million and \$7.8 million of net periodic benefit costs that are not related to service components to other income (expense), net for fiscal 2018 and fiscal 2017, respectively. The adoption of this standard and change in classification is not expected to be material to the Company's consolidated financial statements.

In March 2016, the FASB issued ASU 2016-09, *Improvements to Employee Share-Based Payment Accounting*, which simplifies several aspects of the accounting for share-based payment transactions including the accounting for income taxes, forfeitures, and statutory tax withholding requirements. The Company adopted ASU 2016-09 in the first quarter of fiscal 2018. Certain of the simplification provisions were not applicable to the Company. The Company will continue its existing practice of estimating the number of forfeitures that are expected to occur rather than account for forfeitures when they occur as permitted under the new guidance.

The primary impacts of adopting ASU 2016-09 were those related to excess tax benefits and tax deficiencies. The new guidance requires that such amounts be recognized as income tax expense or benefit in the statement of operations, which could result in fluctuations in the Company's effective tax rate period over period depending on how many awards vest, or options are exercised, in a quarter. The guidance also requires that the cash flows associated with these transactions be presented with other income tax related cash flows in the operating activities section of the statement of cash flows. The Company recognized excess tax benefits, inclusive of the impact of the 2017 Tax Act, of \$14.5 million during fiscal year 2018, as a reduction to income tax expense in the consolidated statement of operations. The effect of adopting ASU 2016-09 resulted in a decrease in the Company's current period effective tax rate. As permitted, the Company adopted the guidance related to the presentation of excess tax benefits in the consolidated statement of cash flows on a prospective basis. Prior period amounts were not adjusted.

In February 2016, the FASB issued ASU 2016-02, *Leases (Topic 842)*, to increase transparency and comparability of accounting for lease transactions. The new leasing standard requires lessees to recognize lease assets and lease liabilities on their balance sheet for all leases with a lease term of greater than 12 months. Lessor accounting is largely unchanged. Topic 842 is effective for fiscal years beginning after December 15, 2018, with early adoption permitted. The new leasing standard currently requires the application of a modified retrospective approach to the beginning of the earliest period presented in the financial statements. In January 2018, the FASB issued an exposure draft of the proposed ASU, *Leases (Topic 842): Targeted Improvements*. The proposed ASU provides an alternative transition method of adoption, permitting the recognition of a cumulative-effect adjustment to retained earnings on the date of adoption. The Company intends to adopt the standard on the effective date and we will make a transition decision upon the FASB deciding whether it will approve an alternative transition method.

A dedicated implementation team has been established that continues to make progress toward completing the evaluation of the impact of the new standard. The Company is currently evaluating its population of leased assets in order to assess the

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impact of Topic 842 on its lease portfolio, and designing and implementing new processes and controls. Until this effort is completed, the Company cannot determine the effect of Topic 842 on our consolidated financial statements.

In May 2014, the FASB issued Accounting Standard Codification No. 606, Revenue from Contracts with Customers (Topic 606). Topic 606, as amended, will replace existing revenue recognition standards by outlining a single set of comprehensive principles for recognizing revenue. The revenue standard will also significantly expand the disclosure requirements for revenue arrangements. Amendments to Topic 606 have generally focused on promoting a more consistent interpretation and application of the principles for recognizing revenue.

Topic 606 was effective for the Company beginning on April 1, 2018 (i.e., beginning with the first quarter fiscal 2019 interim financial statements). The Company will adopt the new revenue standard using the full retrospective transition method, which requires that it be applied to each prior reporting period presented and the cumulative effect of applying the standard would be recognized at the earliest period shown (i.e., April 1, 2016 or the beginning of the first quarter of fiscal 2017). During fiscal 2018, the Company completed its assessment of the cumulative effect of adopting Topic 606 and assessed the impact to be immaterial. Under the full retrospective method, the Company principally recognized the cumulative effect of adoption as an increase in billed and unbilled accounts receivables, an increase in deferred tax liabilities, and a net increase in retained earnings as of April 1, 2016 of less than \$3.0 million. The Company has substantially completed its assessment of the impact of adoption on our fiscal 2017 and 2018 results and the Company believes the retrospective impact of Topic 606 to those prior fiscal periods to be immaterial. The impact of Topic 606 on fiscal 2017 and 2018 results may not be representative of the impact on subsequent years' results.

During fiscal 2018, the Company substantially completed its evaluation of Topic 606, including the impact on our accounting policies and practices, accounting systems and business processes. As a result of our evaluation, the Company identified changes to and modified certain of our accounting policies and practices. While some system changes were complex to design and test, the effect of such changes were not significant upon adoption of Topic 606. The Company also designed and implemented specific controls over our evaluation of the impact of Topic 606, including the calculation of the cumulative effect of adopting Topic 606. Finally, the Company has designed new internal controls and modified certain of our existing internal controls and processes to incorporate the revisions made to accounting policies and practices on a post-adoption basis.

While the Company's comprehensive assessment identified the following notable observations or impacts to our accounting policies and practices, the Company does not believe that adopting Topic 606 under its principles-based approach to recognizing revenue will be material to the Company's fiscal year consolidated financial statements:

- The Company expects insignificant changes related to recognizing revenue and earnings over time for long-term contracts as work progresses because of the continuous transfer of control to the customer, generally using an input measure (e.g., costs incurred) to reflect progress.
- The determination of the customer and contract under Topic 606 will not significantly change.
- Revenue previously deferred for non-federal government arrangements that commenced without a signed, written contract may be recognized under Topic 606 when such arrangements are legally enforceable under applicable laws and regulations.
- The Company has determined that in its U.S. government contract portfolio, there are certain periods of performance option exercises that will be evaluated as separate performance obligations or new arrangements for accounting purposes due to their distinct nature. For example, these situations may arise when options to renew the period of performance are not exercised within a relatively short period after execution of the base contract and are thus evaluated to be separate and unrelated purchasing decisions by the customer, or when an option exercise is not the continuation of an integrated service, finished deliverable, or a single combined output.
- The determination of contract transaction price associated with performance-based contracts (i.e., incentive or award-based contracts) will generally be consistent with the Company's current measurement practices for such contracts. The Company's estimates at completion for most fixed price contracts will now include unfunded components.
- For interim period financial reporting purposes under Topic 606, contract revenue attributable to indirect costs will be recognized using the agreed-upon annual forward-pricing rates established with the U.S. government at the start of each fiscal year. Forward pricing rates are estimated and agreed upon between the Company and the U.S. government and represent indirect contract costs required to execute and administer contract obligations. The impact of any agreed-upon changes, or changes in the estimated annual forward-pricing rates, will be recorded in the interim financial reporting period when such changes are determined. The impact of this change relates to the interim financial reporting period differences between the actual indirect cost incurred and allocated to contracts compared to the estimated amounts allocated to

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contracts using the estimated annual forward-pricing rates established with the U.S. government, which the Company believes represents the transaction price under Topic 606. This change to our interim accounting policies and practices aligns to the principles of Topic 606 indicating that revenue should reflect expectations about the consideration a company will be entitled to receive from a customer and such revenue and profit margin should be applied on a consistent basis using judgment and reliable estimates for contractual arrangements. This will be a change from the Company's current practices in which the Company records during interim reporting periods adjustments to revenue based on the indirect spending incurred as of that interim period ended primarily for cost-reimbursable and fixed-price contracts. Because of the new revenue standard, profit margin on such contracts is expected to be more consistent throughout the interim periods of the fiscal year, notwithstanding seasonality the Company may experience during interim and fiscal year periods due to changes in the government's funding and spending patterns. The Company believes this change in interim period financial reporting will have no impact on the fiscal year end consolidated statements of operations, balance sheets or statements of cash flow as the estimated indirect forward-pricing rates are adjusted to actual rates at that time.

- Contracts with significant up-front materials are expected to see an increase in the amount of revenue and costs recognized upon the date of the adoption, but the change in profitability is not expected to be significant.

Topic 606 will also require expanded disclosures regarding the nature, timing and uncertainty of revenue and contract balances, including how and when the Company satisfies its performance obligations and the relationship between revenue recognized and changes in contract balances during a reporting period. The Company has evaluated these disclosure requirements and incorporated the collection of relevant data into our reporting process.

Other recent accounting pronouncements issued during fiscal 2018 and through the filing date are not expected to have a material impact on the Company's present or historical consolidated financial statements.

### 3. EARNINGS PER SHARE

The Company computes basic and diluted earnings per share amounts based on net income for the periods presented. The Company uses the weighted average number of common shares outstanding during the period to calculate basic earnings per share, or EPS. Diluted EPS adjusts the weighted average number of shares outstanding to include the dilutive effect of outstanding common stock options and other stock-based awards.

The Company currently has outstanding shares of Class A Common Stock. Unvested Class A Restricted Common Stock holders are entitled to participate in non-forfeitable dividends or other distributions. These unvested restricted shares participated in the Company's dividends declared and paid in each quarter of fiscal 2018, 2017, and 2016. As such, EPS is calculated using the two-class method whereby earnings are reduced by distributed earnings as well as any available undistributed earnings allocable to holders of unvested restricted shares. A reconciliation of the income used to compute basic and diluted EPS for the periods presented are as follows:

	Fiscal Year Ended March 31,		
	2018	2017	2016
Earnings for basic computations (1)	\$ 303,224	\$ 250,231	\$ 290,542
Weighted-average Class A Common Stock outstanding	145,964,574	148,218,968	146,494,407
Total weighted-average common shares outstanding for basic computations	145,964,574	148,218,968	146,494,407
Earnings for diluted computations (1)	\$ 303,238	\$ 250,249	\$ 290,596
Dilutive stock options and restricted stock	1,785,448	2,055,672	3,224,730
Average number of common shares outstanding for diluted computations	147,750,022	150,274,640	149,719,137
Earnings per common share			
Basic	\$ 2.08	\$ 1.69	\$ 1.98
Diluted	\$ 2.05	\$ 1.67	\$ 1.94

(1) During fiscal 2018, 2017, and 2016 approximately 0.8 million, 1.3 million, and 1.8 million shares of participating securities were paid dividends totaling \$0.8 million, \$0.9 million, and \$1.0 million, respectively. For fiscal 2018 there were undistributed

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earnings of \$1.1 million allocated to the participating class of securities in both basic and diluted earnings per share. For fiscal 2017 there were undistributed earnings of \$1.4 million allocated to the participating class of securities in both basic and diluted earnings per share. For fiscal 2016 there were undistributed earnings of \$2.5 million allocated to the participating class of securities in both basic and diluted earnings per share. The allocated undistributed earnings and the dividends paid comprise the difference between net income presented on the consolidated statements of operations and earnings for basic and diluted computations for fiscal 2018, 2017, and 2016.

The EPS calculation for fiscal 2018, 2017, and 2016 excludes 0.3 million, 0.05 million, and 0.6 million options as their impact was anti-dilutive.

#### 4. ACQUISITIONS

There were no material acquisitions during fiscal 2018 or through the period subsequent to the issuance of the current financial statements.

##### Fiscal 2017 Acquisition

On January 24, 2017, the Company acquired eGov Holdings, Inc., which we refer to as Aquilent. As a result of the transaction, Aquilent became a wholly owned subsidiary of the Company. Aquilent is an architect of IT solutions for the U.S. Federal government. The acquisition further expands the Company's ability to blend its consulting heritage with advanced technical expertise.

The total purchase consideration paid at closing was \$253.6 million. As part of the acquisition, the Company and the selling shareholders of Aquilent agreed to jointly make an election under Section 338(h)(10) of the Internal Revenue Code of 1986, as amended, or the Code, to treat the acquisition as an asset purchase for income tax purposes. The Company agreed to reimburse the selling stockholders for previously unrealized tax consequences on Aquilent's prior tax-return positions that became realized upon acquisition; and agreed to indemnify the selling stockholders for potential, incremental increases in income taxes and related costs as a result of the Section 338(h)(10) election. The indemnity was evaluated to be acquisition-related contingent consideration, which was preliminarily estimated at the acquisition date fair value of \$3.6 million. The acquisition-related contingent consideration was calculated using probability-weighted cash flows and significant unobservable inputs (Level 3) as described under the fair value hierarchy of ASC 820, *Fair Value Measurements*, or ASC 820.

The Company recorded the assets acquired and liabilities assumed at their acquisition date estimated fair value, with the difference between the fair value of the net assets acquired and the acquisition consideration reflected as goodwill. The following table represents the final allocation of fair value of assets acquired and liabilities assumed:

Current assets	\$	15,809
Other tangible assets		1,144
Customer-relationship intangible assets		69,000
Goodwill		199,826
Current liabilities		(8,450)
Tax liability		(13,554)
Income tax uncertainty		(10,221)
Total purchase consideration transfer at closing	\$	253,554

The identifiable customer-relationship intangible assets of \$69.0 million was valued using the excess earnings method discounted cash flow approach, incorporating Level 3 inputs as described under the fair value hierarchy of ASC 820 and it is being amortized over 12 years. An acquisition date tax of \$13.6 million was relieved and paid during the first quarter of fiscal 2018. The Company continues to carry a related reserve of \$10.2 million for income tax uncertainties created with the acquisition resulting from uncertainty in the sustainability of Aquilent's prior tax-return positions under examination with the relevant tax authorities. The goodwill of \$199.8 million was primarily attributed to the specialized workforce and the expected synergies between the Company and Aquilent. The majority of the goodwill is expected to be deductible for tax purposes. Pro

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forma results of operations for this acquisition are not presented because it is not material to the Company's consolidated results of operations.

**5. GOODWILL AND INTANGIBLE ASSETS**

**Goodwill**

As of March 31, 2018 and 2017, goodwill was 1,581.1 million and 1,571.2 million, respectively. The increase in the carrying amount of goodwill was attributable to an acquisition.

The Company performed an annual impairment test of goodwill as of January 1, 2018 and 2017, and we did not identify any impairment.

**Intangible Assets**

Intangible assets consisted of the following:

	March 31, 2018			March 31, 2017		
	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Amortizable intangible assets:						
Customer relationships and other amortizable intangible assets	\$ 115,808	\$ 45,036	\$ 70,772	\$ 274,915	\$ 193,235	\$ 81,680
Unamortizable intangible assets:						
Trade name	\$ 190,200	\$ —	\$ 190,200	\$ 190,200	\$ —	\$ 190,200
<b>Total</b>	<b>\$ 306,008</b>	<b>\$ 45,036</b>	<b>\$ 260,972</b>	<b>\$ 465,115</b>	<b>\$ 193,235</b>	<b>\$ 271,880</b>

Intangible assets are generally amortized on an accelerated basis over periods ranging from 3 years to 12 years. The weighted-average remaining period of amortization for all customer relationships is 9.3 years.

The Company performed an annual impairment test of the trade name as of January 1, 2018 and 2017, and did not identify any impairment. However, the Company recognized an impairment charge of \$3.8 million in fiscal 2017 for acquired technology, customer relationships and other intangible assets associated with a historical business acquisition. During fiscal 2018, gross carrying value and accumulated amortization was reduced related to fully-amortized intangible assets.

Amortization expense for fiscal 2018, 2017, and 2016 was \$16.9 million, \$13.9 million, and \$12.1 million, respectively. The following table summarizes the estimated annual amortization expense for future periods indicated below:

**For the Fiscal Year Ended March 31,**

2019	\$ 15,723
2020	12,985
2021	10,166
2022	7,647
2023	6,557
Thereafter	17,694
<b>Total estimated amortization expense</b>	<b>\$ 70,772</b>

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**6. ACCOUNTS RECEIVABLE, NET OF ALLOWANCE**

Accounts receivable, net of allowance consisted of the following:

	March 31,	
	2018	2017
<b>Current assets:</b>		
Accounts receivable–billed	\$ 395,136	\$ 340,716
Accounts receivable–unbilled	735,393	651,094
Allowance for doubtful accounts	(77)	—
Accounts receivable, net	<u>1,130,452</u>	<u>991,810</u>
<b>Other long-term assets:</b>		
Accounts receivable–unbilled	59,633	59,913
Total accounts receivable, net	<u>\$ 1,190,085</u>	<u>\$ 1,051,723</u>

Unbilled amounts represent revenues for which billings have not been presented to customers at year end. These amounts are usually billed and collected within one year. Long-term unbilled receivables not anticipated to be billed and collected within one year, which are primarily related to retainage, holdbacks, and long-term rate settlements to be billed at contract closeout, are included in other long-term assets in the accompanying consolidated balance sheets. The Company recognized a provision for doubtful accounts (including certain unbilled reserves) of \$3.2 million, \$0.6 million, and \$1.1 million for fiscal 2018, 2017, and 2016, respectively.

**7. PROPERTY AND EQUIPMENT, NET**

The components of property and equipment, net were as follows:

	March 31,	
	2018	2017
Furniture and equipment	\$ 164,061	\$ 151,552
Computer equipment	79,629	75,159
Software	59,051	48,361
Leasehold improvements	202,133	177,009
Total	<u>504,874</u>	<u>452,081</u>
Less: Accumulated depreciation and amortization	(334,978)	(312,914)
Property and equipment, net	<u>\$ 169,896</u>	<u>\$ 139,167</u>

Property and equipment, net, includes \$15.6 million and \$8.1 million of internally developed software, net of depreciation as of March 31, 2018 and 2017, respectively. Depreciation and amortization expense relating to property and equipment for fiscal 2018, 2017, and 2016 was \$48.1 million, \$46.3 million, and \$50.1 million, respectively. During fiscal 2018 and 2017, the Company reduced the gross cost and accumulated depreciation and amortization by \$16.1 million and \$11.9 million, respectively, for zero net book value assets deemed no longer in service.

**8. ACCOUNTS PAYABLE AND OTHER ACCRUED EXPENSES**

Accounts payable and other accrued expenses consisted of the following:

	March 31,	
	2018	2017
Vendor payables	\$ 339,993	\$ 268,630
Accrued expenses	217,566	235,487
Total accounts payable and other accrued expenses	<u>\$ 557,559</u>	<u>\$ 504,117</u>

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Accrued expenses consisted primarily of the Company's reserve related to potential cost disallowance in conjunction with government audits. Refer to Note 21 for further discussion of this reserve.

**9. ACCRUED COMPENSATION AND BENEFITS**

Accrued compensation and benefits consisted of the following:

	March 31,	
	2018	2017
Bonus	\$ 87,817	\$ 77,765
Retirement	35,743	31,879
Vacation	131,519	124,486
Other	27,671	29,686
Total accrued compensation and benefits	<u>\$ 282,750</u>	<u>\$ 263,816</u>

**10. DEFERRED PAYMENT OBLIGATION**

Pursuant to an Agreement and Plan of Merger, or the Merger Agreement, dated as of May 15, 2008, and subsequently amended, The Carlyle Group indirectly acquired all of the issued and outstanding stock of the Company. In connection with this transaction, on July 31, 2008 the Company established a Deferred Payment Obligation, or DPO, of \$158.0 million, payable 8.5 years after the Closing Date, or until settlement of all outstanding claims, less any settled claims. Pursuant to the Merger Agreement, \$78.0 million of the \$158.0 million DPO was required to be paid in full to the selling shareholders. On December 11, 2009, in connection with a recapitalization transaction, \$100.4 million was paid to the selling shareholders, of which \$78.0 million was the repayment of that portion of the DPO, with approximately \$22.4 million representing accrued interest.

The remaining \$80.0 million is available to indemnify the Company for certain pre-acquisition tax contingencies, related interest and penalties, and other matters pursuant to the Merger Agreement. Any amounts remaining after the settlement of all claims will be paid out to the selling shareholders. As of March 31, 2018, there were no estimated tax indemnified amounts recorded against the DPO. Remaining potential claims outstanding that may be indemnified pursuant to the Merger Agreement relate to former officers and stockholders' suits that are still in litigation (See Note 21 to our consolidated financial statements).

During fiscal 2018, the Company accrued interest at a rate of 5% per six-month period on the unpaid DPO balance, net of any settled claims or payments, which was \$80.0 million as of March 31, 2018 and 2017. Accordingly, the \$81.3 million and \$81.3 million recorded within other current liabilities as of March 31, 2018 and March 31, 2017, respectively, represent the residual balances estimated to be paid to the selling shareholders subject to any remaining potential claims based on consideration of accrued interest and other matters.

A reconciliation of the principal balance of the DPO to the amount recorded in the consolidated balance sheets for the periods presented are as follows:

	March 31,	
	2018	2017
Deferred payment obligation:	\$ 80,000	\$ 80,000
Accrued interest	1,311	1,304
Amount recorded in the consolidated balance sheet	<u>\$ 81,311</u>	<u>\$ 81,304</u>

The Company paid \$8.0 million in each of fiscal 2018 and 2017 of accrued interest to the selling shareholders.

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**11. DEBT**

Debt consisted of the following:

	March 31, 2018		March 31, 2017	
	Interest Rate	Outstanding Balance	Interest Rate	Outstanding Balance
Term Loan A	3.88%	\$ 1,094,275	2.98%	\$ 1,153,425
Term Loan B	3.88%	395,000	3.08%	398,000
Revolving credit facility (ABR)	—%	—	5.00%	80,000
Revolving credit facility (LIBOR)	—%	—	2.98%	50,000
Senior Notes	5.13%	350,000	—%	—
Less: Unamortized debt issuance costs and discount on debt		(20,696)		(18,101)
<b>Total</b>		<b>1,818,579</b>		<b>1,663,324</b>
Less: Current portion of long-term debt		(63,100)		(193,150)
<b>Long-term debt, net of current portion</b>		<b>\$ 1,755,479</b>		<b>\$ 1,470,174</b>

*Terms Loans and Revolving Credit Facility*

On March 7, 2018, Booz Allen Hamilton Inc. and Booz Allen Hamilton Investor Corporation ("Investor"), and certain wholly-owned subsidiaries of Booz Allen Hamilton, entered into the Fifth Amendment (the "Fifth Amendment") to the Credit Agreement (the "Credit Agreement"), dated as of July 31, 2012 among Booz Allen Hamilton, Investor, certain wholly owned subsidiaries of Booz Allen Hamilton and Bank of America, N.A., as Administrative Agent, Collateral Agent and Issuing Lender (as previously amended by the First Amendment to Credit Agreement, dated as of August 16, 2013, the Second Amendment to Credit Agreement, date as of May 7, 2014, the Third Amendment to the Credit Agreement, dated as of July 13, 2016 and the Fourth Amendment to the Credit Agreement, dated as of February 6, 2017). Pursuant to the Fifth Amendment, the Company reduced the interest rate spread applicable to Term Loan B ("Term Loan B" and, together with Term Loan A, the "Term Loans") from 2.25% to 2.00%. The interest rate applicable to the Term Loan A ("Term Loan A") remained unchanged.

Prior to the Fifth Amendment, \$395 million was outstanding under Term Loan B. Pursuant to the Fifth Amendment, certain lenders converted their existing Term Loan B loans into a new tranche of Term Loan B loans in an aggregate amount, along with Term Loan B loans advanced by certain new lenders, of approximately \$395 million. The proceeds from the new lenders were used to prepay in full all of the existing Term B Loans that were not converted into the new Term Loan B tranche.

As of March 31, 2018, the Credit Agreement, as amended, provided the Company with a 1,094.3 million Term Loan A and a \$395 million Term Loan B and a \$500.0 million revolving credit facility (the "Revolving Credit Facility") with a sub-limit for letters of credit of \$100.0 million. As of March 31, 2018, the maturity date of Term Loan A and the termination date for the Revolving Credit Facility was June 30, 2021 and the maturity date of Term Loan B was June 30, 2023. Booz Allen Hamilton's obligations and the guarantors' guarantees under the Credit Agreement, as amended, are secured by a first priority lien on substantially all of the assets (including capital stock of subsidiaries) of Booz Allen Hamilton, Investor and the subsidiary guarantors, subject to certain exceptions set forth in the Credit Agreement, as amended, and related documentation. Subject to specified conditions, without the consent of the then-existing lenders (but subject to the receipt of commitments), the Term Loans or Revolving Credit Facility may be expanded (or a new term loan facility or revolving credit facility added to the existing facilities) by up to (i) \$400.0 million plus (ii) the aggregate principal amount under which pro forma consolidated net secured leverage remains less than or equal to 3.5:1.00.

At Booz Allen Hamilton's option, borrowings under Term Loan A and the Revolving Credit Facility bear interest based either at LIBOR (adjusted for maximum reserves, and subject to a floor of zero) for the applicable interest period or a base rate (equal to the highest of (x) the administrative agent's prime corporate rate, (y) the overnight federal funds rate plus 0.50% and (z) three-month LIBOR (adjusted for maximum reserves, and subject to a floor of zero) plus 1.00%), in each case plus an applicable margin, payable at the end of the applicable interest period and in any event at least quarterly. The applicable margin for Term Loan A and borrowings under the Revolving Credit Facility ranges from 1.50% to 2.25% for LIBOR loans and 0.50% to 1.25% for base rate loans, in each case based on Booz Allen Hamilton's consolidated total net leverage ratio. The applicable margin for Term Loan B is 2.00% for LIBOR and 1.00% for base rate loans. Unused commitments under the Revolving Credit

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Facility are subject to a quarterly fee ranging from 0.30% to 0.40% based on Booz Allen Hamilton's consolidated total net leverage ratio.

Under the Fifth Amendment, the rate at which Term Loan B bears interest is based either on LIBOR (adjusted for maximum reserves and subject to a floor of zero plus 2.00% for the applicable interest period) or a base rate (equal to the highest of (x) the corporate base rate established by the administrative agent, (y) the overnight federal funds rate plus 0.50%, (z) three-month LIBOR (adjusted for maximum reserves) plus 1.00%, plus, in each case, 1.25%, payable at the end of the applicable interest period; provided, that if such rate shall be less than zero, such rate shall be deemed to be zero.

Booz Allen Hamilton occasionally borrows under the Revolving Credit Facility in anticipation of cash demands. During fiscal 2018 and 2017, Booz Allen Hamilton accessed a total of \$125.0 million and \$575.0 million, respectively, of its \$500.0 million Revolving Credit Facility. As of March 31, 2018, there was no outstanding balance on the Revolving Credit Facility. As of March 31, 2017, there was \$130.0 million outstanding on the Revolving Credit Facility.

The Credit Agreement, as amended, requires quarterly principal payments of 1.25% of the stated principal amount of Term Loan A until maturity, and quarterly principal payments of 0.25% of the stated principal amount of Term Loan B until maturity.

The Credit Agreement, as amended, contains customary representations and warranties and customary affirmative and negative covenants. The negative covenants include limitations on the following, in each case subject to certain exceptions: (i) indebtedness and liens, (ii) mergers, consolidations or amalgamations, liquidations, wind-ups or dissolutions, and disposition of all or substantially all assets; (iii) dispositions of property; (iv) restricted payments; (v) investments; (vi) transactions with affiliates; (vii) sale and lease back transactions; (viii) change in fiscal periods; (ix) negative pledges; (x) restrictive agreements; (xi) line of business; and (xii) speculative hedging. The events of default include the following, in each case subject to certain exceptions: (a) failure to make required payments under the Secured Credit Facility; (b) material breaches of representations or warranties under the Secured Credit Facility; (c) failure to observe covenants or agreements under the Secured Credit Facility; (d) failure to pay or default under certain other material indebtedness; (e) bankruptcy or insolvency; (f) certain Employee Retirement Income Security Act, or ERISA events; (g) certain material judgments; (h) actual or asserted invalidity of the Guarantee and Collateral Agreements or the other security documents or failure of the guarantees or perfected liens thereunder; and (i) a change of control. In addition, Booz Allen Hamilton is required to meet certain financial covenants at each quarter end, namely Consolidated Net Total Leverage and Consolidated Net Interest Coverage Ratios. As of March 31, 2018 and 2017, Booz Allen Hamilton was in compliance with all of these covenants.

During fiscal 2018, interest payments of \$38.1 million and \$14.9 million were made for Term Loan A and Term Loan B, respectively. During fiscal 2017, interest payments of \$28.8 million and \$19.5 million were made for Term Loan A and Term Loan B, respectively.

#### *Senior Notes*

On April 25, 2017, Booz Allen Hamilton issued \$350.0 million aggregate principal amount of its 5.125% Senior Notes, or the Senior Notes, under an Indenture, dated as of April 25, 2017, among Booz Allen Hamilton, certain subsidiaries of Booz Allen Hamilton, as guarantors, or the Subsidiary Guarantors, and Wilmington Trust, National Association, as trustee, or the Trustee, as supplemented by the First Supplemental Indenture, dated as of April 25, 2017, among Booz Allen Hamilton, the Subsidiary Guarantors and the Trustee. Each of Booz Allen Hamilton's existing and future domestic restricted subsidiaries that guarantee its obligations under the Secured Credit Facility and certain other indebtedness guarantee the Senior Notes on a senior unsecured basis. Interest is payable semi-annually on May 1 and November 1 of each year, beginning on November 1, 2017, and principal is due at maturity on May 1, 2025. In connection with the Senior Notes, the Company recognized \$6.7 million of issuance costs, which were recorded as an offset against the carrying value of debt and will be amortized to interest expense over the term of the Senior Notes. During fiscal 2018, interest payments of \$9.3 million were made for the Senior Notes. There were no similar payments made or required in fiscal 2017.

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The following table summarizes required future debt principal repayments (in thousands):

	Payments Due By March 31,						
	Total	2019	2020	2021	2022	2023	Thereafter
Term Loan A	\$1,094,275	\$59,150	\$59,150	\$59,150	\$916,825	\$—	\$—
Term Loan B	395,000	3,950	3,950	3,950	3,950	3,950	375,250
Senior Notes	350,000	—	—	—	—	—	350,000
Total	<u>\$1,839,275</u>	<u>\$63,100</u>	<u>\$63,100</u>	<u>\$63,100</u>	<u>\$920,775</u>	<u>\$3,950</u>	<u>\$725,250</u>

Interest on debt and debt-like instruments consisted of the following:

	Fiscal Year Ended March 31,		
	2018	2017	2016
	(In thousands)		
Term Loan A Interest Expense	\$ 37,575	\$ 28,646	\$ 21,790
Term Loan B Interest Expense	14,138	18,874	32,070
Interest on Revolving Credit Facility	271	751	363
Senior Notes Interest Expense	16,742	—	—
Deferred Payment Obligation Interest <sup>1</sup>	7,993	7,985	8,015
Amortization of Debt Issuance Costs (DIC) and Original Issue Discount (OID) <sup>2</sup>	5,361	5,683	8,359
Other	189	359	218
Total Interest Expense	<u>\$ 82,269</u>	<u>\$ 62,298</u>	<u>\$ 70,815</u>

<sup>1</sup> Interest payments on the deferred payment obligation are made twice a year in January and July. See Note 10 to our consolidated financial statements.

<sup>2</sup> DIC and OID on the Company's term loans are recorded as a reduction of long-term debt in the consolidated balance sheet and are amortized ratably over the life of the related debt using the effective rate method. DIC on the Company's Revolving Credit Facility is recorded as a long-term asset on the consolidated balance sheet and amortized ratably over the term of the revolving credit facility.

## 12. DERIVATIVES

The Company utilizes derivative financial instruments to manage interest rate risk related to its variable rate debt. The Company's objectives in using these interest rate derivatives, which were designated as cash flow hedges, are to manage its exposure to interest rate movements and reduce volatility to interest expense. During the first quarter of fiscal 2018, the Company entered into several forward starting floating-to-fixed interest rate swap agreements with multiple financial institutions with a start date of April 30, 2018. The aggregate notional amount of these interest rate swap agreements was \$450 million as of March 31, 2018. The swaps have staggered maturities, ranging from June 30, 2021 to June 30, 2022. These swaps mature within the last tranche of the Company's floating rate debt (June 30, 2023).

The floating-to-fixed interest rate swaps involve the exchange of variable interest amounts from a counterparty for the Company making fixed-rate interest payments over the life of the agreements without exchange of the underlying notional amount and effectively converting a portion of the variable rate debt into fixed interest rate debt.

Derivative instruments are recorded in the consolidated balance sheet on a gross basis at estimated fair value. As of March 31, 2018, \$0.7 million and \$7.2 million were classified as other current assets and other long-term assets, respectively, on the consolidated balance sheet. For interest rate swaps designated as cash flow hedges, the effective portion of changes in the fair value of derivatives is recorded in Accumulated Other Comprehensive Income, or AOCI, net of taxes, and is subsequently reclassified into interest expense in the period that the hedged forecasted interest payments are made on the Company's variable-rate debt. During fiscal 2018, a \$7.9 million gain has been recognized in AOCI and there were no amounts reclassified into interest expense. The ineffective portion of the change in fair value of the derivatives is recognized directly in earnings. As of March 31, 2018, there was no ineffectiveness recognized in earnings.

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Over the next 12 months, the Company estimates that \$0.7 million will be reclassified as a decrease to interest expense. Cash flows associated with periodic settlements of interest rate swaps will be classified as operating activities in the consolidated statement of cash flows.

The Company is subject to counterparty risk in connection with its interest rate swap derivative contracts. Credit risk related to a derivative financial instrument represents the possibility that the counterparty will not fulfill the terms of the contract. The Company mitigates this credit risk by entering into agreements with credit-worthy counterparties and regularly reviews its credit exposure and the creditworthiness of the counterparties.

### 13. INCOME TAXES

On December 22, 2017, Public Law No. 115-97, commonly referred to as the 2017 Tax Act, was enacted into law. The 2017 Tax Act includes a number of changes to existing U.S. tax laws that impact the Company, most notably a reduction of the U.S. corporate income tax rate from 35% to 21% for tax years beginning after December 31, 2017. It also provides for a one-time transition tax on certain foreign earnings and the acceleration of depreciation for certain assets placed into service after September 27, 2017 as well as additional prospective changes beginning in 2018. Those include, but are not limited to: the implication of global intangible low-taxed income (GILTI) and foreign-derived intangible income (FDII), a repeal of the domestic manufacturing deduction, acceleration of tax revenue recognition, additional limitations on executive compensation and changes or limitations on certain tax deductions.

ASC 740 requires the Company to recognize the effect of the 2017 Tax Act in the first interim period including the date of enactment. The tax rate change was administratively effective at the beginning of the Company's 2018 fiscal year utilizing a blended statutory federal rate for the annual period. As a result, the blended federal statutory tax rate for fiscal year 2018 is 31.5%. The lower federal corporate tax rate also required the Company to remeasure its U.S. deferred tax assets and liabilities as well as reassess the realizability of its deferred tax assets and liabilities. The Company recognized the income tax effects in its fiscal 2018 financial statements in accordance with SAB 118 as described in Note 2. At March 31, 2018, the Company has not completed its accounting for the tax effects of the 2017 Tax Act; however, as described below, the Company recorded a provisional amount for the estimated effects on its deferred tax balances.

The Company remeasured its deferred tax asset and liability balances as of the enactment date and at March 31, 2018 based upon the rates at which they are expected to reverse in the future, which is generally 21% for reversals after fiscal 2018 and a blended rate of 31.5% for reversals within fiscal 2018. The provisional amount recorded related to the re-measurement of the net deferred tax balances was a \$9.1 million reduction to income tax expense in the fourth quarter of fiscal 2018. However, the Company is still analyzing certain aspects of the 2017 Tax Act and refining its deferred tax calculations, which may include the impact of interpretative guidance that may be issued by the IRS in the future. As such, the Company's accounting for the impact of the 2017 Tax Act is not yet complete primarily due to the following items: (1) acceleration of depreciation; and (2) limitation on the deductibility of certain executive compensation such as the effects of the adjustment to IRC 162(m). However, the Company was able to make reasonable estimates related to both of these and included these in its provisional amount. The Company continues to wait on additional guidance from the IRS as to the application of the transitional relief provided for under the 2017 Tax Act. As such, the Company will utilize the measurement period under SAB 118 to continue to monitor for any new developments or guidance related to the transitional relief. Upon the release of relevant and appropriate guidance, the Company will update its position accordingly and may make adjustments to its deferred tax assets and liabilities as necessary. These adjustments may result in an impairment or reversal of the assets or liabilities itself. In addition, as discussed in Note 2, a tax accounting method change was filed with the IRS on March 29, 2018 relating to how the Company recognizes revenue for income tax purposes in consideration of revenue changes stemming from ASC 606 and the 2017 Tax Act associated with unbilled receivables. If approved by the IRS, this will impact the deferred tax adjustment in the period it is approved, including the effects of the change in tax rate. The Company expects to finalize its assessment of all provisional amounts within the maximum one-year measurement period, provided for under SAB 118. These estimates are subject to further analysis and review which may result in further adjustments in fiscal 2019 as noted in Note 2.

The provision for income taxes and effective tax rate in fiscal 2018 included a \$23.3 million favorable impact from the change in tax law. This impact is due primarily to the effects of the statutory federal rate provisions of the 2017 Tax Act and the provisional estimates for the re-measurement of the existing deferred tax asset and liability balances as described above. The other key provision that requires recognition in the period of enactment is the one-time transition tax resulting from the mandatory deemed repatriation of undistributed foreign-sourced earnings. As it relates to the Company's operations, there was no impact in fiscal 2018 from the mandatory deemed repatriation as there was no net undistributed foreign taxable income subject to the tax.

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The components of income tax expense were as follows:

	Fiscal Year Ended March 31,		
	2018	2017	2016
<b>Current</b>			
U.S. Federal	\$ 89,300	\$ 115,727	\$ 57,376
State and local	20,074	24,273	20,480
Foreign	10,014	3,874	3,963
<b>Total current</b>	<b>119,388</b>	<b>143,874</b>	<b>81,819</b>
<b>Deferred</b>			
U.S. Federal	15,157	18,451	8,664
State and local	(1,652)	(2,915)	(5,115)
Foreign	—	—	—
<b>Total deferred</b>	<b>13,505</b>	<b>15,536</b>	<b>3,549</b>
<b>Total</b>	<b>\$ 132,893</b>	<b>\$ 159,410</b>	<b>\$ 85,368</b>

A reconciliation of the provision for income tax to the amount computed by applying the statutory federal income tax rate to income from continuing operations before income taxes for each of the three years ended March 31 is as follows:

	Fiscal Year Ended March 31,		
	2018	2017	2016
Income tax expense computed at U.S. federal statutory rate <sup>(1)</sup>	\$ 138,181	\$ 144,165	\$ 132,812
<b>Increases (reductions) resulting from:</b>			
Changes in uncertain tax positions	140	(92)	(56,428)
State and local income taxes, net of federal tax	14,565	13,882	10,092
Foreign income taxes, net of federal tax	6,855	2,518	2,576
Meals and entertainment	2,247	1,328	1,321
Re-measurement of deferred taxes related to the Act	(9,107)	—	—
Excess tax benefits from stock-based compensation	(14,457)	—	—
Federal tax credits	(6,563)	(4,402)	(4,286)
Other	1,032	2,011	(719)
<b>Income tax expense from operations</b>	<b>\$ 132,893</b>	<b>\$ 159,410</b>	<b>\$ 85,368</b>

(1) The U.S. federal statutory income tax rate for fiscal 2018 is a blended rate of 31.5% due to the 2017 Tax Act.

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The significant components of the Company's deferred income tax assets and liabilities were as follows:

	March 31,	
	2018	2017
<b>Deferred income tax assets:</b>		
Accrued expenses	53,322	85,459
Accrued compensation	28,326	41,421
Stock-based compensation	7,785	15,326
Pension and postretirement benefits	34,449	48,672
Property and equipment	—	3,885
Net operating loss/Capital loss carryforwards	3,362	246
Deferred rent and tenant allowance	20,931	25,167
Extended disability benefits	5,963	8,860
State tax credits	9,822	4,829
Other	1,184	1,988
Total gross deferred income tax assets	165,144	235,853
Less: Valuation allowance	(1,373)	—
Total net deferred income tax assets	163,771	235,853
<b>Deferred income tax liabilities:</b>		
Unbilled receivables	(105,498)	(141,357)
Intangible assets	(57,020)	(78,871)
Debt issuance costs	(3,264)	(4,709)
Property and equipment	(398)	—
Interest rate swaps	(2,076)	—
Other	—	(91)
Total deferred income tax liabilities	(168,256)	(225,028)
Net deferred income tax asset (liability)	\$ (4,485)	\$ 10,825

Deferred tax balances arise from temporary differences between the carrying amount of assets and liabilities and their tax basis and are stated at the enacted tax rates in effect for the year in which the differences are expected to reverse. A valuation allowance is provided against deferred tax assets when it is more likely than not that some or all of the deferred tax asset will not be realized. In determining if the Company's deferred tax assets are realizable, management considers all positive and negative evidence, including the history of generating financial reporting earnings, future reversals of existing taxable temporary differences, projected future taxable income, as well as any tax planning strategies.

As of March 31, 2018, the Company has available federal net operating loss and foreign net operating loss ("NOL carryforwards") of \$2.6 million and \$0.8 million, respectively, that may be applied against future taxable income. The net operating losses are primarily attributable to an acquisition and will begin to expire in fiscal 2037. A valuation allowance of \$1.4 million related to net operating losses, has been recorded due to the uncertainty regarding the realization of the asset.

***Uncertain Tax Positions***

The Company maintains reserves for uncertain tax positions related to unrecognized income tax benefits. These reserves involve considerable judgment and estimation and are evaluated by management based on the best information available including changes in tax laws and other information. As of March 31, 2018, 2017, and 2016, the Company has recorded \$11.8 million, \$11.6 million, and \$1.5 million, respectively, of reserves for uncertain tax positions which includes potential tax benefits of \$11.6 million, \$1.4 million, and \$1.4 million, respectively, that, when recognized, impact the effective tax rate.

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For the fiscal year ended March 31, 2016, the Company's reserves for uncertain tax positions decreased primarily as a result of expired statute of limitations for a prior tax year and management's conclusion that the uncertain tax positions related to the statute lapse were effectively settled. The Company released approximately \$56.9 million of its pre-acquisition uncertain tax positions during fiscal 2016, including \$3.2 million of net interest and penalties that were incurred by the Company subsequent to the acquisition. This resulted in a decrease in the Company's effective tax rate for fiscal 2016. As part of this settlement, an amount of \$21.4 million, previously indemnified under the remaining available DPO was relieved. As of March 31, 2016, there were no estimated tax indemnified amounts recorded against the DPO.

A reconciliation of the beginning and ending amount of potential tax benefits for the periods presented is as follows:

	March 31,		
	2018	2017	2016
Beginning of year	\$ 11,588	\$ 1,449	\$ 55,164
Increases in prior year position	41	127	79
Increases in current year position	—	10,278	—
Settlements with taxing authorities	—	—	(2,581)
Lapse of statute of limitations	(21)	(266)	(51,213)
End of year	<u>\$ 11,608</u>	<u>\$ 11,588</u>	<u>\$ 1,449</u>

The Company recognized (released) accrued interest and penalties of \$0.1 million, \$(9) thousand and \$(3.2) million for fiscal 2018, 2017, and 2016, respectively, related to the reserves for uncertain tax positions in the income tax provision. Included in the total reserve for uncertain tax positions are accrued penalties and interest of approximately \$0.2 million, \$0.1 million and \$0.1 million at March 31, 2018, 2017, and 2016 respectively.

The Company is subject to taxation in the United States and various state and foreign jurisdictions. As of March 31, 2018, the Company's tax years ended March 31, 2013 and forward are open and subject to examination by the federal tax authorities. The other jurisdictions currently open or under examination are not considered to be material.

The Company is currently contesting tax assessments from the District of Columbia Office of Tax and Revenue for fiscal years 2013 through 2015 at various stages of applicable administrative and judicial processes, with a combined amount at issue of approximately \$11.5 million, net of associated tax benefits. The Company has taken similar tax positions with respect to subsequent fiscal years, totaling in aggregate \$22.3 million. As of March 31, 2018, the Company does not maintain reserves for any uncertain tax positions related to the contested tax benefits and given the recoverable nature of the state tax expense it does not believe the resolution of these matters will have a material adverse effect on its results of operations, cash flows or financial condition.

#### 14. EMPLOYEE BENEFIT PLANS

##### *Defined Contribution Plan*

The Company sponsors the Employees' Capital Accumulation Plan, or ECAP, which is a qualified defined contribution plan that covers eligible U.S. and international employees. ECAP provides for distributions, subject to certain vesting provisions, to participants by reason of retirement, death, disability, or termination of employment. Effective April 1, 2014, the Company transitioned from a discretionary employer contribution to an annual matching contribution of up to 6% of eligible annual income as determined by the Internal Revenue Code for the ECAP. Total expense recognized under ECAP for fiscal 2018, 2017, and 2016 was \$126.9 million, \$116.6 million, and \$108.7 million, respectively, and the Company-paid contributions were \$123.9 million, \$114.8 million, and \$107.5 million, respectively.

##### *Defined Benefit Plan and Other Postretirement Benefit Plans*

The Company provides postretirement healthcare benefits to former officers under a medical indemnity insurance plan, with premiums paid by the Company. This plan is referred to as the Officer Medical Plan. The Company also established a non-qualified defined benefit plan for all officers in May 1995, or the Retired Officers' Bonus Plan, which pays a lump-sum amount of \$10,000 per year of service as an officer, provided the officer meets retirement vesting requirements. In addition, the Company provides a fixed annual allowance after retirement to cover financial counseling and other expenses. The Retired

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Officers' Bonus Plan is not salary related, but rather is based primarily on years of service. During fiscal 2017, the Company adopted a new plan which will provide for a one-time, lump sum retirement payment of one month's salary when a vice-president retires from the Company, effective April 1, 2017. This is referred to as the Retired Vice-President Bonus Plan.

The Company recognizes a liability for the defined benefit plans' underfunded status, measures the defined benefit plans' obligations that determine its funded status as of the end of the fiscal year, and recognizes as a component of accumulated other comprehensive income the changes in the defined benefit plans' funded status that are not recognized as components of net periodic benefit cost. The components of net postretirement medical expense for the Officer Medical Plan were as follows:

	Fiscal Year Ended March 31,		
	2018	2017	2016
Service cost	\$ 4,464	\$ 4,851	\$ 5,702
Interest cost	5,008	4,782	4,505
Net actuarial loss	2,271	3,052	3,536
Total postretirement medical expense	<u>\$ 11,743</u>	<u>\$ 12,685</u>	<u>\$ 13,743</u>

The weighted-average discount rate used to determine the year-end benefit obligations was as follows:

	Fiscal Year Ended March 31,		
	2018	2017	2016
Officer Medical Plan	4.10%	4.30%	4.25%
Retired Officers' Bonus Plan	4.10%	4.30%	4.25%
Retired Vice Presidents' Bonus Plan	4.10%	4.30%	—%

Assumed healthcare cost trend rates for the Officer Medical Plan at March 31, 2018 and 2017 were as follows:

	2018	2017
<b>Pre-65 initial rate</b>		
Healthcare cost trend rate assumed for next year	7.75%	7.25%
Rate to which the cost trend rate is assumed to decline (the ultimate trend rate)	4.50%	4.50%
Year that the rate reaches the ultimate trend rate	2027	2024
<b>Post-65 initial rate</b>		
Healthcare cost trend rate assumed for next year	8.00%	8.50%
Rate to which the cost trend rate is assumed to decline (the ultimate trend rate)	4.50%	4.50%
Year that the rate reaches the ultimate trend rate	2027	2024

Assumed healthcare cost trend rates have a significant effect on the amounts reported for the healthcare plans. A one-percentage-point change in assumed healthcare cost trend rates calculated as of March 31, 2018 would have the following effects:

	1% Increase	1% Decrease
Effect on total of service and interest cost	\$ 2,049	\$ (1,591)
Effect on postretirement benefit obligation	21,514	(17,308)

Total defined benefit plan expense, consisting of service, interest, and net actuarial gain associated with the Retired Officers' Bonus Plan was \$0.7 million for fiscal 2018, 2017, and 2016. Benefits paid associated with the Retired Officers' Bonus Plan were \$1.5 million, \$0.9 million, and \$0.3 million for fiscal 2018, 2017, and 2016, respectively. The end-of-period benefit obligation of \$3.8 million and \$4.4 million as of March 31, 2018 and 2017, respectively, is included in postretirement obligations within other long-term liabilities in the accompanying consolidated balance sheets.

Total defined benefit plan expense, consisting of service, interest, prior service cost, and net actuarial gain associated with the Retired Vice-President Bonus Plan was \$0.2 million for fiscal 2018. There was no defined benefit plan expense associated with the Retired Vice-President Bonus Plan for fiscal 2017. There were no benefits paid associated with the Retired Vice-President Bonus Plan for fiscal 2018 and 2017, respectively. The end-of-period benefit obligation associated with the Retired

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Vice-President Bonus Plan was \$0.9 million and \$1.0 million as of March 31, 2018 and 2017, respectively, which are recorded as postretirement obligations within other long-term liabilities in the accompanying consolidated balance sheets.

Other comprehensive loss for fiscal 2018 includes unrecognized gross actuarial gain and prior service cost of \$2.7 million, reduced by taxes of \$1.0 million, that has not yet been recognized in net periodic pension cost for fiscal 2018 for the Retired Officers' Bonus Plan, the Officer Medical Plan, and the Retired Vice-President Bonus Plan. Other comprehensive loss for fiscal 2017 includes unrecognized gross actuarial gain and prior service cost of \$1.1 million, reduced by taxes of \$0.4 million, that has not yet been recognized in net periodic pension cost for fiscal 2017 for the Retired Officers' Bonus Plan, the Officer Medical Plan, and the Retired Vice-President Bonus Plan.

The amounts in accumulated other comprehensive loss expected to be recognized as components of net periodic cost in fiscal 2019 are \$2.1 million of net actuarial loss, \$0.1 million of net prior service cost, and no net transition (asset) obligation.

The changes in the benefit obligation, plan assets, and funded status of the Officer Medical Plan were as follows:

	Fiscal Year Ended March 31,		
	2018	2017	2016
Benefit obligation, beginning of the year	\$ 118,089	\$ 114,008	\$ 107,317
Service cost	4,464	4,851	5,702
Interest cost	5,008	4,782	4,505
Net actuarial (gain) loss	2,744	(2,219)	(496)
Benefits paid	(3,419)	(3,333)	(3,020)
Benefit obligation, end of the year	<u>\$ 126,886</u>	<u>\$ 118,089</u>	<u>\$ 114,008</u>
Changes in plan assets	Fiscal Year Ended March 31,		
	2018	2017	2016
Fair value of plan assets, beginning of the year	\$ —	\$ —	\$ —
Employer contributions	3,419	3,333	3,020
Benefits paid	(3,419)	(3,333)	(3,020)
Fair value of plan assets, end of the year	<u>\$ —</u>	<u>\$ —</u>	<u>\$ —</u>

As of March 31, 2018 and 2017, the unfunded status of the Officer Medical Plan was \$126.9 million and \$118.1 million, respectively, which is included in other long-term liabilities in the accompanying consolidated balance sheets.

***Funded Status for Defined Benefit Plans***

Generally, annual contributions are made at such times and in amounts as required by law and may, from time to time, exceed minimum funding requirements. The Retired Officers' Bonus Plan and the Retired Vice-President Bonus Plan are unfunded plans and contributions are made as benefits are paid. As of March 31, 2018 and 2017, there were no plan assets for either the Retired Officers' Bonus Plan or the Retired Vice-President Bonus Plan and therefore, the accumulated liability of \$4.7 million and \$5.4 million, respectively, is unfunded. The liability will be distributed in a lump-sum payment as each officer or vice-president retires.

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The expected future medical benefit payments and related contributions are as follows:

**For the Fiscal Year Ending March 31,**

2019	\$	3,585
2020	\$	3,936
2021	\$	4,271
2022	\$	4,679
2023	\$	5,588
2024 - 2028	\$	34,503

***Long-term Disability Benefits***

The Company offers medical and dental benefits to inactive employees (and their eligible dependents) on long-term disability. These benefits do not vary with an employee's years of service; therefore, the Company is required to accrue the costs of the benefits at the date the inactive employee becomes disability eligible and elects to participate in the benefit. The accrued cost for such benefits is calculated using an actuarial estimate. The accrued cost for these benefits was \$22.8 million and \$22.5 million at March 31, 2018 and 2017, respectively, and are presented in other long-term liabilities in the accompanying consolidated balance sheets.

**15. ACCUMULATED OTHER COMPREHENSIVE LOSS**

All amounts recorded in other comprehensive loss are related to the Company's post-retirement plans and interest rate swaps designated as cash flow hedges. The following table shows the changes in accumulated other comprehensive income (loss), net of tax:

	<b>Fiscal Year Ended March 31, 2018</b>		
	<b>Post-retirement plans</b>	<b>Derivatives designated as cash flow hedges</b>	<b>Totals</b>
Beginning of year	\$ (17,077)	\$ —	\$ (17,077)
Other comprehensive income (loss) before reclassifications (1)	(1,698)	4,993	3,295
Amounts reclassified from accumulated other comprehensive loss	1,527	—	1,527
Net current-period other comprehensive income (loss)	(171)	4,993	4,822
Reclassification of AOCI due to the Act (2)	(3,707)	856	(2,851)
End of year	\$ (20,955)	\$ 5,849	\$ (15,106)

(1) Changes in other comprehensive income (loss) before reclassification for derivatives designated as cash flow hedges are recorded net of tax expenses of \$2.9 million for the fiscal year ended March 31, 2018.

(2) The amount reclassified from accumulated other comprehensive income to retained earnings from the adoption of ASU 2018-02 as discussed in Note 2.

	<b>Fiscal Year Ended March 31, 2017</b>		
	<b>Post-retirement plans</b>	<b>Derivatives designated as cash flow hedges</b>	<b>Totals</b>
Beginning of year	\$ (19,613)	\$ —	\$ (19,613)
Other comprehensive income (loss) before reclassifications	688	—	688
Amounts reclassified from accumulated other comprehensive loss	1,848	—	1,848
Net current-period other comprehensive income (loss)	2,536	—	2,536
End of year	\$ (17,077)	\$ —	\$ (17,077)

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	Fiscal Year Ended March 31, 2016		
	Post-retirement plans	Derivatives designated as cash flow hedges	Totals
Beginning of year	\$ (22,159)	\$ —	\$ (22,159)
Other comprehensive income (loss) before reclassifications	404	—	404
Amounts reclassified from accumulated other comprehensive loss	2,142	—	2,142
Net current-period other comprehensive income (loss)	2,546	—	2,546
End of year	\$ (19,613)	\$ —	\$ (19,613)

The following table presents the reclassifications out of accumulated other comprehensive loss to net income:

	March 31,		
	2018	2017	2016
Amortization of net actuarial loss included in net periodic benefit cost (See Note 14)			
Total before tax	\$ 2,387	\$ 3,050	\$ 3,536
Tax benefit	(860)	(1,202)	(1,394)
Net of tax	\$ 1,527	\$ 1,848	\$ 2,142

## 16. OTHER LONG-TERM LIABILITIES

Other long-term liabilities consisted of the following:

	March 31,	
	2018	2017
Deferred rent	\$ 79,913	\$ 63,854
Postretirement benefit obligations	131,526	123,492
Other (1)	29,382	28,946
Total other long-term liabilities	\$ 240,821	\$ 216,292

(1) Balances at March 31, 2018 and 2017 include the Company's long-term disability obligation of \$22.8 million and \$22.5 million, respectively, as well as contingent consideration of \$3.6 million as discussed in Note 4.

## 17. STOCKHOLDERS' EQUITY

### Common Stock

Holders of Class A Common Stock and Class E Special Voting Common Stock are entitled to one vote for each share as a holder. The holders of the Voting Common Stock shall vote together as a single class.

Class E Special Voting Common Stock represents the voting rights that accompany the Rollover Options. Rollover Options have a fixed vesting and exercise schedule to comply with IRS Section 409A. Upon exercise, the option will convert to Class A Common Stock, and the corresponding Class E Special Voting Common Stock will be repurchased by the Company and retired. On September 30, 2015, the Company purchased, at par value, all issued and outstanding shares of Class E special voting common stock in connection with the exercise of the final tranche of rollover options during the second quarter of fiscal 2016.

Each share of common stock, except for Class E Special Voting Common Stock, is entitled to participate equally in dividends, when and if declared by the Board of Directors from time to time, such dividends and other distributions in cash, stock, or property from the Company's assets or funds become legally available for such purposes subject to any dividend preferences that may be attributable to preferred stock that may be authorized. The Company's ability to pay dividends to stockholders is limited as a practical matter by restrictions in the credit agreements governing the Senior Credit Facilities.

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The authorized and unissued Class A Common Stock shares are available for future issuance upon share option exercises, without additional stockholder approval.

**Employee Stock Purchase Plan**

In connection with the Company's initial public offering in November 2010, the Company established a tax qualified Employee Stock Purchase Plan, or ESPP, which is designed to enable eligible employees to periodically purchase shares of the Company's Class A Common Stock up to an aggregate of 10,000,000 shares at a five percent discount from the fair market value of the Company's common stock. The ESPP provides for quarterly offering periods, the first of which commenced on April 1, 2011. For the year ended March 31, 2018, 254,380 Class A Common Stock shares were purchased by employees under the ESPP. Since the program's inception, 2,189,287 shares have been purchased by employees.

**Share Repurchase Program**

On December 12, 2011, the Board of Directors approved a \$30.0 million share repurchase program, to be funded from cash on hand. A special committee of the Board of Directors was appointed to evaluate market conditions and other relevant factors and initiate repurchases under the program from time to time. On January 27, 2015, January 25, 2017, and November 2, 2017, the Board of Directors approved increases to the share repurchase authorization to \$180.0 million, \$410.0 million and \$610.0 million, respectively. The share repurchase program may be suspended, modified or discontinued at any time at the Company's discretion without prior notice. During fiscal 2018, the Company purchased 7.2 million shares of the Company's Class A Common Stock in a series of open market transactions for \$257.6 million. During fiscal 2017, the Company purchased 1.3 million shares of the Company's Class A Common Stock in a series of open market transactions for \$46.4 million. As of March 31, 2018, the Company had \$197.9 million remaining under the repurchase program.

**Dividends**

The following table summarizes the cash distributions recognized in the consolidated statement of cash flows:

	Fiscal Year Ended March 31,		
	2018	2017	2016
Recurring dividends (1)	\$ 103,411	\$ 92,925	\$ 80,015
Dividend equivalents (2)	951	2,254	31,802
<b>Total distributions</b>	<b>\$ 104,362</b>	<b>\$ 95,179</b>	<b>\$ 111,817</b>

(1) Amounts represent recurring quarterly dividends that were declared and paid for during each quarter of fiscal 2018, 2017, and 2016.

(2) Dividend equivalents are distributions made to option holders equal to the special dividends declared and paid.

The total payout of the dividend and the dividend equivalents have been presented as a financing activity within the consolidated statement of cash flows.

**18. STOCK-BASED COMPENSATION**

The following table summarizes stock-based compensation expense recognized in the consolidated statements of operations:

	Fiscal Year Ended March 31,		
	2018	2017	2016
Cost of revenue	\$ 7,771	\$ 5,756	\$ 7,001
General and administrative expenses	15,547	15,493	17,991
<b>Total</b>	<b>\$ 23,318</b>	<b>\$ 21,249</b>	<b>\$ 24,992</b>

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The following table summarizes the total stock-based compensation expense recognized in the consolidated statements of operations by the following types of equity awards:

	Fiscal Year Ended March 31,		
	2018	2017	2016
Equity Incentive Plan Options	\$ 2,036	\$ 2,523	\$ 3,702
Restricted Stock Awards	21,282	18,726	21,290
<b>Total</b>	<b>\$ 23,318</b>	<b>\$ 21,249</b>	<b>\$ 24,992</b>

As of March 31, 2018 and 2017, there was \$17.3 million and \$12.8 million, respectively, of total unrecognized compensation cost related to unvested stock-based compensation agreements. The unrecognized compensation cost as of March 31, 2018 is expected to be fully amortized over the next 4 years. Absent the effect of accelerating stock compensation cost for any departures of employees who may continue to vest in their equity awards, the following tables summarize the unrecognized compensation cost, the weighted average period the cost is expected to be amortized, and the estimated annual compensation cost for the future periods indicated below (excludes any future awards):

	Unrecognized Compensation Cost		Weighted Average Remaining Period to be Recognized	
	March 31, 2018	March 31, 2017	March 31, 2018	March 31, 2017
Equity Incentive Plan Options	\$ 2,809	\$ 1,777	3.60	2.84
Restricted Stock Awards	14,512	11,007	1.87	1.75
<b>Total</b>	<b>\$ 17,321</b>	<b>\$ 12,784</b>		

	Total Unrecognized Compensation Cost					
	Total	2019	2020	2021	2022	2023
Equity Incentive Plan Options	\$ 2,809	\$ 1,417	\$ 812	\$ 404	\$ 176	\$ —
Restricted Stock Awards	14,512	9,910	4,589	13	—	—
<b>Total</b>	<b>\$ 17,321</b>	<b>\$ 11,327</b>	<b>\$ 5,401</b>	<b>\$ 417</b>	<b>\$ 176</b>	<b>\$ —</b>

**Equity Incentive Plan**

The Company's Equity Incentive Plan, or EIP, was adopted in connection with the Merger Agreement for employees and directors of Holding. The EIP was amended and restated in 2010 in connection with the Company's initial public offering, and was again amended and restated on May 22, 2014. Awards under the EIP may be made in the form of stock options; stock purchase rights; restricted stock; restricted stock units; performance shares; performance units; stock appreciation rights; dividend equivalents; deferred share units; dividend equivalents; and other stock-based awards.

*Stock Options*

Stock options under the EIP are granted at the discretion of the Board of Directors or its Compensation Committee and expire ten years from the grant date. Stock options generally vest in equal installments over a five-year period subject to the grantee's continued service on each applicable vesting. All options under the EIP are exercisable, upon vesting, for shares of Class A common stock of Holding. The Company calculates the pool of additional paid-in capital associated with excess tax benefits using the "simplified method."

On May 17, 2017, 211,822 options were granted under the EIP. The estimated fair value of the per-option grant was \$9.32, resulting in a total fair value of \$2.0 million.

On May 19, 2017, 158,283 options were granted under the EIP. The estimated fair value of the per-option grant was \$9.48, resulting in a total fair value of \$1.5 million.

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On August 2, 2017, 5,631 options were granted under the EIP. The estimated fair value of the per-option grant was \$8.88, resulting in a total fair value of \$0.05 million.

On January 31, 2018, 17,274 options were granted under the EIP. The estimated fair value of the per-option grant was \$8.68, resulting in a total fair value of \$0.1 million.

The aggregate grant date fair value of the EIP Options issued during fiscal 2018 and 2017, was \$3.7 million and \$0.4 million, respectively, and is being recorded as expense over the vesting period. The total fair value of EIP Options vested during fiscal 2018 and 2017 was \$2.7 million and \$11.8 million, respectively. The total intrinsic value of EIP options exercised during fiscal 2018 and 2017 was \$36.7 million and \$49.0 million, respectively. As of March 31, 2018 and 2017, there were 11,433,883 and 12,026,970 options, respectively, available for future grant under the EIP.

*Annual Incentive Plans*

On October 1, 2010, the Board of Directors adopted an Annual Incentive Plan (or "AIP") in connection with the initial public offering to more appropriately align the Company's compensation programs with those of similarly situated companies. The amount of the annual incentive payment is determined based on performance targets established by the Board of Directors and a portion of the bonus may be paid in the form of equity (including stock and other awards under the EIP). For bonus periods prior to the 2018 fiscal year, if the Board of Directors elected to make a portion of the payments in equity, the value of the portion of the AIP award paid in equity was increased by 20%. Such equity awards vest over a three-year period subject to the employee's continued service to the Company. The portion paid in the form of equity was recognized in the accompanying consolidated statements of operations based on grant date fair value over the vesting period of three years. The portion paid in cash was accrued ratably during the fiscal year in which the employees provide service and paid out during the first quarter of the subsequent fiscal year.

During fiscal 2018, the Company implemented a new annual incentive program for officers. The equity compensation would be issued in the form of restricted stock units of which a portion would vest based on the passage of time, and the other portion would vest based on specified performance conditions to be achieved over a specified time period. A restricted stock unit represents a contingent right to receive one share of Class A Common Stock upon vesting. Service-based restricted stock units vest in equal installments over a three-year period subject to the grantee's continued service on each applicable vesting date and are settled for shares of the Company's common stock. Dividend equivalents are paid in respect of the service-based restricted stock units when dividends are paid on the Company's common stock. Performance-based awards vest at the end of a three-year period subject to certain specified financial performance criteria and the grantee's continued service through the period. These awards are settled for Company Class A Common Stock and dividend equivalents. Compensation expense for performance-based awards during the performance period is estimated at each reporting date using management's expectation of the probable achievement of the specified performance criteria.

*Grants of Class A Restricted Common Stock and Restricted Stock Units*

During fiscal 2018, the Board of Directors granted an aggregate of 786,350 Restricted Stock Units with service-based and performance-based vesting conditions to existing officers and vice presidents of the Company, as well as to newly promoted and hired partners and vice presidents. A portion of these awards were issued in conjunction with the Annual Incentive Plan, whereby a portion of the incentive payment was paid in the form of Restricted Stock Units. The awards issued to newly hired and promoted employees will vest over a three-year period subject to the employees' continued employment with the Company.

The Board of Directors also granted 58,735 shares of Class A Restricted Common Stock to members of the Board of Directors during fiscal 2018. These awards generally vest over one year.

The aggregate fair value of all awards issued during fiscal 2018 was \$29.3 million and was based on the grant date stock price, which ranged from \$32.55 to \$39.18. This amount will be recognized in the accompanying consolidated statements of operations over the applicable vesting period of the awards.

The total fair value of restricted stock shares vested during fiscal 2018 and 2017 was \$26.7 million and \$30.2 million, respectively.

As permitted under the terms of the EIP, the Compensation Committee, as Administrator of the Plan, authorized the withholding of taxes not to exceed the minimum statutory withholding amount, through the surrender of shares of Class A common stock issuable upon the vesting or accelerated vesting of Restricted Stock. As a result of these transactions, the

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Company repurchased 140,534 shares on June 30, 2017 and 190,295 shares on March 31, 2018 and recorded them as treasury shares at a total cost of \$11.9 million in fiscal 2018.

**Methodology**

The Company uses the Black-Scholes option-pricing model to determine the estimated fair value for stock-based awards. The fair value of the Company's stock is based on the closing price on the New York Stock Exchange.

During fiscal 2018, the Company's Board of Directors authorized and declared three regular quarterly cash dividends of \$0.17 per share and one quarterly cash dividend of \$0.19 per share. Therefore, an annualized dividend yield between 1.89% and 2.00% was used in the Black-Scholes option-pricing model for all grants issued during the fiscal year. The Company plans to continue paying recurring dividends in the near term and assessing its excess cash resources to determine the best way to utilize its excess cash flow to meet its objectives. One way the Company may utilize excess cash includes the payment of special dividends. The Company does not anticipate or forecast the payment of special dividends and therefore does not include special dividends in the annual dividend yield that the company uses to calculate the fair value of stock options, as the Company does not pay these special dividends on a regular basis.

Implied volatility is calculated as of each grant date based on our historical volatility. Other than the expected life of the option, volatility is the most sensitive input to our option grants.

The risk-free interest rate is determined by reference to the U.S. Treasury yield curve rates with the remaining term equal to the expected life assumed at the date of grant. The average expected life is calculated based on the Company's historical experience with respect to its stock plan activity in combination with an estimate of when vested and unexercised option shares will be exercised. Forfeitures were estimated based on the Company's historical analysis of officer and vice-president attrition levels and actual forfeiture rates by grant date.

The weighted average assumptions used in the Black-Scholes option-pricing model for stock option awards were as follows:

	<b>For The Fiscal Year Ended March 31,</b>		
	<b>2018</b>	<b>2017</b>	<b>2016</b>
Dividend yield	1.9%	1.94%	1.83%
Expected volatility	33.04%	29.65%	29.85%
Risk-free interest rate	1.81%	1.38%	1.33%
Expected life (in years)	5.00	5.00	5.08
Weighted-average grant date fair value	\$9.35	\$7.16	\$6.67

**Special Dividends**

The Compensation Committee, acting as the Administrator of the EIP, has discretion in how to effect the required adjustment to keep option holders whole in the event of a distribution of dividends that trigger certain anti-dilution clauses within the respective plans. In the event the Compensation Committee elects to grant option holders a cash payment equal to the amount of the special dividend, the Company accrues a stock-based compensation liability as the EIP options are scheduled to be vested. The obligation will be settled on the later of the date the dividend is paid or the vesting date of the EIP options. The stock-based compensation liability includes all special dividends declared for which eligible EIP option holders have not yet received a distribution.

On June 30, 2017, vested EIP option holders received a payment of \$0.9 million related to the special dividends declared in fiscal years, 2014, and 2015. On March 31, 2018, vested EIP option holders received a payment of \$0.06 million related to the special dividends declared in fiscal years 2014 and 2015. Payment of the dividend equivalents were accounted for as modifications resulting in incremental benefit to the option holders resulting in additional compensation expense. Total compensation expense recorded in conjunction with the payment of all dividend equivalents to holders of unvested EIP options for the fiscal year ended March 31, 2018 was \$0.03 million.

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The following table summarizes unvested restricted stock activity for the periods presented:

	Number of Shares	Weighted Average Grant Date Fair Value
<b>Unvested Restricted Stock Awards</b>		
Unvested at March 31, 2017	1,277,508	25.71
Granted	845,085	34.70
Vested	1,007,214	26.46
Forfeited	158,273	28.66
Unvested at March 31, 2018	957,106	32.36

The following table summarizes stock option activity for the periods presented:

	Number of Options	Weighted Average Exercise Price
<b>Equity Incentive Plan Options</b>		
Options outstanding at March 31, 2017	3,824,237	\$ 13.99 *
Granted	393,010	35.89
Forfeited	108,369	23.17
Expired	47,835	22.70
Exercised	1,261,089	9.59
Options outstanding at March 31, 2018	2,799,954	\$ 18.55 *

\* Reflects exercise price adjustment of \$6.36 per grant for the \$6.50 dividend per share issued July 30, 2012.

The following table summarizes unvested stock options for the periods presented:

	Number of Options	Weighted Average Grant Date Fair Value
<b>Equity Incentive Plan Options</b>		
Unvested at March 31, 2017	812,561	\$ 5.61
Granted	393,010	9.35
Vested	459,335	5.95
Forfeited	108,369	5.59
Unvested at March 31, 2018	637,867	\$ 7.68

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The following table summarizes stock options outstanding at March 31, 2018:

Range of exercise prices	Stock Options Outstanding	Weighted Average Exercise Price	Weighted Average Remaining Contractual Life (In years)	Intrinsic Value	Stock Options Exercisable	Weighted Average Exercise Price	Weighted Average Remaining Contractual Life (In years)	Intrinsic Value	
									<b>Equity Incentive Plan</b>
\$4.28 - \$39.18	2,799,954	\$18.55	(1)	4.99	\$ 56,477	2,162,087	\$14.96	4.13	\$51,372

(1) Reflects exercise price adjustment of \$6.36 per grant for the \$6.50 dividend per share issued July 30, 2012.

**19. FAIR VALUE MEASUREMENTS**

The accounting standard for fair value measurements establishes a three-tier value hierarchy, which prioritizes the inputs used in measuring fair value as follows: observable inputs such as quoted prices in active markets (Level 1); inputs other than quoted prices in active markets that are observable either directly or indirectly (Level 2); and unobservable inputs in which there is little or no market data, which requires the Company to develop its own assumptions (Level 3).

A financial instrument's level within the fair value hierarchy is based on the lowest level of input that is significant to the fair value measurement. The financial instruments measured at fair value in the accompanying consolidated balance sheets consist of the following:

**Recurring Fair Value Measurements  
as of March 31, 2018**

	Level 1	Level 2	Level 3	Total
<b>Cash and cash equivalents:</b>				
Cash and cash equivalents	\$ 51,870	\$ —	\$ —	\$ 51,870
Money market funds (1)	207,618	27,470	—	235,088
<b>Total cash and cash equivalents</b>	<b>\$ 259,488</b>	<b>\$ 27,470</b>	<b>\$ —</b>	<b>\$ 286,958</b>
<b>Other Assets:</b>				
Current derivative instruments (3)	\$ —	\$ 700	\$ —	\$ 700
Long-term derivative instruments (3)	—	7,225	—	7,225
<b>Total Other Assets</b>	<b>\$ —</b>	<b>\$ 7,925</b>	<b>\$ —</b>	<b>\$ 7,925</b>
<b>Liabilities:</b>				
Contingent consideration liability (2)	\$ —	\$ —	\$ 3,576	\$ 3,576
<b>Total liabilities</b>	<b>\$ —</b>	<b>\$ —</b>	<b>\$ 3,576</b>	<b>\$ 3,576</b>

**Recurring Fair Value Measurements  
as of March 31, 2017**

	Level 1	Level 2	Level 3	Total
<b>Cash and cash equivalents:</b>				
Cash and cash equivalents	\$ 59,825	\$ —	\$ —	\$ 59,825
Money market funds (1)	—	157,592	—	157,592
<b>Total cash and cash equivalents</b>	<b>\$ 59,825</b>	<b>\$ 157,592</b>	<b>\$ —</b>	<b>\$ 217,417</b>
<b>Liabilities:</b>				
Contingent consideration liability (2)	—	—	\$ 3,576	3,576
<b>Total liabilities</b>	<b>\$ —</b>	<b>\$ —</b>	<b>\$ 3,576</b>	<b>\$ 3,576</b>

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(1) Level 2 cash and cash equivalents are invested in money market funds that are intended to maintain a stable net asset value of \$1.00 per share by investing in liquid, high quality U.S. dollar-denominated money market instruments. Therefore, the fair value approximates the carrying value. Depending on our short-term liquidity needs, we make regular transfers between money market funds and other cash equivalents.

(2) As discussed in Note 4, the Company recognized a contingent consideration liability in connection with the acquisition of Aquilent. As of March 31, 2018 and 2017, the estimated fair value of the contingent consideration liability was \$3.6 million and was valued using probability-weighted cash flows, which is based on the use of Level 3 fair value measurement inputs. The liability is recorded in other long-term liabilities in the consolidated balance sheet.

(3) The Company's interest rate swaps are considered over-the-counter derivatives and fair value is estimated based on the present value of future cash flows using a model-derived valuation that uses Level 2 observable inputs such as interest rate yield curves. See Note 12 to our consolidated financial statements for further discussion on the Company's derivative instruments designated as cash flow hedges.

The fair value of the Company's debt instruments approximated its carrying value at March 31, 2018 and 2017. The fair value of debt is determined using quoted prices or other market information obtained from recent trading activity of each debt tranche in markets that are not active (Level 2 inputs). The fair value is corroborated by prices derived from the interest rate spreads of recently completed leveraged loan transactions of a similar credit profile, industry, and terms to that of the Company. The fair value of Senior Notes is determined using quoted prices or other market information from recent trading activity in the high-yield bond market (Level 2 inputs).

## **20. RELATED-PARTY TRANSACTIONS**

In March 2017, the Company supported the formation of the Booz Allen Foundation, a nonprofit corporation organized and operated exclusively for charitable, scientific and educational purposes within the meaning of Section 501(c)(3) of the Code. The Company is the sole member of the foundation, which gives it the authority to appoint two out of five of the Booz Allen Foundation's directors and consent rights regarding certain extraordinary corporate actions approved by the board of directors. The Company has made a binding and irrevocable pledge of \$5.0 million to the Booz Allen Foundation and recorded the pledge obligation in other current liabilities on the consolidated balance sheet of the Company in March 2017. As of March 31, 2018, \$1.7 million of the pledge has been paid to the Booz Allen Foundation and is classified within operating activities in the consolidated statement of cash flows.

## **21. COMMITMENTS AND CONTINGENCIES**

### *Leases*

The Company leases office space under noncancelable operating leases that expire at various dates through 2031. The terms for the facility leases generally provide for rental payments on a graduated scale, which are recognized on a straight-line basis over the terms of the leases, including reasonably assured renewal periods, from the time the Company controls the leased property. Sometimes lease payments include payments for insurance, maintenance, and property taxes. There are no purchase options on operating leases at terms favorable to market rents. Lease incentives are recorded as a deferred credit and recognized as a reduction to rent expense on a straight-line basis over the lease term. Rent expense was approximately \$81.2 million, net of \$0.6 million of sublease income, \$81.6 million, net of \$0.5 million of sublease income, and \$88.5 million, net of \$0.5 million of sublease income, for fiscal 2018, 2017, and 2016, respectively.

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Future minimum operating lease payments for noncancelable operating leases and future minimum income for noncancelable sublease rentals are summarized as follows:

For the Fiscal Year Ending March 31,	Operating Lease Payments	Operating Sublease Income
2019	\$ 71,013	\$ 276
2020	66,879	24
2021	56,153	—
2022	45,800	—
2023	41,773	—
Thereafter	141,889	—
	<u>\$ 423,507</u>	<u>\$ 300</u>

Rent expense is included in occupancy costs, a component of general and administrative expenses, as shown on the consolidated statements of operations, and includes rent, sublease income from third parties, real estate taxes, utilities, parking, security, repairs and maintenance, and storage costs.

***Letters of Credit and Third-Party Guarantees***

As of March 31, 2018 and 2017, the Company was contingently liable under open standby letters of credit and bank guarantees issued by our banks in favor of third parties that totaled \$6.3 million and \$8.6 million, respectively. These letters of credit and bank guarantees primarily support insurance and bid and performance obligations. At March 31, 2018 and 2017, approximately \$1.4 million and \$1.7 million, respectively, of these instruments reduce the available borrowings under the Revolving Credit Facility. The remainder is guaranteed under a separate \$15.0 million facility established in fiscal 2015 of which \$10.1 million and \$3.1 million, respectively, was available to the Company at March 31, 2018 and 2017.

***Government Contracting Matters***

For fiscal 2018, 2017, and 2016, approximately 97%, 97%, and 97%, respectively, of the Company's revenue was generated from contracts where the end user was an agency or department of the U.S. government, including contracts where the Company performed in either as a prime contractor or subcontractor, and regardless of the geographic location in which the work was performed. U.S. government contracts and subcontracts are subject to extensive legal and regulatory requirements. From time to time and in the ordinary course of business, agencies of the U.S. government audit our contract costs and conduct inquiries and investigations of our business practices with respect to government contracts to determine whether the Company's operations are conducted in accordance with these requirements and the terms of the relevant contracts. U.S. government agencies, including the Defense Contract Audit Agency, routinely audit our contract costs, including allocated indirect costs for compliance with the Cost Accounting Standards and the Federal Acquisition Regulation. These agencies also conduct reviews and investigations and make inquiries regarding our accounting and other systems in connection with our performance and business practices with respect to our government contracts. U.S. government audits, inquiries, or investigations of the Company, whether related to the Company's U.S. government contracts or subcontracts or conducted for other reasons, could result in administrative, civil, or criminal liabilities, including withholding of payments, suspension of payments, repayments, fines, or penalties being imposed upon the Company, or could lead to suspension or debarment from future U.S. government contracting. Management believes it has recorded the appropriate provision for any such audit, inquiry, or investigation of which it is aware. Management believes it has recorded the appropriate provision for the estimated losses that may be experienced from any such reductions and/or penalties. As of March 31, 2018 and 2017, the Company has recorded a liability of approximately \$168.6 million and \$175.7 million, respectively, for its current best estimate of amounts to be refunded to customers for potential adjustments from audits or reviews of contract costs incurred subsequent to fiscal year 2011, and for contracts not yet closed that are impacted by settlement of audits or reviews of contract costs incurred in prior fiscal years.

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***Litigation***

The Company is involved in legal proceedings and investigations arising in the ordinary course of business, including those relating to employment matters, relationships with clients and contractors, intellectual property disputes, and other business matters. These legal proceedings seek various remedies, including claims for monetary damages in varying amounts, none of which are considered material, or are unspecified as to amount. Although the outcome of any such matter is inherently uncertain and may be materially adverse, based on current information, management does not expect any of the currently ongoing audits, reviews, investigations, or litigation to have a material adverse effect on the Company's financial condition and results of operations. As of March 31, 2018 and 2017, there were no material amounts accrued in the consolidated financial statements related to these proceedings.

Six former officers and stockholders who had departed the company prior to the acquisition of the Company by the Carlyle Group (the "Carlyle Acquisition") have filed a total of nine suits in various jurisdictions, with original filing dates ranging from July 3, 2008 through December 15, 2009, against us and certain of our current and former directors and officers. Three of these suits were amended on July 2, 2010 and then further amended into one consolidated complaint on September 7, 2010. Another two of the original nine suits were consolidated into one complaint on September 24, 2014. Each of the suits arises out of the Carlyle Acquisition and alleges that the former stockholders are entitled to certain payments that they would have received if they had held their stock at the time of the Carlyle Acquisition. Some of the suits also allege that the acquisition price paid to stockholders was insufficient. The various suits assert claims for breach of contract, tortious interference with contract, breach of fiduciary duty, civil Racketeer Influenced and Corrupt Organizations Act, or RICO, violations, violations of the ERISA, and/or securities and common law fraud. Three of these suits have been dismissed with all appeals exhausted. The two suits that were consolidated into one action on September 24, 2014 were settled on April 16, 2015. One of the remaining suits has been dismissed by the United States District Court for the Southern District of California and such dismissal was upheld by the United States Court of Appeals for the Ninth Circuit. The plaintiff in this suit subsequently filed a Petition for Writ of Certiorari to the United States Supreme Court, which was denied by the United States Supreme Court on January 9, 2017. The other three remaining suits that were previously consolidated on September 7, 2010 have been dismissed by the United States District Court for the Southern District of New York and were on appeal before the United States Court of Appeals for the Second Circuit. On July 13, 2017, the United States Court of Appeals for the Second Circuit affirmed the ruling of the United States District Court for the Southern District of New York, except for one plaintiff's securities fraud claim, which was remanded to the United States District Court for the Southern District of New York to give the plaintiff, Paul Kocourek, leave to file another amended complaint to attempt to plead a securities fraud claim. On April 6, 2018, the plaintiff filed an amended complaint in which Mr. Kocourek, individually, as Trustee of the Paul Kocourek Trust and on behalf of the putative class, alleges that the Company and certain former officers and directors violated Sections 10(b), 20(a) and 14(e) of the Securities Exchange Act of 1934, as amended (the "Exchange Act"). On April 25, 2018, the court entered an order postponing the deadline within which the defendants must answer or move to dismiss the amended complaint. A lead plaintiff has not been appointed.

As of March 31, 2018, the aggregate alleged damages that will be sought in the remaining suit is unknown. As of March 31, 2018, although the outcome of any of these cases is inherently uncertain and may be materially adverse, based on current information, management does not expect them to have a material adverse effect on our financial condition and results of operations.

On June 7, 2017, Booz Allen Hamilton Inc. was informed that the U.S. Department of Justice (DOJ) is conducting a civil and criminal investigation of the Company. In connection with the investigation, the DOJ has requested information from the Company relating to certain elements of the Company's cost accounting and indirect cost charging practices with the U.S. government. Since learning of the investigation, the Company has engaged a law firm experienced in these matters to represent the Company in connection with this matter and respond to the government's requests. As is commonly the case with this type of matter, the Company has also been in contact with other regulatory agencies and bodies, including the Securities and Exchange Commission, which notified the Company that it is conducting an investigation that the Company believes relates to matters that are also the subject of the DOJ's investigation. The Company may receive additional regulatory or governmental inquiries related to the matters that are the subject of the DOJ's investigation. In accordance with the Company's practice, the company is cooperating with all relevant government parties. The total cost associated with these matters will depend on many factors, including the duration of these matters and any related findings. At this stage, the Company is not able to reasonably estimate the expected amount or range of cost or any loss associated with these matters.

On June 19, 2017, a purported stockholder of the Company filed a putative class action lawsuit in the United States District Court for the Eastern District of Virginia styled *Langley v. Booz Allen Hamilton Holding Corp.*, No. 17-cv-00696

**BOOZ ALLEN HAMILTON HOLDING CORPORATION**  
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naming the Company, its Chief Executive Officer and its Chief Financial Officer as defendants purportedly on behalf of all purchasers of the Company's securities from May 19, 2016 through June 15, 2017. On September 5, 2017, the court named two lead plaintiffs and on October 20, 2017, the lead plaintiffs filed a consolidated amended complaint. The complaint asserts claims under Sections 10(b) and 20(a) of the Exchange Act, and Rule 10b-5 promulgated thereunder, alleging misrepresentations or omissions by the Company purporting to relate to matters that are the subject of the DOJ investigation described above. The plaintiffs seek to recover from the Company and the individual defendants an unspecified amount of damages. The Company believes the suit lacks merit and intends to defend against the lawsuit. Motions to dismiss were argued on January 12, 2018, and on February 8, 2018, the court dismissed the amended complaint in its entirety without prejudice. At this stage of the lawsuit, the Company is not able to reasonably estimate the expected amount or range of cost or any loss associated with the lawsuit.

On November 13, 2017, a Verified Shareholder Derivative Complaint was filed in the United States District Court for the District of Delaware styled Celine Thum v. Rozanski et. al., C.A. No. 17-cv-01638, naming the Company as a nominal defendant and numerous current and former officers and directors as defendants. The complaint asserts claims for breach of fiduciary duties, unjust enrichment, waste of corporate assets, abuse of control, gross mismanagement, and violations of Sections 14(a), 10(b) and 20(a) of the Exchange Act, purportedly relating to matters that are the subject of the DOJ investigation described above. The parties have stipulated to a stay of the proceedings pending the outcome of the securities litigation (described above), which the court so ordered on January 24, 2018. At this stage of the lawsuit, the Company is not able to reasonably estimate the expected amount or range of cost or any loss associated with the lawsuit.

## 22. BUSINESS SEGMENT INFORMATION

The Company reports operating results and financial data in one operating and reportable segment. The Company manages its business as a single profit center in order to promote collaboration, provide comprehensive functional service offerings across its entire client base, and provide incentives to employees based on the success of the organization as a whole. Although certain information regarding served markets and functional capabilities is discussed for purposes of promoting an understanding of the Company's complex business, the Company manages its business and allocates resources at the consolidated level of a single operating segment.

## 23. UNAUDITED QUARTERLY FINANCIAL DATA

	2018 Quarters			
	First	Second	Third	Fourth
Revenue	\$ 1,493,570	\$ 1,542,085	\$ 1,499,914	\$ 1,636,284
Operating income	139,464	126,486	118,087	136,048
Income before income taxes	121,478	106,091	98,013	112,422
Net income	79,540	70,913	69,773	84,885
Earnings per common share:				
Basic (1)	\$ 0.53	\$ 0.48	\$ 0.48	\$ 0.59
Diluted (1)	\$ 0.53	\$ 0.47	\$ 0.47	\$ 0.58

	2017 Quarters			
	First	Second	Third	Fourth
Revenue	\$ 1,422,722	\$ 1,394,853	\$ 1,404,638	\$ 1,582,071
Operating income	129,301	117,661	108,124	129,161
Income before income taxes	113,364	97,747	92,615	108,174
Net income	67,817	62,830	55,590	66,253
Earnings per common share:				
Basic (1)	\$ 0.46	\$ 0.42	\$ 0.37	\$ 0.44
Diluted (1)	\$ 0.45	\$ 0.41	\$ 0.37	\$ 0.44

**BOOZ ALLEN HAMILTON HOLDING CORPORATION**  
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(1) Earnings per share are computed independently for each of the quarters presented and therefore may not sum to the total for the fiscal year.

**24. SUPPLEMENTAL FINANCIAL INFORMATION**

The following schedule summarizes valuation and qualifying accounts for the periods presented:

	Fiscal Year Ended March 31,		
	2018	2017	2016
<b>Allowance for doubtful accounts:</b>			
Beginning balance	\$ —	\$ 656	\$ 357
Provision for doubtful accounts	706	(135)	352
Charges against allowance	(629)	(521)	(53)
Ending balance	<u>\$ 77</u>	<u>\$ —</u>	<u>\$ 656</u>
<b>Tax valuation allowance</b>			
Beginning balance	—	—	—
Deductions and other adjustments	(1,373)	—	—
Ending balance	<u>\$ (1,373)</u>	<u>—</u>	<u>—</u>

**BOOZ ALLEN HAMILTON HOLDING CORPORATION**  
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**25. SUBSEQUENT EVENTS**

*Shares repurchased and withheld to cover taxes*

The Company paid \$1.8 million and \$7.3 million during the first quarter of fiscal 2019, respectively, for 46,300 shares repurchased and 190,295 shares withheld to cover taxes related to Restricted Stock vesting during the fourth quarter of fiscal 2018 that had not settled in cash by March 31, 2018.

*Dividend Declared*

On May 29, 2018, the Company announced that its Board of Directors had declared a quarterly cash dividend of \$0.19 per share. Payment of the dividend will be made on June 29, 2018 to stockholders of record at the close of business on June 14, 2018.

*Share Repurchase Authorization*

On May 24, 2018, the Board of Directors approved an increase to our share repurchase authorization from \$610.0 million to up to \$910.0 million. As of May 24, 2018, taking into effect the increase in the share repurchase authorization, the Company may repurchase up to approximately \$493.7 million of additional shares of common stock under its share repurchase program.

**Item 9. Changes in and Disagreements With Accountants on Accounting and Financial Disclosure.**

None.

**Item 9A. Controls and Procedures**

**Disclosure Controls and Procedures**

The Company's management, with the participation of our Chief Executive Officer and Chief Financial Officer, has evaluated the effectiveness of our disclosure controls and procedures, as defined in Rules 13a-15(e) and 15d-15(e) of the Securities Exchange Act of 1934, as of the end of the period covered by this Annual Report. Based on that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that, as of the end of the period covered by this Annual Report, our disclosure controls and procedures were effective as of March 31, 2018.

**Management's Annual Report on Internal Control over Financial Reporting and Attestation Report of the Registered Public Accounting Firm**

Our management is responsible for establishing and maintaining adequate internal control over financial reporting. Our internal control system was designed to provide reasonable assurance to our management and board of directors regarding the reliability of financial reporting and the preparation of consolidated financial statements for external purposes.

Our management conducted an assessment of the effectiveness of our internal control over financial reporting as of March 31, 2018. This assessment was based on the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission in *Internal Control — Integrated Framework (2013 framework)*. Based on this assessment, management has concluded that, as of March 31, 2018, our internal control over financial reporting was effective.

Our independent registered public accounting firm has issued a report on the effectiveness of our internal control over financial reporting, which is below.

**Changes in Internal Control Over Financial Reporting**

There have been no changes in our internal control over financial reporting, as defined in Rules 13a-15(f) and 15d-15(f) of the Securities Exchange Act of 1934, that occurred in the fourth fiscal quarter of the period covered by this Annual Report that materially affected, or are reasonably likely to materially affect, our internal control over financial reporting.

**Report of Ernst & Young LLP,  
Independent Registered Public Accounting Firm,  
Regarding Internal Control over Financial Reporting**

To the Shareholders and Board of Directors of  
Booz Allen Hamilton Holding Corporation

**Opinion on Internal Control over Financial Reporting**

We have audited Booz Allen Hamilton Holding Corporation's internal control over financial reporting as of March 31, 2018, based on criteria established in Internal Control - Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (2013 framework) (the COSO criteria). In our opinion, Booz Allen Hamilton Holding Corporation maintained, in all material respects, effective internal control over financial reporting as of March 31, 2018 based on the COSO criteria.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States) (PCAOB), the consolidated balance sheets of Booz Allen Hamilton Holding Corporation as of March 31, 2018 and March 31, 2017 and the related consolidated statements of operations, comprehensive income, stockholders' equity, and cash flows for each of the three years in the period ended March 31, 2018 and related notes, of Booz Allen Hamilton Holding Corporation and our report dated May 29, 2018 expressed an unqualified opinion thereon.

**Basis for Opinion**

The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying Management's Annual Report on Internal Control over Financial Reporting. Our responsibility is to express an opinion on the company's internal control over financial reporting based on our audit. We are a public accounting firm registered with the PCAOB and are required to be independent with respect to the Company in accordance with the U.S. federal securities laws and the applicable rules and regulations of the Securities and Exchange Commission and the PCAOB.

We conducted our audit in accordance with the standards of the PCAOB. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether effective internal control over financial reporting was maintained in all material respects. Our audit included obtaining an understanding of internal control over financial reporting, assessing the risk that a material weakness exists, testing and evaluating the design and operating effectiveness of internal control based on the assessed risk, and performing such other procedures as we considered necessary in the circumstances. We believe that our audit provides a reasonable basis for our opinion.

**Definition and Limitations of Internal Control Over Financial Reporting**

A company's internal control over financial reporting is a process designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles. A company's internal control over financial reporting includes those policies and procedures that (1) pertain to the maintenance of records that, in reasonable detail, accurately and fairly reflect the transactions and dispositions of the assets of the company; (2) provide reasonable assurance that transactions are recorded as necessary to permit preparation of financial statements in accordance with generally accepted accounting principles, and that receipts and expenditures of the company are being made only in accordance with authorizations of management and directors of the company; and (3) provide reasonable assurance regarding prevention or timely detection of unauthorized acquisition, use, or disposition of the company's assets that could have a material effect on the financial statements.

Because of its inherent limitations, internal control over financial reporting may not prevent or detect misstatements. Also, projections of any evaluation of effectiveness to future periods are subject to the risk that controls may become inadequate because of changes in conditions, or that the degree of compliance with the policies or procedures may deteriorate.

/s/ Ernst & Young LLP

Tysons, Virginia  
May 29, 2018

**Item 9B. Other Information.**

On May 23, 2018, the Company's compensation committee approved for the 2019 fiscal year certain changes to the incentive compensation opportunities for Horacio D. Rozanski, the Company's President and Chief Executive Officer. Effective for fiscal year 2019, Mr. Rozanski's target annual cash bonus and target annual equity grant value will be increased to \$1.125 million and \$4.0 million, respectively. His base salary will remain the same.

**PART III**

**Item 10. Directors, Executive Officers and Corporate Governance.**

Information related to our directors is set forth under the caption "Election of Directors" of our Proxy Statement for our Annual Meeting of Stockholders scheduled for July 26, 2018 (the "2018 Proxy Statement"). Such information is incorporated herein by reference.

Information relating to our Executive Officers is included in Part I of this Annual Report under the caption "Executive Officers of the Registrant."

Information relating to compliance with Section 16(a) of the Exchange Act is set forth under the caption "Section 16(a) Beneficial Ownership Reporting Compliance" of our 2018 Proxy Statement. Such information is incorporated herein by reference.

Information related to our code of ethics is set forth under the caption "Corporate Governance and General Information Concerning the Board of Directors and its Committees" of our 2018 Proxy Statement. Such information is incorporated herein by reference.

Information relating to the Audit Committee and Board of Directors determinations concerning whether a member of the Audit Committee is a "financial expert" as that term is defined under Item 407(d)(5) of Regulation S-K is set forth under the caption "Corporate Governance and General Information Concerning the Board of Directors and its Committees" of our 2018 Proxy Statement. Such information is incorporated herein by reference.

**Item 11. Executive Compensation.**

Information relating to this item is set forth under the captions "Compensation Discussion and Analysis," "Director Compensation," "Compensation Committee Interlocks and Insider Participation" and "Compensation Committee Report on Executive Compensation" of our 2018 Proxy Statement. Such information is incorporated herein by reference.

**Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters.****Equity Compensation Plans**

The following table presents information concerning the securities authorized for issuance pursuant to our equity compensation plans as of March 31, 2018:

<b>Plan Category</b>	<b>Number of Securities to Be Issued Upon Exercise of Outstanding Options, Warrants and Rights (a)</b>		<b>Weighted Average Exercise Price of Outstanding Options, Warrants and Rights (b)</b>	<b>Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)</b>
Equity compensation plans approved by securityholders	3,731,116	(1)(2)	\$ 18.55	11,433,883
Equity compensation plans not approved by securityholders	—		N/A	—
<b>Total</b>	<b>3,731,116</b>	<b>(1)(2)</b>	<b>\$ 18.55</b>	<b>11,433,883</b>

(1) Column (a) includes: 931,162 shares that have been granted as restricted stock units (RSUs) and 2,799,954 shares granted as options under our equity compensation plans. The weighted average price in column (b) does not take into account shares issued pursuant to RSUs.

Information relating to the security ownership of certain beneficial owners and management is included in our 2018 Proxy Statement under the caption “Security Ownership of Certain Beneficial Owners and Management” and is incorporated herein by reference.

**Item 13. Certain Relationships and Related Transactions, and Director Independence.**

Information relating to this item is set forth under the captions “Certain Relationships and Related Party Transactions” and “Corporate Governance and General Information Concerning the Board of Directors and its Committees” of our 2018 Proxy Statement. Such information is incorporated herein by reference.

**Item 14. Principal Accounting Fees and Services**

Information relating to this item is set forth under the caption “Independent Registered Public Accounting Firm Fees” of our 2018 Proxy Statement. Such information is incorporated herein by reference.

**Item 15. Exhibits, Financial Statement Schedules.**

(a) The following documents are filed as part of this Annual Report:

- (1) Financial Statements

Our consolidated financial statements filed herewith are set forth in Item 8 of this Annual Report.

- (2) Financial Statement Schedules

Consolidated financial statement schedules have been omitted because either they are not applicable or the required information is included in the consolidated financial statements or the notes thereto.

- (3) Exhibits

## Exhibit Index

<u>Exhibit Number</u>	<u>Description</u>
2.1	<a href="#"><u>Agreement and Plan of Merger, dated as of May 15, 2008, by and among Booz Allen Hamilton Inc., Booz Allen Hamilton Holding Corporation (formerly known as Explorer Holding Corporation), Booz Allen Hamilton Investor Corporation (formerly known as Explorer Investor Corporation), Explorer Merger Sub Corporation and Booz &amp; Company Inc. (Incorporated by reference to Exhibit 2.1 to the Company's Registration Statement on Form S-1 (File No. 333-167645)).</u></a>
2.2	<a href="#"><u>Spin Off Agreement, dated as of May 15, 2008, by and among Booz Allen Hamilton Inc., Booz &amp; Company Holdings, LLC, Booz &amp; Company Inc., Booz &amp; Company Intermediate I Inc. and Booz &amp; Company Intermediate II Inc. (Incorporated by reference to Exhibit 2.2 to the Company's Registration Statement on Form S-1 (File No. 333-167645)).</u></a>
2.3	<a href="#"><u>Amendment to the Agreement and Plan of Merger and the Spin Off Agreement, dated as of July 30, 2008, by and among Booz Allen Hamilton Inc., Booz Allen Hamilton Holding Corporation (formerly known as Explorer Holding Corporation), Booz Allen Hamilton Investor Corporation (formerly known as Explorer Investor Corporation), Explorer Merger Sub Corporation, Booz &amp; Company Holdings, LLC, Booz &amp; Company Inc., Booz &amp; Company Intermediate I Inc. and Booz &amp; Company Intermediate II Inc. (Incorporated by reference to Exhibit 2.3 to the Company's Registration Statement on Form S-1 (File No. 333-167645)).</u></a>
3.1	<a href="#"><u>Third Amended and Restated Certificate of Incorporation of Booz Allen Hamilton Holding Corporation (Incorporated by reference to Exhibit 3.1 to the Company's Quarterly Report for the period ended September 30, 2014 on Form 10-Q (File No. 001-34972)).</u></a>
3.2	<a href="#"><u>Third Amended and Restated Bylaws of Booz Allen Hamilton Holding Corporation (Incorporated by reference to Exhibit 3.2 to the Company's Quarterly Report for the period ended December 31, 2017 on Form 10-Q (File No. 001-34972)).</u></a>
4.1	<a href="#"><u>Form of Stock Certificate (Incorporated by reference to Exhibit 4.5 to the Company's Registration Statement on Form S-1 (File No. 333-167645)).</u></a>
4.2	<a href="#"><u>Indenture, dated April 25, 2017, among Booz Allen Hamilton Inc., the Subsidiary Guarantors party thereto and Wilmington Trust, National Association (Incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on April 25, 2017 (File No. 001-34972)).</u></a>
4.3	<a href="#"><u>First Supplemental Indenture, dated April 25, 2017, among Booz Allen Hamilton Inc., the Subsidiary Guarantors party thereto and Wilmington Trust, National Association (Incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on April 25, 2017 (File No. 001-34972)).</u></a>
4.4	<a href="#"><u>Form of 5.125% Senior Note due 2025 (Incorporated by reference to Exhibit 4.3 to the Company's Current Report on Form 8-K filed on April 25, 2017 (File No. 001-34972) (included in Exhibit 4.1 thereto)).</u></a>
10.1†	<a href="#"><u>Second Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation (Incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report for the period ended September 30, 2014 on Form 10-Q (File No. 001-34972)).</u></a>
10.2†	<a href="#"><u>Form of Stock Option Agreement under the Equity Incentive Plan of Booz Allen Hamilton Holding Corporation (Incorporated by reference to Exhibit 10.10 to the Company's Registration Statement on Form S-1 (File No. 333-167645)).</u></a>
10.3†	<a href="#"><u>Form of Stock Option Agreement under the Equity Incentive Plan of Booz Allen Hamilton Holding Corporation (Incorporated by reference to Exhibit 10.11 to the Company's Registration Statement on Form S-1 (File No. 333-167645)).</u></a>
10.4†	<a href="#"><u>Form of Subscription Agreement (Incorporated by reference to Exhibit 10.12 to the Company's Registration Statement on Form S-1 (File No. 333-167645)).</u></a>
10.5†	<a href="#"><u>Amended and Restated Booz Allen Hamilton Holding Corporation Annual Incentive Plan (Incorporated by reference to Exhibit 10.10 to the Company's Quarterly Report for the period ended September 30, 2014 on Form 10-Q (File No. 001-34972)).</u></a>
10.6†	<a href="#"><u>Booz Allen Hamilton Holding Corporation Officers' Retirement Plan*</u></a>
10.7†	<a href="#"><u>Officer's Comprehensive Medical and Dental Choice Plans*</u></a>

- 10.8† [Retired Officer's Comprehensive Medical and Dental Choice Plans\\*](#)
- 10.9† [Group Variable Universal Life Insurance \(Incorporated by reference to Exhibit 10.14 to the Company's Annual Report for the year ended March 31, 2015 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.10† [Group Personal Excess Liability Insurance\\*](#)
- 10.11† [Officer Annual Performance Bonus Policy\\*](#)
- 10.12† [Form of Booz Allen Hamilton Holding Corporation Director and Officer Indemnification Agreement \(Incorporated by reference to Exhibit 10.23 to the Company's Registration Statement on Form S-1 \(File No. 333-167645\)\)](#)
- 10.13† [Form of Stock Option Agreement under the Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.23 to the Company's Annual Report for the year ended March 31, 2011 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.14† [Officer Transition Policy\\*](#)
- 10.15† [Form of Stock Option Agreement under the Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.25 to the Company's Quarterly Report for the period ended December 31, 2011 on Form 10-Q \(File No. 001-34972\)\)](#)
- 10.16 [Credit Agreement among Booz Allen Hamilton Inc., as the Borrower, the several lenders from time to time parties thereto, Bank of America, N.A., as Administrative Agent, Collateral Agent and Issuing Lender, Merrill Lynch, Pierce, Fenner & Smith Incorporated and Credit Suisse Securities \(USA\) LLC, as Joint Lead Arrangers, Merrill Lynch, Pierce, Fenner & Smith Incorporated, Credit Suisse Securities \(USA\) LLC, Barclays Bank PLC, Citigroup Global Markets Inc., HSBC Securities \(USA\) Inc., J.P. Morgan Securities LLC, Morgan Stanley Senior Funding, Inc. and Sumimoto Mitsui Banking Corporation, as Joint Bookrunners, Credit Suisse Securities \(USA\) LLC, as Syndication Agent, Barclays Bank PLC, Citigroup Global Markets Inc., HSBC Securities \(USA\) Inc., J.P. Morgan Securities LLC, Morgan Stanley Senior Funding, Inc., Sumimoto Mitsui Banking Corporation and The Bank of Tokyo-Mitsubishi UFJ, Ltd., as Co-Documentation Agents, dated as of July 31, 2012 \(Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on August 1, 2012 \(File No. 001-34972\)\)](#)
- 10.17 [Guarantee and Collateral Agreement, among Booz Allen Hamilton Investor Corporation, Booz Allen Hamilton Inc., ASE, Inc. and Booz Allen Hamilton International, Inc., in favor of Bank of America, N.A., as Collateral Agent, dated as of July 31, 2012 \(Incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on August 1, 2012 \(File No. 001-34972\)\)](#)
- 10.18 [First Amendment to Credit Agreement, dated as of August 16, 2013, among Booz Allen Hamilton Inc., as Borrower, Booz Allen Hamilton Investor Corporation, Booz Allen Hamilton Engineering Holding Co., LLC, Booz Allen Hamilton Engineering Services, LLC, SDI Technology Corporation, and Booz Allen Hamilton International, Inc., as Guarantors, Bank of America, N.A., as Administrative Agent, Collateral Agent and New Refinancing Tranche B Term Lender, and the other Lenders and financial institutions from time to time party thereto. \(Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on August 20, 2013 \(File No. 001-34972\)\)](#)
- 10.19† [Form of Employment Agreement \(Incorporated by reference to Exhibit 10.27 to the Company's Annual Report for the year ended March 31, 2014 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.20† [Form of Restricted Stock Agreement under the Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.28 to the Company's Annual Report for the year ended March 31, 2014 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.21† [Form of Restricted Stock Unit Agreement under the Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.29 to the Company's Annual Report for the year ended March 31, 2014 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.22 [Second Amendment to Credit Agreement, dated as of May 7, 2014, among Booz Allen Hamilton Inc., as Borrower, Booz Allen Hamilton Investor Corporation, Booz Allen Hamilton Engineering Holding Co., LLC, Booz Allen Hamilton Engineering Services, LLC, SDI Technology Corporation, ASE, Inc. and Booz Allen Hamilton International, Inc., as Guarantors, Bank of America, N.A., as Administrative Agent, Collateral Agent and Issuing Lender, and the other Lenders and financial institutions from time to time party thereto \(Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on May 13, 2014 \(File No. 001-34972\)\)](#)
- 10.23 [Third Amendment to Credit Agreement, dated as of July 13, 2016, among Booz Allen Hamilton Inc., as Borrower, Booz Allen Hamilton Investor Corporation, Booz Allen Hamilton Engineering Holding Co., LLC, Booz Allen Hamilton Engineering Services, LLC, SDI Technology Corporation, ASE, Inc. and Booz Allen Hamilton International, Inc., as Guarantors, Bank of America, N.A., as Administrative Agent, Collateral Agent and New Refinancing Tranche B Term Lender, and the other Lenders and financial institutions from time to time party thereto \(Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on July 18, 2016 \(File No. 001-34972\)\)](#)

- 10.24 [Fourth Amendment to Credit Agreement, dated as of February 6, 2017, among Booz Allen Hamilton Inc., as Borrower, Booz Allen Hamilton Investor Corporation, Booz Allen Hamilton Engineering Holding Co., LLC, Booz Allen Hamilton Engineering Services, LLC and SDI Technology Corporation, as Guarantors, Bank of America, N.A., as Administrative Agent, Collateral Agent and New Refinancing Tranche B Term Lender, and the other Lenders and financial institutions from time to time party thereto \(Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on February 7, 2017 \(File No. 001-34972\)\)](#)
- 10.25 [Fifth Amendment to Credit Agreement, dated as of March 7, 2018, among Booz Allen Hamilton Inc., as Borrower, Booz Allen Hamilton Investor Corporation, Booz Allen Hamilton Engineering Holding Co., LLC, Booz Allen Hamilton Engineering Services, LLC, SDI Technology Corporation, eGov Holdings, Inc. and Aquilent, Inc., as Guarantors, Bank of America, N.A., as Administrative Agent, Collateral Agent, Exchanging Lender and New Refinancing Tranche B Term Lender, and the other Lenders and financial institutions from time to time party thereto \(Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on March 7, 2018 \(File No. 001-34972\)\)](#)
- 10.26 [ISDA 2002 Master Agreement, by and between Booz Allen Hamilton Inc. and Bank of America, N.A., dated as of December 17, 2014 \(the "Bank of America Master Agreement"\), and the Amended and Restated Schedule to the Bank of America Master Agreement, dated as of February 6, 2017 \(Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on April 11, 2017 \(File No. 001-34972\)\)](#)
- 10.27 [ISDA 2002 Master Agreement, by and between Booz Allen Hamilton Inc. and JPMorgan Chase Bank, N.A., dated as of December 17, 2014 \(the "JPM Master Agreement"\), and the Amended and Restated Schedule to the JPM Master Agreement, dated as of February 8, 2017 \(Incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on April 11, 2017 \(File No. 001-34972\)\)](#)
- 10.28 [ISDA 2002 Master Agreement, by and between Booz Allen Hamilton Inc. and Fifth Third Bank, dated as of December 16, 2014 \(the "Fifth Third Master Agreement"\), and the Amended and Restated Schedule to the Fifth Third Master Agreement, dated as of February 7, 2017 \(Incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K filed on April 11, 2017 \(File No. 001-34972\)\)](#)
- 10.29 [ISDA Master Agreement, by and between Booz Allen Hamilton Inc. and The Bank of Tokyo-Mitsubishi UFJ, Ltd. dated as of January 13, 2015 \(the "Bank of Tokyo-Mitsubishi Master Agreement"\), and the Amendment to the Bank of Tokyo-Mitsubishi Master Agreement, dated as of April 18, 2017 \(including the Schedule thereto\) \(Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on May 31, 2017 \(File No. 001-34972\)\)](#)
- 10.30 [ISDA Master Agreement, by and between Booz Allen Hamilton Inc. and Barclays Bank Plc, dated as of December 11, 2014 \(the "Barclays Master Agreement"\), and the Amendment to the Barclays Master Agreement, dated as of May 18, 2017 \(including the Amended and Restated Schedule thereto\) \(Incorporated by reference to Exhibit 10.2 to the Company's Current Report on Form 8-K filed on May 31, 2017 \(File No. 001-34972\)\)](#)
- 10.31 [ISDA Master Agreement, by and between Booz Allen Hamilton Inc. and Wells Fargo Bank, N.A., dated as of February 13, 2017 \(the "Wells Fargo Master Agreement"\), including the Schedule thereto \(Incorporated by reference to Exhibit 10.3 to the Company's Current Report on Form 8-K filed on May 31, 2017 \(File No. 001-34972\)\)](#)
- 10.32 [Confirmation of transaction, by and between Booz Allen Hamilton Inc. and Bank of America, N.A., dated as of April 6, 2017 \(Incorporated by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K filed on April 11, 2017 \(File No. 001-34972\)\)](#)
- 10.33 [Confirmation of transaction, by and between Booz Allen Hamilton Inc. and JPMorgan Chase Bank, N.A., dated as of April 6, 2017 \(Incorporated by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K filed on April 11, 2017 \(File No. 001-34972\)\)](#)
- 10.34 [Confirmation of transaction, by and between Booz Allen Hamilton Inc. and Fifth Third Bank, dated as of April 6, 2017 \(Incorporated by reference to Exhibit 10.6 to the Company's Current Report on Form 8-K filed on April 11, 2017 \(File No. 001-34972\)\)](#)
- 10.35 [Confirmation of transaction, by and between Booz Allen Hamilton Inc. and The Bank of Tokyo-Mitsubishi UFJ, Ltd., dated as of May 26, 2017 \(Incorporated by reference to Exhibit 10.4 to the Company's Current Report on Form 8-K filed on May 31, 2017 \(File No. 001-34972\)\)](#)
- 10.36 [Confirmation of transaction, by and between Booz Allen Hamilton Inc. and Barclays Bank Plc, dated as of May 30, 2017 \(Incorporated by reference to Exhibit 10.5 to the Company's Current Report on Form 8-K filed on May 31, 2017 \(File No. 001-34972\)\)](#)
- 10.37 [Confirmation of transaction, by and between Booz Allen Hamilton Inc. and Wells Fargo Bank, N.A., dated as of May 25, 2017 \(Incorporated by reference to Exhibit 10.6 to the Company's Current Report on Form 8-K filed on May 31, 2017 \(File No. 001-34972\)\)](#)

- 10.38 [Assumption Agreement, dated as of April 14, 2017, by eGov Holdings, Inc. and Aquilent, Inc. in favor of Bank of America, N.A., as collateral agent for the banks and other financial institutions or entities party to the Credit Agreement, as amended \(Incorporated by reference to Exhibit 10.10 to the Company's Quarterly Report for the period ended June 30, 2017 on Form 10-Q \(File No. 001-34972\)\)](#)
- 10.39† [Booz Allen Hamilton Inc. Nonqualified Deferred Compensation Plan \(Incorporated by reference to Exhibit 10.35 to the Company's Annual Report for the year ended March 31, 2017 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.40† [Form of Stock Option Agreement under the Second Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.36 to the Company's Annual Report for the year ended March 31, 2017 of Form 10-K \(File No. 001-34972\)\)](#)
- 10.41† [Form of Performance Restricted Stock Unit Agreement under the Second Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.37 to the Company's Annual Report for the year ended March 31, 2017 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.42† [Form of Restricted Stock Unit Agreement under the Second Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.38 to the Company's Annual Report for the year ended March 31, 2017 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.43† [Form of Restricted Stock Unit Agreement under the Second Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.39 to the Company's Annual Report for the year ended March 31, 2017 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.44† [Form of Restricted Stock Agreement for Directors under the Second Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation\\*](#)
- 10.45† [Officer Perquisites Policy\\*](#)
- 21 [Subsidiaries of the registrant\\*](#)
- 23 [Consent of Ernst & Young LLP, Independent Registered Public Accounting Firm\\*](#)
- 31.1 [Rule 13a-14\(a\)/15d-14\(a\) Certification of the Chief Executive Officer\\*](#)
- 31.2 [Rule 13a-14\(a\)/15d-14\(a\) Certification of the Chief Financial Officer\\*](#)
- 32.1 [Certification of the Chief Executive Officer required by Rule 13a-14\(b\) or Rule 15d-14\(b\) and Section 1350 of Chapter 63 of Title 18 of the United States Code \(18 U.S.C. 1350\)\\*](#)
- 32.2 [Certification of the Chief Financial Officer required by Rule 13a-14\(b\) or Rule 15d-14\(b\) and Section 1350 of Chapter 63 of Title 18 of the United States Code \(18 U.S.C. 1350\)\\*](#)
- 101 The following materials from Booz Allen Hamilton Holding Corporation's Annual Report on Form 10-K for the fiscal year ended March 31, 2018, formatted in XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets as of March 31, 2018 and 2017; (ii) Consolidated Statements of Operations for the fiscal years ended March 31, 2018, 2017 and 2016; (iii) Consolidated Statements of Comprehensive Income for the fiscal years ended March 31, 2018, 2017 and 2016; (iv) Consolidated Statements of Cash Flows for the fiscal years ended March 31, 2018, 2017 and 2016; (v) Consolidated Statements of Stockholders' Equity for the fiscal years ended March 31, 2018, 2017 and 2016; and (vi) Notes to Consolidated Financial Statements.

\* Filed electronically herewith.

† Management contract or compensatory arrangement.

**Item 16. Form 10-K Summary.**

None.

## SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned, thereunto duly authorized on this 29th day of May, 2018.

BOOZ ALLEN HAMILTON HOLDING CORPORATION  
(Registrant)

By: /s/ Horacio D. Rozanski  
Name: Horacio D. Rozanski  
Title: President and Chief Executive Officer

## SIGNATURES

Pursuant to the requirements of the Securities Act of 1934, this report has been signed by the following persons in the capacities and on the dates indicated.

Signature	Title	Date
<u>/s/ Horacio D. Rozanski</u> Horacio D. Rozanski	President, Chief Executive Officer and Director (Principal Executive Officer)	May 29, 2018
<u>/s/ Lloyd W. Howell, Jr.</u> Lloyd W. Howell, Jr.	Executive Vice President, Chief Financial Officer and Treasurer (Principal Financial Officer)	May 29, 2018
<u>/s/ Laura S. Adams</u> Laura S. Adams	Vice President, Corporate Controller and Chief Accounting Officer (Principal Accounting Officer)	May 29, 2018
<u>/s/ Ralph W. Shrader</u> Ralph W. Shrader	Chairman of the Board	May 29, 2018
<u>/s/ Joan Lordi C. Amble</u> Joan Lordi C. Amble	Director	May 29, 2018
<u>/s/ Melody C. Barnes</u> Melody C. Barnes	Director	May 29, 2018
<u>/s/ Peter Clare</u> Peter Clare	Director	May 29, 2018
<u>/s/ Ian Fujiyama</u> Ian Fujiyama	Director	May 29, 2018
<u>/s/ Mark Gaumond</u> Mark Gaumond	Director	May 29, 2018
<u>/s/ Arthur E. Johnson</u> Arthur E. Johnson	Director	May 29, 2018

/s/ Gretchen W. McClain

Gretchen W. McClain

Director

May 29, 2018

/s/ Philip A. Odeen

Philip A. Odeen

Director

May 29, 2018

/s/ Charles O. Rossotti

Charles O. Rossotti

Director

May 29, 2018

## Retirement

### SCOPE:

Retirement for an Officer implies significant change in a relationship — typically of considerable duration — involving substantial commitment by and benefit to both the Officer and the firm. The retirement process and program should reflect the nature of this relationship. It is expected that both the Officer and the firm will feel a strong mutual obligation to conduct the retirement process with respect, dignity, and generosity.

To be most effective, the retirement process should be characterized by openness, honesty, clarity, and equitability. Both the process and post-retirement programs should foster close continuing relations between the retired Officer and the firm.

The retirement program is intended to facilitate transition to retirement. Performance issues will be treated independent of retirement considerations.

### GENERAL POLICY STATEMENT:

An Officer is eligible to retire, with full retirement benefits, after a minimum of:

- Five years of service as an Officer and upon reaching age 60, or
- Ten years of service as an Officer and upon reaching age 50.

For business continuity and succession planning, an Officer is requested to provide written notification of intention to retire at least one year prior to the Officer's anticipated retirement date to the Chief Personnel Officer. In order for a retirement to become effective and for the Officer to become entitled to the benefits described in this Policy a minimum of 6 months is required. In some cases additional notification time may be necessary for business reasons and appropriate planning. During this notification period, the Officer shall retain the Officer's current compensation and benefits. All or any portion of the notification period may be waived by the firm, but only upon the written approval of the Chief Personnel Officer. Former Officers rehired within five years from the date of the termination of their previous employment will be granted credit for prior service with the firm in determining eligibility for retirement benefits. Officers with more than a five-year break-in-service will not be given credit for prior service.

At the firm's discretion, retiring officers may receive the firm's transition benefits as outlined in the Transition Policy in lieu of all retirement benefits. Officers must make this request in writing to the Chief Personnel Officer.

At the firm's discretion, Officers departing the firm who do not meet the eligibility criteria to retire as an Officer but have been with the firm for at least 25 years, in either an Officer or staff position, may be offered continued health and dental coverage in concert with the U.S. Retired Officer Medical and Dental Plan.

### Approaching Retirement

When an Officer is within one year of retirement eligibility, he/she will be provided with an overview of retirement policies and benefits. Beginning at age 55, formal appraisals may specifically address the issue of the Officer's future role. Officers are expected to inform their team/management of intentions regarding retirement well in advance to allow adequate time for transition planning and management.

Retirement may be staged in one of two ways:

- From full engagement to full retirement on an agreed date
- “Phase down” with reduced points, objectives, and level of effort over a period that is not expected to exceed three years. (The Flexible Work Arrangements Policy, which allows Officers and staff to work at less than 100% with compensation reduced accordingly, continues to be an option and is not affected by the Retirement Policy.)

Level of involvement, role, and activities of Officers in “phase down” mode will be agreed upon with the appropriate team/management and reviewed annually.

### **Retirement Payment**

For each year of service as an Officer, an Officer is eligible for a retirement payment of \$10,000, pro-rated as appropriate. An Officer’s eligibility to receive the retirement payment shall be determined on the following basis:

- The Officer has retired on his/her own volition, his/her employment with the firm has not been terminated by the firm, and he/she has not received severance benefits to which an Officer who has been terminated would be entitled, and
- The Officer has completed at least five years of service as an Officer and has reached the age of 60, or
- The Officer has completed at least 10 years of service as an Officer and has reached the age of 50.
- Any Officer terminated for cause will be ineligible to receive this payment.

### **Other Retirement-related Policies**

The firm has established other Officer Policies that include provisions applicable to Officers upon retirement:

- Bonus Awards for Departing Officers
- Officer Perquisites - Financial Counseling (Pre-retirement)
- Retirement Celebration and Gift

### **Benefits in Retirement**

#### **Financial Counseling and Annual Physical Examinations**

Upon retirement, \$4,000 is available each year as a combined amount to be applied toward financial counseling/tax preparation assistance and/or an annual physical examination if not covered under the retired Officer’s medical insurance plan.

These benefits will be provided to non-U.S. citizen, non-U.S. based, retired Officers at the same pre-tax cost to the firm as incurred for U.S.-citizen/U.S.-based retired Officers.

#### **Medical Insurance**

Comprehensive medical insurance coverage will continue for U.S.-based/U.S.-citizen Officers in retirement under the U.S. Retired Officer Medical and Dental Insurance Plan or a successor plan (the “Retired Officer Medical Plan”); premiums are paid by the firm. If a retired Officer pre-deceases his/her spouse or domestic partner, the spouse/domestic partner can remain in the Retired Officer Medical Plan for life at the firm’s expense. Officers based outside the U. S. will be provided comparable coverage. (Coverage in the Medical Plus plan ends on the date of retirement.)

If during the five-year period after a “change in control” (as defined in the Amended and Restated Equity Incentive Plan) the Retired Officer Medical Plan is terminated or modified in a manner that is materially adverse to Officers or retired Officers, all Officers (and their spouses/domestic partners) and all retired Officers (and their spouses/domestic partners) who are covered by the Retired Officer Medical Plan will be guaranteed continued benefits under the Retired Officer Medical Plan through the fifth anniversary of the change in control. In addition, each Officer (or their spouse/domestic partner) and each retired Officer (or their spouse/domestic partner) who is covered by the Retired Officer Medical Plan shall be paid, during the 90-day period following the fifth anniversary of the change in control, an amount equal to the excess of the actuarial cost of the Officer’s (and their spouse’s/domestic partner’s) or retired Officer’s (and spouse’s/domestic partner’s) benefits under the Retired Officer Medical Plan that would be accrued on the firm’s financial statements on the fifth anniversary of the change in control in the absence of such termination or modification of the Retired Officer Medical Plan over the amount that is accrued on the firm’s financial statements on the fifth anniversary of the change in control giving effect to the termination or modification (but excluding any accrual for the payment itself). The actuarial and other assumptions used in calculating the accruals will be the same assumptions as those used to calculate the accrual immediately prior to the change in control, with such changes as are required under generally accepted accounting principles or as otherwise approved by a majority of the members of the firm’s leadership team, as constituted immediately prior to the change in control (the “CIC Team”).

The firm will notify the Officers of any termination or modification that will result in a payment under this policy within 30 days after a decision to terminate or modify the Retired Officer Medical Plan is approved and in any event no later than 90 days prior to the fifth anniversary of the change in control. Within 30 days after the fifth anniversary of the change in control, the firm will prepare and deliver to the CIC Team a statement setting forth the calculation of the aggregate payments to the Officers. The CIC Team, acting by majority vote, will have 30 days following receipt of the calculation to deliver a written notice that the Officers dispute the calculation of the payments, which notice will set forth in reasonable detail the basis for the dispute (e.g., mathematical errors or a change in assumptions other than as required by generally accepted accounting principles). If the CIC Team does not submit a notice of dispute prior to the end of the 30-day period, the calculation will be deemed final and binding. The firm and the CIC Team will work in good faith to resolve any dispute as promptly as possible. Any portion of the accruals that are not in dispute (i.e., the payment as originally calculated by the firm) will be paid to the Officers on or before the 90th day following the fifth anniversary of the change in control.

If the firm and the CIC Team are unable to resolve a dispute on or before the 30th day following receipt by the firm of the notice of dispute, the firm will retain a nationally recognized independent public accounting firm (the “Accounting Firm”) selected by the CIC Team to resolve any remaining disputes contained in the notice of dispute. The Accounting Firm will return a determination to the firm and the CIC Team as soon as practicable and no later than 60 days after being engaged to resolve the disputes. The determination of the Accounting Firm will be final and binding with respect to all disputes presented to it. The firm will pay any remaining amount within 30 days of the resolution of the dispute and, in any event, no later than December 31 of the year in which the Accounting Firm delivers its final determination. For purposes of this provision, “Officer” shall include those Vice Presidents of the firm who were Senior Directors as of 10/1/2009.

#### **Retirement Plan**

Retired Officers are eligible for a distribution of vested benefits from their firm-sponsored capital accumulation/retirement/pension plan, subject to plan distribution requirements.

#### **Miscellaneous**

The \$10,000 per year retirement payment and the \$4,000 annual combined financial counseling/physical exam payments are based on current economics and purchasing power. In the future, the Board is

**OFFICER POLICY**

expected to revise these amounts, at its discretion, to reflect purchasing power, point values, and the like.

Income taxes payable with respect to payments made under this policy are subject to determination based on the tax residence of the retired Officer.

Matters related to equity in Booz Allen Hamilton Holding Corporation from terminated Officers shall be under the authority of the Compensation Committee of the Board of Directors of Booz Allen Hamilton Holding Corporation, and shall be governed generally by the Amended and Restated Stockholders Agreement, applicable Stock Option Agreements and Restricted Stock Agreements, Amended and Restated Equity Incentive Plan (EIP), Rollover Stock Option Agreement, and Officers' Rollover Stock Plan, as applicable.

**Release of Claims**

Retirement payments and benefits shall be contingent upon the Officer's execution and non-revocation of a release of claims in the form provided by the firm. Any payment that would otherwise have been made during such execution and revocation period shall be paid in a lump sum on the first payment date to occur after the release becomes irrevocable, provided that, if such execution and revocation period spans more than one calendar year, no such payments shall be made until the first payroll date in the second calendar year. Failure by an Officer to execute an irrevocable release of claims within the time frame established by the firm will result in the Officer's forfeiture of all payments and benefits otherwise due under this Policy.

**POINTS OF CONTACT AND ADDITIONAL RESOURCES:**

Any request for variations from this policy must be reviewed and approved by the Chief Personnel Officer.

DISCLAIMER

Please note that this policy and any other firm policies are not a contract and do not create any contractual relationship of any kind between the firm and any of its employees, including without limitation any right to continued employment for any period of time with the firm. Rather, this policy and other firm policies provide general guidance as to the firm's policies and procedures.

All employees are employed at all times "at-will," which means that either the employee or the firm has the right to terminate the employee's employment at any time for any or no reason with or without notice.

The policy applies to all directors, officers, and employees of the firm; the failure of any of these individuals to comply with the policy may result in disciplinary action up to and including termination of employment. In accordance with the Code of Business Ethics and Conduct (Green Book), all such individuals also are obligated to report any observed or reasonably suspected violations of this policy. The firm's non-retaliation policy applies to anyone making a report and is strictly enforced.

This policy is proprietary and confidential. The firm reserves the right to change, amend, or discontinue any or all of its policies and procedures, at any time in its discretion with or without notice. This policy supersedes any and all previous such firm policies that may at any time have been applicable to the employee.

**U.S. Officer Medical and  
Dental Insurance Plan**

Insured by: Aetna Inc.

**Booz | Allen | Hamilton**

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**INTRODUCTION**

Cost-effective, quality health care is a concern for all of us today. Without adequate medical coverage, the expenses resulting from an illness or injury can be a significant financial burden. The

U.S. Officer Medical and Dental Insurance Plan (the “Plan”)\* covers a variety of services and supplies for your immediate medical needs as well as protection against long-term or catastrophic health care costs. With Plan coverage, you can enjoy the security of knowing that you and your family are well prepared to meet most health care needs.

This booklet is the Plan document. It is also available at <http://people.bah.com> (accessible outside the firewall via <https://secure.bah.com>). This booklet explains who is eligible for coverage, when coverage begins and ends, what expenses are covered, and how to file a claim. In the back of this booklet you will find a glossary of significant definitions. You should familiarize yourself with the Plan and keep this booklet for future reference.

Although this booklet provides essential information about the Plan, you should understand that it is not a complete description of the insurance policy under which benefits are provided. If there is ever a conflict between this booklet and the insurance policy, the insurance policy will take precedence. If you have questions about the Plan, please contact your Human Resources Representative.

The benefits described in this booklet are provided under an insurance policy underwritten by Aetna Inc.

**YOUR PLAN-AT-A-GLANCE**

This section provides an overview of the key features of the Plan. See the pages that follow for further details, applicable limitations, and exclusions that are not shown here.

**Medical Plan**

<b>Plan Features</b>	<b>Benefits</b>
<b>Calendar Year Deductible</b>	None
<b>Out-of-Pocket Maximum per Calendar Year</b>	N/A
<b>Lifetime Maximum benefit</b>	Unlimited
<b>Hospital Services</b>	
Inpatient coverage	100%
Outpatient coverage	100%
Emergency Room	100%
Non-emergency use of the Emergency Room	100%
<b>Outpatient Surgical Expenses</b>	100%
<b>Second Surgical Opinion</b>	100%
<b>Maternity Care</b>	100%, pre- and post-natal care, delivery, new-born nursery care
<b>Physician Office visits</b>	100%
<b>Prescription Drug</b>	100%, including oral contraceptives
<b>Mail Order Prescription Drug</b>	100%, including oral contraceptives
<b>Allergy Testing</b>	100%
<b>Allergy serum, allergy injections, and injectable drugs</b>	100%
<b>Routine Baby Care/Immunizations</b>	100%, 7 visits 1st year of life, 2 visits 2nd year,

\* \* This plan is a separate plan, which covers only eligible officers of Booz Allen Hamilton Inc. The Plan is not a part of the Booz Allen Hamilton Inc. Employee Medical Plan, or any other medical plan covering non-officer employees of Booz Allen Hamilton Inc. or its affiliates.

<b>Plan Features</b>	<b>Benefits</b>
	1 exam per year thereafter
<b>Annual Routine Physicals/ Immunizations</b>	100%, age 2+ and adults one per calendar year
<b>Routine Ob/GYN visits, pap smears</b>	100%
<b>Routine Mammograms</b>	100%, females Ages 35 – 40: one baseline mammogram; Age 40+ one mammogram per calendar year
<b>Annual Routine Prostate Screening</b>	100%, Males Age 40+ one PSA test per calendar year
<b>Annual Routine Hearing Exam</b>	100%, one per calendar year
<b>Hearing Aids</b>	100%, up to a maximum of \$1,000 each ear per 36 month period
<b>Annual Routine Eye Exam</b>	100%, one per calendar year
<b>Physical and Occupational Therapy</b>	100%, up to 90 visits per calendar year (excludes spinal manipulation)
<b>Spinal Disorders</b>	100%, up to 20 visits per calendar year
<b>Acupuncture</b>	100%
<b>Speech Therapy</b>	100%, up to 90 visits per calendar year
<b>Advanced Reproductive Services</b>	100%, covered when infertility is certified by the Plan. Includes artificial insemination, IVE, GIFT, ZIFT, ICSI
<b>Diagnostic x-ray and Laboratory</b>	100%
<b>Mental Health Services</b> Inpatient Coverage Outpatient Coverage	100% 100%
<b>Alcohol and Drug Abuse Services</b> Inpatient Coverage Outpatient Coverage	100% 100%, up to 60 visits per calendar year, including 20 family visits
<b>Convalescent Facility</b>	100%, up to 120 days per calendar year
<b>Home Health Care</b>	100%, up to 120 visits per calendar year
<b>Hospice Care</b>	100%, up to a maximum benefit of 210 days per period of care and 5 bereavement visits
<b>Private Duty Nursing</b>	100%, up to 70 eight hour shifts per calendar year

#### **State-Mandated Benefits**

Since the Medical Plan is fully insured by Aetna Inc., certain states mandate that benefits be offered to plan participants. If you reside in one of the following states, please see the State-Mandated Benefits Section of this booklet for additional benefits that may be available to you:

California	New Mexico
Colorado	New York
Connecticut	Ohio
Florida	South Carolina
Georgia	Texas
Maryland	Utah
Massachusetts	Virginia
New Hampshire	Washington

## ***Aetna Navigator***

Under the Plan, you can access Aetna Navigator, an online tool that provides you with health and benefit information 24/7. You will have online access to: IntelliHealth, Aetna's consumer information Web site backed by Harvard Medical School; DocFind (provider directory) and up-to-date information on hospitals, physicians, and specialists; pharmacy benefits information (e.g., Rx Formulary and Aetna Rx Home Delivery to refill mail-order prescriptions). For personalized information, you can register for Aetna Navigator and gain access to Healthwise Knowledgebase, a comprehensive resource to help you make more informed health care decisions. When you register at [www.aetna.com](http://www.aetna.com), you can perform a number of self-service functions related to your benefits plan such as claim status information, health information, and e-mail communication with Member Services.

## ***Identification Cards***

A Plan identification card will be issued to you and each of your covered dependents. This card provides the Member Services Number, the Officer's name, and unique identifier. Please note that Officers enrolling in Family coverage will be issued two identification cards, both of which will include the Officer's name and unique identifier. Additional ID cards for dependent children are available upon request.

## ***Informed Health Line***

Anytime, day or night, 365 days a year, you can speak to a registered nurse to get information about your health questions. The registered nurse can provide you and your family with health information to help you make more informed health care decisions. You can also call to listen to your topic of interest confidentially through the audio health library. The number for Aetna's Informed Health Line is 1-800-556-1555.

## ***Discount Programs***

Under the Plan, you have the opportunity to take advantage of special discount arrangements that Aetna has made available to Plan members. Go to [www.aetna.com](http://www.aetna.com) under Products and Programs for information in your geographic location.

## ***Vision One Eye Care Program***

The Vision One Program offers discounts on eyeglasses, contact lenses and Lasik—a laser vision corrective procedure, available through participating providers. Savings on non-prescription items, such as sunglasses, contact lens solutions and accessories are also available. To choose a Vision One Provider near you, and view program details, visit [www.aetna.com](http://www.aetna.com) or call the Vision Care service line at 1-800-793-8616 with your questions. At the time of service, present your Aetna ID card to the optical staff and Vision One discounts will apply.

## ***Alternative Health Care Programs***

- *Professional Services*—members have access to reduced rates from natural therapy professionals which include acupuncturists, chiropractors, massage therapists and dietetic counselors. Natural therapy professionals are available to members through direct access. Aetna members will receive at least a 25% discount off the provider's standard charges for the services rendered from a natural therapy professional who participates in the vendor's provider network.
- *Products*—members have access to discounts on over 2,400 health-related products, including over-the-counter vitamins, herbal and nutritional supplements and natural products. Members will receive at least a 15% discount off the MSRP on all products offered by the vendor as well

as free standard shipping. Go to [www.aetna.com](http://www.aetna.com) to find the most current listing of participating providers and vendors.

### ***Fitness Program***

GlobalFit offers discounts on membership rates at independent health clubs contracted with GlobalFit. Go to [www.globalfit.com/fitness](http://www.globalfit.com/fitness) or call 1-800-298-7800 for more information.

### ***National Advantage Program (NAP)***

NAP provides access to contracted rates for many medical claims from providers that are part of the National Advantage Program. For a list of providers participating in NAP, go to [www.aetna.com](http://www.aetna.com).

Search for NAP providers under DocFind. Providers should bill Aetna directly for Covered Services. *If your provider is in agreement, you should not make payment at the time of service.* When the Provider submits the claim, Aetna will process it at the contracted rate (when applicable) and reflect the contracted amount on your Explanation of Benefits (EOB). You are responsible for any applicable non-covered service.

### ***Emergency Care and Urgent Care***

Knowing how to handle medical emergencies will not only help you and your dependents receive the care you (or they) may need, but it will also help you take full advantage of the coverage provided by the Plan.

The Plan covers emergency room services for conditions that reasonably appear to constitute an emergency, based on the patient's presenting symptoms. An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- 1) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman and her unborn child) in serious jeopardy,
- 2) serious impairment to bodily functions, or
- 3) serious dysfunction of any bodily organ or part. Examples of medical emergencies are: severe chest pains, insulin shock, seizures/convulsions, and severe shortness of breath.

Emergency Room Services are covered at 100%.

Claims involving non-emergency use of the emergency room will be paid at 100%.

### ***Emergency Care***

In an emergency, if possible, you should attempt to call your Physician, explain the symptoms, and provide any other important information. You should go, as soon as possible, to the nearest emergency facility, if:

- Directed by your Physician; or
- You cannot reach the Physician or covering Physician; or
- You believe a delay would be detrimental to your health.

### **Urgent Care**

The Plan covers urgent care if the services are medically necessary and immediately required because of unforeseen illness, injury, or condition and it is not reasonable given the circumstances to obtain the services through your Physician. Examples of urgent care needs include: respiratory or flu like symptoms with high fever, sprains or fractures, severe abdominal cramps, vomiting, or diarrhea.

For a list of Urgent Care Facilities near you, go to [www.aetna.com](http://www.aetna.com). Under DocFind, search for Urgent Care Facilities. The urgent care facility or treating Physician should try to contact your Physician to allow the Physician to contribute to the treatment you require. If this is not possible, you should notify your Physician of the treatment received as soon as possible.

### **Foreign Travel**

Members traveling overseas who need to contact Member Services may dial the Corporate Contact Center's direct line: 860-273-0123 or can use the Toll free number on their ID card.

The Corporate Contact Center is available Monday – Friday, 7 a.m. – 7 p.m. EST. Members will be routed to a Service Center that handles their account.

### **National Medical Excellence (NME) Program**

Aetna's National Medical Excellence (NME) Program was established to provide access to Physicians and Hospitals demonstrating continual achievement in the delivery of complex care when local care is not available. NME coordinates all solid organ and bone marrow transplants and other specialized care with nationally respected doctors and medical facilities. The Plan will pay a benefit for travel and lodging expenses between home and the medical facility for you and a companion if the medical facility is located more than 100 miles from your home. Lodging expenses cannot exceed the maximum of \$50 per person per night. Expenses are subject to IRS Guidelines and are payable up to a maximum of \$10,000 per episode, for all travel and lodging expenses.

Benefits will only be payable for such expenses incurred during a period which begins on the day you become an NME patient and ends either one year after the day the procedure is performed or, the date you cease to receive any services from the facility in connection with the procedure, whichever occurs first. Travel and lodging expenses do not include expenses incurred by more than one companion per night.

Note: Overseas members with acute illness should call NME at 877-212-8811 during normal business hours. After hours, members with an acute illness may call 215-775-6445. If you are treated outside the U.S., you must pay for the services up front and then submit the invoice to Aetna for reimbursement.

### **Dental Plan**

<b>General Plan Provisions</b>	<b>Benefits</b>
Calendar Year Deductible	None
Calendar Year Benefit Maximum	\$1,500 per individual

<b>Plan Features</b>	<b>Benefits</b>
Preventive Services	100% up to the Calendar Year Benefit Maximum as shown above
Basic Services (e.g., fillings, extractions, oral surgery)	
Major Services (e.g., crowns, bridgework)	
<i>Note: Orthodontia and dental implants are covered under the Executive Medical Plan only</i>	

## ELIGIBILITY FOR PLAN COVERAGE

### Your Eligibility for Plan Coverage

As a Booz Allen Officer, you are eligible for coverage if you are in a Covered Class. You are considered to be in a Covered Class if:

- You live in the U.S. and are on the U.S. payroll; and
- You are not covered by another firm-sponsored basic medical plan

In addition to belonging to a Covered Class, to be eligible for coverage you must be either a:

- Full-time employee; or
- Part-time\* employee working on a regular basis.

The Plan does not cover temporary employees, contract consultants, and employees hired pursuant to an agreement providing that such employees shall not participate in the Plan.

### Your Dependents' Eligibility for Plan Coverage

As long as you are eligible for Plan coverage, your dependent(s) will be eligible for Plan coverage if they are:

- Your spouse or eligible domestic partner\*\* (regardless of gender);
- Your and your spouse's or domestic partner's children who are unmarried, under age 26, not working full-time, and who can qualify as dependents under the provisions of the Internal Revenue Code.  
Your children include:
  - Your biological children
  - Your adopted children (as of the date the child is "placed for adoption" which means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child)
  - Your stepchildren
  - Any other child you support who lives with you in a parent-child relationship
- Your and your spouse's or domestic partner's children (as defined above) age 26 or older, if they are primarily supported by you or your spouse or domestic partner and incapable of self-sustaining employment by reasons of mental or physical handicap. The dependent must have become incapable of self-support before age 26. You must give Aetna proof that the child meets these conditions when requested.

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\* To be considered a part-time employee working on a regular basis, you must work at least 50% of the standard number of hours per week as defined for your business unit. For example, if the standard number of hours per week for your business unit is 40 hours, you must work at least 20 hours per week to be benefits eligible.

\*\* If you have completed and signed a "Declaration of Domestic Partnership" and the Declaration is acceptable to the firm, you may cover as your dependent the person who is the "domestic partner" named in your Declaration.

Your dependents are not eligible for coverage if they are on active duty in the armed forces of any country. In addition, no person may be covered both as an employee and dependent and no person may be covered as a dependent of more than one employee.

### **When You Can Enroll for Coverage**

There are only four periods of time during which you can enroll for coverage:

- 1) Within 31 days after first becoming eligible to enroll;
- 2) During the annual open enrollment period;
- 3) Within 31 days after a qualified status change; or
- 4) You may defer enrollment if you have coverage from your prior employer that extends beyond your initial date of hire with the firm. You may enroll at a future date provided it is within 31 days after the coverage ends.

### **Making Changes During the Year**

Federal law limits the types of coverage changes employers can allow employees to make to their medical plan elections during the year. Generally, you may make a change only if you experience a qualified status change that affects eligibility for coverage under the Plan, or in certain other limited situations such as a significant change in cost or coverage of a benefit option.

#### **Qualified status changes that allow you to change your Plan election include:**

- You marry, legally separate (in states where legal separation equals divorce), have your marriage annulled, or get divorced;
- Your unmarried dependent is no longer eligible for plan coverage;
- You have a baby, adopt a child, have a child placed with you for adoption, or have a child live with you that you can claim as a dependent for federal tax purposes;
- You, your spouse, or your dependent experiences a change in employment status (for example, loss of a job, start of a new job, a strike or lockout, commencement of or return from a leave of absence, or going from full-time to part-time employment or vice versa);
- You, your spouse, or your dependent(s) move; or
- Your spouse or dependent(s) dies.

#### **Qualified status changes may also include changes to certain benefits resulting from other events, such as:**

- If another employer's medical plan allows for a change in your family member's coverage (either during that plan's open enrollment period or due to a mid-year election change permitted under the Internal Revenue Code), you may be able to make a corresponding election change under the Plan. For example, if your spouse elects family coverage during that plan's open enrollment period, you may drop your coverage under the Plan.
- If the Plan receives a judgment, decree, or order (including a Qualified Medical Child Support Order, or QMCSO) requiring the Plan to provide accident or health coverage to your child or

foster child who is your dependent. In this instance, the Plan will automatically change your benefit elections to provide coverage for the child. In the case of a child whom you are required to cover pursuant to a QMCSO, coverage will begin on the date specified in the order, or if none is specified, the date of the order. You may decrease your coverage for that child, if the court order requires the child's other parent to provide coverage, and your spouse's or former spouse's plan actually provides that coverage. You may also make other corresponding changes to your benefit elections under the Plan, to the extent permitted by the Internal Revenue Code and the Plan.

- If you, your spouse or a dependent becomes entitled to, or loses entitlement to, coverage under a government institution, Medicare, Medicaid, or state children's health program, you may make corresponding changes to your benefit elections under the Plan.

Your change in coverage must be consistent with your qualified status change. In addition, your status change must cause a gain or loss of eligibility in the program or another employer's plan, and your new election must correspond with the event. For example, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependent(s), provided you request enrollment within 31 days, after the marriage, birth, adoption, or placement for adoption.

If you experience a qualified status change, you must inform Booz Allen of your new election within 31 days of the change and provide proof of the change upon request. Otherwise, you will lose your right to change your election—until open enrollment. Your new election shall take effect prospectively only, but not earlier than the date of the change in status.

### **Special Enrollment Events Under HIPAA**

A person, including yourself, will not be considered to be a Late Enrollee if all of the following are met:

- You did not elect Health Expense Coverage for yourself or any eligible dependent during the Initial Enrollment Period (or during a subsequent late enrollment period) because at that time:
  - a) The person was covered under another group health plan or other health insurance coverage; and
  - b) You stated, in writing, at the time you refused coverage that the reason for the refusal was because the person had such coverage, but such written statement is required only if the firm requires the statement and gives you notice of the requirement; and the person loses such coverage because:
    - i) It was provided under a COBRA continuation provision, and coverage under that provision was exhausted; or
    - ii) It was not provided under a COBRA continuation provision, and either the coverage was terminated as a result of loss of eligibility for the coverage, including loss of eligibility as a result of:
      - Legal separation or divorce;
      - Death;
      - Termination of employment;
      - Reduction in the number of hours of employment;

- The employer's decision to stop offering the group health plan to the Eligible Class to which the employee belongs;
  - Cessation of a dependent's status as an eligible dependent as such is defined under this Plan;
  - The operation of another Plan's lifetime maximum on all benefits, if applicable; or
  - Employer contributions toward the coverage were terminated.
- You elect coverage within 31 days of the date the person loses coverage for one of the above reasons.

In addition, you and any eligible dependents will not be considered to be Late Enrollees if the firm offers multiple health benefit plans and you elect a different plan during the open enrollment period.

Also, the following persons will not be considered to be Late Enrollees given any of the following circumstances:

- You, if you are eligible, but not enrolled, and your newly acquired dependents through marriage, birth, adoption, or placement for adoption. However, you must request enrollment for your newly acquired dependent(s) and yourself, if you are not already enrolled, within 31 days of the marriage, birth, adoption, or placement for adoption.
- Your spouse from whom you are separated or divorced, or child who would meet the definition of a dependent, if you are subject to a court order requiring you to provide health expense coverage for such spouse or child. However, you must request enrollment within 31 days of the court order.

Coverage will be effective:

- 1) In the case of marriage, on the date the completed request for enrollment is received;
- 2) In the case of a newborn, on the date of birth;
- 3) In the case of adoption, on the date of the child's adoption or placement for adoption;
- 4) In the case of court ordered coverage of a spouse or child, on the date of the court order;
- 5) In the case of loss of coverage under COBRA continuation, on the date COBRA continuation ended; and
- 6) In the case of loss of coverage for other reasons, the date on which the applicable event occurred.

*Note: Under the firm's policy, qualified change in status rules will apply to domestic partnerships.*

### **When Coverage Begins**

Your and your dependents' medical and dental coverage will begin on the first day of active employment, the first day you are eligible to participate in the Plan, or the day of the Qualified status change, provided that you sign the benefit enrollment forms within 31 days from the date of the event. Newborns are automatically covered under the Plan for the first 31 days following their birth. For

coverage to continue beyond the first 31 days, you must enroll your newborn in the Plan. Please contact your Human Resources Representative for enrollment forms.

If you enroll for coverage for the first time during open enrollment, your coverage will begin on January 1 of the following year.

### **When Coverage Ends**

Your coverage under the Plan will end on the day after:

- You are no longer employed by the firm;
- You are no longer a part of a Covered Class (see page 6);
- The Plan ends; or
- You are covered as a dependent and you lose your dependent status.

You and your dependents may also lose eligibility if your I.D. card is given to and used by a non-eligible person, or if you or your dependents supply incorrect or incomplete information to the firm or Aetna to receive coverage.

You or your dependents may be eligible to extend coverage through COBRA after the date the Plan would otherwise end. See page 41 for details.

Medical coverage may be extended, for up to 12 months, after the date that COBRA coverage would end if, on that date, the covered person is Totally Disabled from a sickness or injury and is under a Physician's care. Dental coverage will be available while disabled for up to 12 months. The benefits will be available only if expenses are for covered services and supplies which have been rendered and received, including delivered and installed, if these apply, prior to the end of that 12 month period.

For the Dental Plan only, if coverage ends and the covered person is not Totally Disabled, expenses for dentures, fixed bridgework, and crowns will be deemed to be incurred when ordered. This applies only if the item is finally installed or delivered, no more than 30 days after coverage ends. "Ordered" means impressions have been taken from which the dentures, crowns, or fixed bridgework will be made and, as to fixed bridgework and crowns, the teeth must have been fully prepared if they will serve as retainers or support, or they are being restored.

### **HOW THE PLAN WORKS**

The Plan gives you complete freedom to choose any Physician, Dentist or Hospital. There are no requirements for referrals or pre-certification.

#### **Coinsurance and Deductibles**

You are not required to pay coinsurance and deductibles as part of the Plan.

### **WHAT THE MEDICAL PLAN PAYS**

The Medical Plan pays 100% of most eligible hospital charges and 100% of other eligible charges such as preventive and routine care, second surgical opinions, outpatient surgical expenses, National Medical Excellence travel and lodging expenses, and prescription drugs. All eligible charges are subject to Plan limitations, exclusions, and maximums.

## Your Lifetime Benefit Maximum

There are specific lifetime maximums for the following benefits:

- Hospice care—210 days per period of care
- Hospice care bereavement counseling—5 days

## WHAT THE MEDICAL PLAN COVERS

This section of the booklet explains the covered medical expenses. Refer to the “Plan-At-A-Glance” or “How the Plan Works” sections for details.

To be eligible for coverage under the Medical Plan, services and supplies must be considered Necessary and not Experimental or Investigational. (See “Glossary” and “What the Medical Plan Does Not Cover” for definitions of these terms.) All other applicable Medical Plan provisions and exclusions apply.

### Prescription Drugs

The prescription drug program covers prescriptions, including oral contraceptives and diaphragms, that are filled by a licensed pharmacist. Some injectables, such as insulin and injectable drugs used to treat infertility, are covered under the prescription drug program. The Medical Plan treats most other injectables as a medical service and supply and will cover eligible charges. Diabetic testing supplies (lancets and test strips) are covered. To receive testing supplies, a prescription from your Physician is required. Prescriptions for smoking cessation are also covered. Certain drugs such as Claritin are now available over the counter. Over-the-counter drugs are not covered by the Medical Plan.

Your prescription will be paid at 100% whether you choose to have your prescription filled at a participating Aetna pharmacy or at a non-participating pharmacy. If you choose to have your prescription filled at a participating Aetna pharmacy, you only need to show your Aetna identification card to the pharmacist and your prescription will be filled at 100%. Aetna contracts with most major pharmacy chains and some local pharmacies as well. For a list of participating Aetna pharmacies please refer to the Aetna web site at [www.aetna.com](http://www.aetna.com).

If you choose to have your prescription filled at a non-participating pharmacy, you will need to file a claim for reimbursement.

### Mail Order Prescription Drugs

Maintenance drugs can be purchased by ordering through Aetna Rx Home Delivery. To take advantage of the mail order benefit, you will need to complete a mail order form along with your original prescription(s). Be sure your Physician has specified *more than* a 30 day supply on your prescription.

After the initial form has been submitted, you can order refills online at <http://www.aetnarxhomedelivery.com>, call in refills at 1-866-612-3862, or mail request for a refill. New prescriptions must be mailed. Prescription orders are typically processed and shipped via U.S. mail within a few days for all prescriptions that do not require additional information. When requesting medications by mail, make sure you order a refill about 14 days before your medicine runs out to allow sufficient time for processing the order. Keep in mind there is an additional expense for overnight delivery of medications, which will be charged to you. If you need a mail order form, please go to <http://people.bah.com> (accessible outside the firewall via <https://secure.bah.com>).

### **Annual Routine Physical Exams/Immunizations**

The Plan covers eligible charges for routine physical exams for you and your dependents. (A routine physical exam is a medical exam given by a Physician for a reason other than to diagnose or treat

an injury or disease.) Expenses covered include x-rays, laboratory, immunizations for infectious disease, testing for tuberculosis, and other tests given in connection with the exam.

### **Annual Routine Eye Exam**

The Plan covers eligible charges for a complete eye exam, including refraction, which is furnished by a legally qualified ophthalmologist or optometrist.

### **Annual Routine Hearing Exam**

The Plan covers eligible charges for an audiometric exam given by a certified otolaryngologist or otologist; or a qualified audiologist who performs the exam at the written direction of the otolaryngologist or otologist.

### **Annual Routine Prostate Screening**

The Plan covers screening for cancer of the prostate for males age 40 and above, including a digital rectal exam, and a Prostate Specific Antigen (PSA) test.

### **Routine Mammograms**

The Plan covers eligible charges for routine mammograms according to the schedule below.

<b>If You Are a Woman Who Is...</b>	<b>You Will Be Covered for:</b>
Age 35 – 39	One baseline mammogram
Age 40+	One baseline mammogram per calendar year
Any age	Mammograms as recommended by your Physician

### **Routine OB/GYN Services**

The Plan covers eligible charges for obstetrical and gynecological services including routine GYN visits, pap smears and gynecological problems.

### **Maternity Care—Pre- and Post-Natal Care, Delivery, Newborn Nursery Care**

Benefits are payable for pregnancy-related expenses and newborn nursery baby care. For Hospital inpatient care, there is a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If discharged sooner, benefits will be payable for 2 post-delivery home visits by a health care provider.

The Plan also pays for charges made by a Birthing Center to include pre-natal care, delivery, and post- partum care rendered within 24 hours after the delivery. Charges for the initial post-delivery home visit will be paid at 100%.

### **Routine Baby Care/Immunizations**

The Plan covers seven routine well baby care visits (exams and immunizations) in the first 12 months of your child's life, and two visits in the 13th – 24th month of your child's life, for reasons other than to diagnose or treat an injury or disease.

## **Infertility, In Vitro and Artificial Insemination Services**

The charges made for the diagnosis and/or treatment of the underlying cause of infertility may be included as Covered Medical Expenses. Examples of these charges include but are not limited to:

- Initial evaluation, which may include medical, surgical, and sexual histories as well as a physical exam, psychological evaluation, and accompanying diagnostic testing;
- Hormonal and related services for the external augmentation of ovulatory cycles to achieve pregnancy;
- Subsequent visits, including follow-up exams and diagnostic procedures;
- Injectable drugs used to treat infertility, payable under the prescription drug benefit.

In addition, the following services and supplies, even though they are not incurred in connection with the diagnosis or treatment of a disease or injury, furnished to you or your spouse, are eligible charges, but only if:

- The person shows that she or her spouse has a history of infertility which has lasted at least 12 months; or provides a Physician's certification that a physical disorder caused the infertility.
- The person and her spouse has not had voluntary sterilization (with or without surgical reversal); or a hysterectomy.
- The person's Physician must certify that all of the necessary tests have been given to find the cause of the infertility; and no less costly treatment will result in pregnancy.
- Successful pregnancy cannot be attained through less costly treatment *for which there is coverage on the plan*.

The procedures must be performed in medical facilities that conform to guidelines set forth by the American College of Obstetrics and Gynecology or The American Fertility Society.

### **Services and Supplies**

- Artificial insemination, including analysis and preparation of the semen with which such person is to be inseminated.
- Implementation of an embryo of such person, but only in connection with in vitro fertilization or other embryo transfer procedures, including:
  - egg retrieval;
  - semen analysis and preparation;
  - embryo culture; embryo transfer;
  - Gamete Intrafallopian Transfer (GIFT);
  - Zygote Intrafallopian Transfer (ZIFT);
  - Intracytoplasmic Sperm Injection (ICSI).

- Surrogate and Gestational Carrier—In both cases, the plan covers only those tests and procedures that are to be performed on the member. In no event will any of these procedures, tests or charges be covered if the person is acting as a surrogate mother and no procedures or tests performed on the carrier will be covered.

Expenses that are not covered include charges for:

- Purchase of donor sperm
- Care of donor egg retrievals or transfers
- Cryopreservation or storage of cryopreserved embryos—except in the case of Testicular Cancer HCPCS Codes S4030 & S4031
- Prescription drugs including injectable fertility medications—covered through pharmacy benefit
- Home ovulation predictor kits
- Gestational carrier programs

### **Mental Health Services**

The Medical Plan covers eligible charges for the treatment of mental disorders. A mental disorder is understood to be a disease whether or not it has a physiological or organic basis. Treatment is provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes, but is not limited to, schizophrenia, bipolar disorder, autism, panic disorder, major depressive disorder, psychotic depression, and obsessive compulsive disorder.

### **Substance Abuse Services**

Medical expenses related to the effective treatment of substance abuse are covered if they are for a program of alcoholism or drug abuse therapy that is prescribed and supervised by a Physician and either has a follow-up therapy program directed by a Physician on at least a monthly basis or includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse. Treatments that are not covered include:

- Detoxification. This means mainly treating the after effects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

Outpatient coverage is limited to 60 visits per calendar year, including 20 family visits. Intensive outpatient care (3 - 5 hours per day in a treatment facility) is considered one outpatient visit.

### **OTHER COVERED SERVICES AND SUPPLIES**

**Acupuncture** by a certified acupuncturist will be provided if it is used as a form of anesthesia in connection with surgery that is covered under the Plan, to treat a disease or injury, or to alleviate chronic pain.

**Allergy serum**, allergy injections and injectable drugs.

**Ambulance use** to transport a person from the place where he or she is injured or stricken by disease to the first Hospital where treatment is given.

**Anesthetics** and oxygen.

**Artificial limbs and eyes** as well as larynx, heart pacemakers, casts, splints, trusses, and braces. Not covered are eye glasses, vision aids, communication aids, and orthopedic shoes, foot orthotics, or other devices to support the feet.

**Blood and blood plasma**—Aetna covers medically necessary transfusion of blood and blood products, regardless of type.

**Chemotherapy**, or treatment by X-ray, radium, or any other radioactive substance.

**Contraceptives** covered under the prescription drug program and drugs and devices not obtainable at a pharmacy.

**Convalescent facility**—Convalescent care is provided by a convalescent facility on an inpatient basis to patients recovering from a disease or injury. Expenses include room, board, X-ray and lab work; physical, occupational or speech therapy; oxygen and other gas therapy; and other medical services.

Confinement in a convalescent facility is covered when:

- 1) The confinement is recommended by a doctor and begins during a convalescent period;
- 2) The patient is under the continuing care of a doctor;
- 3) The patient receives necessary skilled nursing care, physical rehabilitation services, or both, and;
- 4) It is expected that the care received will improve the patient's condition and facilitate discharge.

#### ***Limitations To Convalescent Facility Expenses***

This section does not cover charges made for treatment of:

- Drug addiction
- Chronic brain syndrome
- Alcoholism
- Senility
- Mental retardation
- Any other mental disorder

**Cosmetic surgery** *only* if needed to correct the result of an accident, treat a condition that impairs the function of a body organ, or reconstruct a breast after a mastectomy. See Reconstructive Surgery on page 19.

**Dental** expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for services rendered and supplies needed for the following treatment of or related to conditions of the:

- teeth, mouth, jaws, jaw joints; or
- supporting tissues (this includes bones, muscles, and nerves).

For these expenses, **physician** includes a **dentist**. Surgery needed to:

- Treat a fracture, dislocation, or wound;
- Cut out teeth partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when not done in connection with the removal, replacement, or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

Non-surgical treatment of infections or diseases. This does not include those of or related to the teeth.

Dental work, surgery, and orthodontic treatment needed to remove, repair, replace, restore, or reposition natural teeth damaged, lost, or removed; or other body tissues of the mouth fractured or cut due to injury. Any such teeth must have been free from decay; or in good repair; and firmly attached to the jaw bone at the time of the injury.

The treatment must be done in the calendar year of the accident or the next one if crowns (caps); or dentures (false teeth); or bridgework; or in-mouth appliances are installed due to such injury, Covered Medical Expenses include only charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.

#### **Diagnostic lab work and x-rays.**

**Donors**, including any of the medical services and supplies listed here that are required for an organ, sperm, or egg donor as a result of a surgical transplant procedure. This applies whether the covered person is the donor or the recipient of the transplant. In the case of a covered person who is the recipient of the transplant, both of the following will apply:

- 1) The services and supplies will be considered to be furnished on account of the recipient's sickness or injury.

- 2) There is an eligible charge limit on the charges for those services and supplies. That limit is the extent to which benefits for charges, services and supplies are not provided by reason of the donor's coverage under one or more of the following:
- a) the group contract, or any other group or individual contract;
  - b) any arrangement of coverage for individuals in a group (whether on an insured or uninsured basis), including any prepayment coverage.

**Durable medical and surgical equipment** in lieu of rental. The initial purchase of such equipment is appropriate if Aetna is shown that long term care is planned, and that such equipment either cannot be rented or is likely to cost less to purchase than to rent. Repair of purchased equipment or replacement of purchased equipment is also covered if Aetna is shown that it is needed due to a change in the person's physical condition, or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

Durable medical and surgical equipment means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is: made to withstand prolonged use; made for and mainly used in the treatment of a disease or injury; suited for use in the home; not normally of use to persons who do not have a disease or injury; not for use in altering air quality or temperature; not for exercise or training. Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; and telephone alert systems.

**Family planning** expenses for a vasectomy for voluntary sterilization; a tubal ligation for voluntary sterilization; and voluntary abortions.

**Glucose strips and lancets** for persons who are insulin dependent whether or not they are diagnosed with diabetes.

**Hearing aids** are covered up to a maximum of \$1,000 each ear per 36 month period.

**Home health care** expenses if the charge is made by a Home Health Care Agency, and the care is given under a Home Health Care Plan, and the care is given to a person in his or her home. Home health care expenses are charges for: part-time or intermittent care given or supervised by an R.N.; part-time or intermittent home health aide services for patient care; Physician, occupational, and speech therapy from a Home Health Care Agency; the following to the extent they would have been covered under this Plan if the person had been confined in a Hospital or skilled nursing facility as defined in Title XVIII of the Social Security Act: medical supplies; drugs and medications prescribed by a Physician; and lab services provided by or for a Home Health Care Agency. Each four hours of home health aide services is one visit. Not covered are charges for transportation and custodial care.

**Hospice care and bereavement** counseling expenses furnished to a terminally ill person for Hospice Care when given as a part of a Hospice Care Program.

*Facility expenses*—The charges made in its own behalf by a Hospice Facility, Hospital, or Convalescent Facility which are for board and room and other services and supplies furnished to a person while a full-time inpatient for pain control and other acute and chronic symptom management.

*Other expenses*—The charges may be a Hospice Care Agency for part-time or intermittent nursing care by an R.N. or L.P.N. for up to 8 hours in any one day; medical social services under the direction of a Physician. These include assessment of the person's social, emotional and medical needs; the home and family situation; identification of the community resources which are available to the person; and assisting the person to obtain those resources needed to meet the person's assessed needs; psychological and dietary counseling; bereavement counseling; consultation or case management

services by a Physician; physical and occupational therapy; part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person, medical supplies, drugs and medicines prescribed by the Physician.

Charges made by the providers below (but only if the provider is not an employee of a Hospice Care Agency and such Agency retains responsibility for the care of the person): a Physician for consultant or case management services, a physical or occupational therapist, a Home Health Care Agency for physical and occupational therapy, part-time or intermittent home health aide services for up to 8 hours in any one day. These consist mainly of caring for the person, medical supplies, drugs and medicines prescribed by a Physician, and psychological and dietary counseling.

Not included are charges made for funeral arrangements; for pastoral counseling; for financial or legal counseling including estate planning and the drafting of a will; for homemaker or caretaker services such as sitter or companion services for either the person who is ill or other members of the family; for transportation; for housecleaning and maintenance of the home; and for respite care furnished during a period of time when the person's family or usual caretaker cannot, or will not, attend to the person's needs.

Hospital room and board charges at the semiprivate rate. If a private room is used, the daily charge will be covered if the person's Physician requests the private room and the request is approved by Aetna.

### **Hospital supplies and non-professional services**

*Inpatient hospital expenses*—Charges made by a hospital for giving board and room and other hospital services and supplies to a person who is confined as a full-time inpatient. Not included is any charge for daily board and room in a private room over the Private Room Limit.

*Outpatient hospital expenses*—Charges made by a hospital for hospital services and supplies which are given to a person who is not confined as a full-time inpatient.

### **Inhalation therapy.**

**Injectables** not covered by the pharmacy benefit.

**Outpatient surgical expense charges** made in its own behalf by a surgery center or the outpatient department of a Hospital; or by a Physician for outpatient services and supplies furnished in connection with a surgical procedure performed in the center or in a Hospital. The procedure must meet these tests: it is not expected to result in extensive blood loss, require major or prolonged invasion of a body cavity, or involve any major blood vessels. It can safely and adequately be performed only in a surgery center or in a Hospital, and it is not normally performed in the office of a Physician or a Dentist.

Outpatient services and supplies furnished by the surgery center or by a hospital on the day of the procedures:

- 1) Services of the operating Physician for performing the procedure and for related pre- and post-operative care and the administering of an anesthetic;
- 2) Services of any other Physician for the administering of an anesthetic; this does not include a local anesthetic.

No benefit is paid for charges incurred for the services of a Physician who renders technical assistance to the operating Physician or while the person is confined as a full-time inpatient in a Hospital.

## Oxygen and anesthetics.

**Physical or occupational therapy**, up to 90 combined visits provided by a physical or occupational therapist, which is expected to result in the improvement or maintenance of a body function, which has been lost or impaired due to an injury, a disease, or a congenital defect. Not covered are any services, unless they are provided in accordance with a specific treatment plan, which details the treatment to be rendered and the frequency and duration of the treatment and provides for ongoing reviews and is renewed only if therapy is still necessary.

**Private duty nursing care** provided by an R.N. or L.P.N. will be covered, if the care is not mainly custodial, and:

- 1) You require intensive nursing care for treatment of an acute sickness or injury; and
- 2) You are not in a Hospital or other health care facility that supplies nursing care.
- 3) Visiting nursing care by an R.N. or L.P.N. means a visit of not more than 4 hours for the purpose of performing specific skilled nursing tasks.

Benefits will not be paid during a calendar year for private duty nursing for any shifts in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

**Reconstructive Surgery** expenses for:

- 4) Breast reconstruction—if elected after the mastectomy for:
  - a) Reconstruction of the breast on which a mastectomy has been performed;
  - b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
  - c) Prostheses; and
  - d) Treatment of physical complications of all stages of mastectomy, including lymphedemas.
- 5) Cleft lip/cleft palate—covers charges for oral and facial surgery, obturators, orthodontic appliances, orthodontic treatment, prosthodontic treatment, habilitative speech therapy, otolaryngology treatment and audiological assessment and treatments.
- 6) Craniofacial disorders—Covers dependent children to age 18 and includes charges for partially or fully removable dentures or fixed bridgework; replacement of dentures by denture or fixed bridgework when required as a result of structural changes in the mouth or jaw due to growth; prosthodontic treatment such as obturators; speech appliances and feeding appliances, and cleft orthodontic therapy.

**Second Surgical Opinion** charges of a Physician for a second surgical opinion on the need or advisability of performing a surgical procedure. A benefit is also paid for charges made for a third surgical opinion. This will be done when the second opinion does not confirm the recommendation of the first Physician who proposed to perform the surgery. A surgical opinion is an exam of the person, an X-ray and lab work and a written report by the Physician who renders the opinion. The surgical opinion must both be performed by a Physician who is certified by the American Board of Surgery, or other specialty board and takes place before the date the proposed surgery is scheduled to be done. Benefits are not paid for a surgical opinion if the Physician who renders the surgical opinion is

associated or in practice with the first Physician who recommended and proposed to perform the surgery.

**Short-term rehabilitation**—includes charges for Developmental Delay with the same terms and conditions as for other diagnoses.

**Speech therapy\*** charges incurred up to 90 visits for the following services for diagnostic or nonsurgical treatment of loss or impairment of speech. Covered medical expenses include:

- 7) Diagnostic speech evaluations to find out if, and to what extent, the person's ability is to speak. Not included are charges for speaking aids or training in their use;
- 8) Services given to treat delays in speech development only if resulting from disease, injury or birth defect;
- 9) Rehabilitative speech and language therapy to restore or improve a person's ability to speak if the loss of speech is not caused by a mental disorder.

Not included are charges for special education to teach a person whose ability to speak has been lost or impaired to function without that ability. This includes lessons in sign language.

**Sperm banking** is covered in the case of testicular cancer only. Sperm collection and storage will be paid for by the Plan.

**Spinal disorder treatment** covers manipulative (adjustive) treatment or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine. The treatment can be given by a Physician or a licensed chiropractor. The calendar year maximum does not apply to expenses incurred while the person is a full-time inpatient in a Hospital for treatment of scoliosis; for fracture care; or for surgery. This includes pre- and post-surgical care given or ordered by the operating Physician.

**Transplants**—Solid organ and bone marrow transplants will be covered if they meet the definition of Necessary and are not considered Experimental or Investigational as defined in the "What the Plan Does Not Cover" section of this document.

#### **X-ray, radium, and radioactive isotope therapy. WHAT THE MEDICAL PLAN DOES NOT COVER**

The following expenses are not covered:

**Blood or blood plasma** that is replaced by you or by someone else for you. Aetna does not cover the collection or storage or cost of blood or blood plasma.

**Charges made by the employer or a close relative** including charges for a service or supply furnished by your employer, or you, your spouse or domestic partner, or a child, brother, sister, or parent of you or your spouse or domestic partner.

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\* Speech therapy services are considered medically necessary only if there is a reasonable expectation that speech therapy will achieve measurable improvement in the patient's condition in a reasonable and predictable period of time.

**Comfort or convenience items and services. Communication aids.**

**Cosmetic surgery**, except to correct the result of an accidental injury sustained while you are covered under the Plan; to treat a condition, including a birth defect, that impairs the function of a body organ, or reconstruct a breast after a mastectomy. See Reconstructive Surgery.

**Custodial care**—Services and supplies are considered custodial when they are furnished mainly to train or assist the insured family member in personal hygiene and other activities of daily living rather than to provide therapeutic treatment.

**Dental** except as provided for injury, not included are charges:

- For in-mouth appliances, crowns, bridgework, dentures, tooth restorations, or any related fitting or adjustment services; whether or not the purpose of such services or supplies is to relieve pain;
- For root canal therapy;
- For routine tooth removal (not needing cutting of bone).

Not included are charges:

- To remove, repair, replace, restore or reposition teeth lost or damaged in the course of biting or chewing;
- To repair, replace, or restore fillings, crowns, dentures or bridgework;
- For non-surgical periodontal treatment;
- For dental cleaning, in-mouth scaling, planing or scraping;
- For myofunctional therapy; this is muscle training therapy; or training to correct or control harmful habits.

**Education testing, training, or treatment related to learning disabilities or developmental delays.**

However, educational services or supplies may be covered for training in the activities of daily living if they are directly related to treatment of a sickness or injury that resulted in a loss of a previously demonstrated ability to perform those activities.

**Education or special education or job training** whether or not given in a facility that also provides medical or psychiatric treatment.

**Eyeglasses or lenses of any type** (except initial replacements for loss of the natural lens).

**Eye surgery to correct refractive impairments.**

**Experimental or investigational**—a drug, a device, a procedure, or treatment will be determined experimental or investigational if Aetna determines that:

- 1) There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
- 2) If required by the FDA, approval has not been granted for marketing; or
- 3) A recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
- 4) The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.

However, this exclusion will not apply with respect to services or supplies (other than drugs) received in connection with a disease, if Aetna determines that: (1) the disease can be expected to cause death within one year, in the absence of effective treatment; and (2) the care or treatment is effective for that disease or shows promise of being effective for that disease as demonstrated by scientific data. In making this determination Aetna will take into account the results of a review by a panel of independent medical professionals. They will be selected by Aetna. This panel will include professionals who treat the type of disease involved.

Also, this exclusion will not apply with respect to drugs that: (1) have been granted treatment investigational new drug (IND) or Group c/treatment IND status; or (2) are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; if Aetna determines that available scientific evidence demonstrates that the drug is effective or shows promise of being effective for the disease.

**Foot orthotics** (shoe inserts), orthopedic shoes, or other devices to support the feet.

**Government plans**—for those services and supplies:

- 1) Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
- 2) Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to “no fault” auto insurance if it is required by law; provided on other than a group basis; and is included in the definition of Other Plans in the section entitled “If You or Your Dependents Have Other Coverage Excluding Medicare”. In addition, this exclusion will not apply to a plan established by a government for its own employees or their dependents; or Medicare.)

**Hearing exams** not included are charges for:

- Any ear or hearing exam to diagnose or treat a disease or injury;
- Drugs or medicines;
- Any hearing care service or supply which is a covered expense in whole or in part under any other part of this Plan or under any other plan of group benefits provided through your Employer;

- Any hearing care service or supply for which a benefit is provided under any workers' compensation law or any other law of like purpose, whether benefits are payable as to all or only part of the charges;
- Any hearing care service or supply which does not meet professionally accepted standards;
- Any service or supply received while the person is not covered;
- Any exams given while the person is confined in a hospital or other facility for medical care;
- Any exam required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement or is required by any law of a government.

**Infertility** caused by voluntary sterilization or a hysterectomy.

**Payment that you are not legally required to pay** includes, but is not limited to, all charges for services or supplies for which the provider has agreed to accept any benefits payable under the Plan as full payment for those charges.

**Private duty nursing** does not include that part or all of any nursing care that does not require the education, training, and technical skills of an R.N. or L.P.N.; such as transportation, meal preparation, charting of vital signs, and companionship activities; or

- Any private duty nursing care given while the person is an inpatient in a hospital or other health care facility; or
- Care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
- Care provided solely for skilled observation; or
- Any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by an R.N. or L.P.N.

**Reversal of a sterilization procedure.**

**Services and supplies** that are not Necessary, as determined by Aetna.

**Sex changes** or any treatment of gender identity disorders.

**Sexual dysfunction** expenses for therapy, supplies, or counseling for sexual dysfunction or inadequacies that do not have a physiological or organic basis.

**Vision aids.**

**Work-related illness or injury** expenses connected to an injury arising from work for wage or profit (whether or not work was performed for this firm), or for diseases covered by any workers' compensation law, occupational disease law, or similar law.

## **STATE-MANDATED BENEFITS**

If you reside in one of the following states, the state-mandated benefits also apply to your coverage under the Medical Plan.

State	Benefit	State-Mandated Benefit
California	Continuation of Coverage after COBRA Ceases	<p>The terms of this Continuation of Coverage after COBRA Ceases apply to you and your spouse.</p> <p>If you or you and your spouse:</p> <ul style="list-style-type: none"> <li>• Continued health expense coverage under this Plan in accordance with COBRA for the maximum period for which such continuation is available; and</li> <li>• You were 60 years of age or over with 5 years of service when you terminated employment;</li> </ul> <p>you may, prior to the date coverage under COBRA terminates, elect to further continue the same health expense coverage for you and your spouse, or for you only or for your spouse only. If you die during the period in which you can elect this further continuation, your spouse who was covered under COBRA for the maximum period may elect to further continue coverage provided such election is made during the period in which you could elect the further continuation. The election must include an agreement to pay contributions. The contributions may be up to 213% of the cost to the Plan. Premium payments must be continued.</p> <p>Coverage for a person will not be continued beyond the first to occur of:</p> <ul style="list-style-type: none"> <li>• The date the person becomes covered for like coverage under any group plan;</li> <li>• Failure to make any required contributions;</li> <li>• The date health expense coverage discontinues, and is not replaced, as to employees of the Eligible Class of which you were a member;</li> <li>• The date you attain age 65;</li> <li>• As to any spouse, the date the spouse attains age 65;</li> <li>• As to any spouse, 5 years from the date you terminated employment.</li> </ul> <p>The Conversion Privilege will be available when coverage is no longer available under this section.</p>
Colorado	Cleft Lip/ Palate of a Dependent Child	<p>Charges incurred for covered treatment given to a dependent child for a congenital cleft lip or cleft palate may be included as covered medical expenses. They are included to the extent they would have been included if incurred for a disease.</p> <p>Covered treatment means any of the services or supplies listed below given for cleft lip or cleft palate or for any other condition related to or developed as a result of the cleft lip or palate:</p> <ul style="list-style-type: none"> <li>• Oral surgery and facial surgery. This includes pre-operative and post-operative care performed by a Physician.</li> <li>• Oral prosthesis treatment (obturators and orthotic devices).</li> <li>• First installation of partial or full removable dentures or of fixed bridgework, if dentures are not professionally adequate.</li> <li>• Replacement of dentures or fixed bridgework when required as a result of structural changes in the mouth or jaw due to growth.</li> </ul>

State	Benefit	State-Mandated Benefit
		<ul style="list-style-type: none"> <li>• Cleft orthodontic therapy.</li> <li>• Diagnostic services of a Physician to find out if and to what extent the child’s ability to speak or hear has been lost or impaired.</li> <li>• Habilitative speech therapy rendered by a Physician that is expected to overcome congenital or early acquired handicaps as well as to restore or improve the child’s ability to speak.</li> </ul> <p>An audiologist or speech therapist who is legally qualified will be deemed a Physician for the purposes of this section.</p> <p>Charges for the following are not included:</p> <ul style="list-style-type: none"> <li>• Oral prosthesis, dentures or bridgework ordered before the child becomes covered, or ordered while covered but installed or delivered more than 60 days after termination of coverage.</li> <li>• Services given to treat delays of speech development unless such delays are shown to be caused by cleft lip or cleft palate or any condition related to or developed as a result of cleft lip or cleft palate.</li> <li>• Speech aids and training in the use of such aids.</li> <li>• Augmentive (assistive) Communication Systems and training in the use of such systems.</li> </ul>
Connecticut	Recovery of Benefits	The Recovery of Benefits provision does not apply.
Florida	Definition of Dependents  Conversion of Health Expense Coverage   Mammograms	Dependent children who meet the eligibility definition are covered until the end of the calendar year in which the child attains age 25.  In addition, your dependents include a child whose parent is your child and is covered as a dependent under this Plan. Conversion of health expense coverage or extension of benefits requirements may differ in some respects from the provisions of the Plan. In no event will the terms or conditions under which conversion coverage may be continued be less favorable to you or your dependents than the terms and conditions stated on page 45 of this document. Contact your HR Representative for additional information.  There is no age or frequency limitation for mammograms.
Georgia	Prescription Drug Coverage	Prescription Drugs paid at 100% at non-participating pharmacies.
Maryland	Outpatient Alcoholism and Drug Abuse  Pregnancy Coverage	Outpatient alcoholism and drug abuse coverage—no limits on the number of visits or the number of counseling sessions.  Benefits will be payable for one post-delivery home visit by a health care provider whether or not a person is discharged prior to the minimum time period allowed for inpatient confinement.









## WHAT THE DENTAL PLAN PAYS

The Dental Plan pays benefits for charges for dental services and supplies incurred for treatment of a dental disease or injury. The plan pays 100% for Preventive, Basic and Major Services up to the calendar year maximum benefit of \$1,500 per individual.

### Calendar Year Maximum Benefit

The Dental Plan has a calendar year maximum benefit of \$1,500 per covered person. This is the most that is payable for all dental expenses incurred by a person in a calendar year.

## WHAT THE DENTAL PLAN COVERS

This section of the booklet explains the covered dental expenses. Refer to the “Plan-At-A-Glance” or “How the Plan Works” sections for details on the level of dental benefits payable.

To be eligible for coverage under the Dental Plan, services and supplies must be considered Necessary and not Experimental or Investigational. (See “Glossary” and “What the Dental Plan Does Not Cover” for definitions of these terms.) All other applicable Dental Plan provisions and exclusions apply.

### Preventive Services

- Oral exams once every 6 months, including prophylaxis, scaling and cleaning of teeth;
- Topical application of sodium or stannous fluoride for persons under 19 years of age;
- X-rays for diagnosis, also other X-rays not to exceed one full mouth series in a 36 month period and one set of bitewings in a 6 month period;
- First installation of a space maintainer to replace any baby tooth which is lost prematurely;
- Sealants for dependent children under 14 years of age.

### Basic Services

Oral surgery;

- Surgical and non-surgical extractions;
- Fillings;
- General anesthetics given in connection with covered dental services;
- Surgical and non-surgical treatment of diseased periodontal structures;
- Surgical and non-surgical endodontic treatment, including root canal therapy;
- Injection of antibiotic drugs;
- Repair or recementing of crowns, inlays, bridgework or dentures;
- Relining and rebasing of dentures (one per 36 month period);

- For installation of removable dentures to replace one or more natural teeth extracted while the person is covered. This includes adjustments for the 6 month period following the date they were installed;
- Replacement of an existing removable denture or fixed bridgework by new fixed bridgework, or the adding of teeth to existing fixed bridgework. The “Prosthesis Replacement Rule” (see below) must be met.

### **Major Services**

- Inlays, gold fillings, or crowns; this includes precision attachments for dentures;
- First installation of fixed bridgework to replace one or more natural teeth extracted while the person is covered, including inlays and crowns as abutments;
- Replacement of an existing removable denture or fixed bridgework by a new denture, or the adding of teeth to a partial removable denture; the “Prosthesis Replacement Rule” must be met.

### **Advance Claim Review**

Aetna recommends that before starting a course of treatment for which Dentists’ charges are expected to be \$150 or more, details of the proposed course of treatment and charges to be made be filed with Aetna. Aetna will then estimate the benefits. You and the Dentist will be told what they are before treatment starts.

Some services may be given before Advance Claim Review is made. These are oral exams, including prophylaxis and X-rays and treatment of any traumatic injury or condition which occurs unexpectedly, requires immediate diagnosis and treatment, and is characterized by symptoms such as severe pain and bleeding.

A course of treatment is a planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending Dentist as a result of an oral exam. The treatment may be given by one or more Dentists. The course of treatment starts on the date a Dentist first gives a service to correct or treat such dental condition.

*Note:* As part of Advance Claim Review and as part of proof of any claim, Aetna has the right to require an oral exam of the person at its own expense. You must give Aetna all diagnostic and evaluative materials which it may require. These include X-rays, models, charts and written reports.

The benefits for a course of treatment may be for a lesser amount than would otherwise be paid if Advance Claim Review is not made or if any required verifying materials are not furnished. In this event, benefits will be reduced by the amount of covered dental expenses that Aetna cannot verify.

### **Prosthesis Replacement Rule**

Certain replacements or additions to existing dentures or bridgework will be covered under the Dental Plan. Proof satisfactory to Aetna must be given that:

- The replacement or addition of teeth is required to replace teeth extracted after the present denture or bridgework was installed. The person must have been covered when the tooth was extracted.
- The present denture or bridgework is a least 5 years old and cannot be made serviceable.

- The present denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered and cannot be made permanent. Replacement
- by a permanent denture is needed. It takes place within 12 months from the date the immediate temporary one was first installed.

### **Alternate Treatment**

If alternate services or supplies are used to treat a dental condition, covered dental expenses will be limited to those services and supplies which are customarily used nationwide for treatment and are deemed by the profession to be appropriate for treatment. They must meet broadly accepted national standards of dental practice. The person's total current oral condition will be taken into account.

When the Alternate Treatment part of this Dental Plan applies, benefits will be limited. Some examples of how this works follow:

### **Restorative**

*Gold, Baked Porcelain, Crowns, and Jackets.* Covered dental expenses will be limited to the charges for the procedure using amalgam or like material, if it would restore a tooth. This limit applies even if you and the Dentist choose some other type of restoration.

*Reconstruction.* Covered dental expenses will be limited to the charges for the procedure needed to eliminate oral disease and replace missing teeth. Appliances or restorations needed to increase vertical dimension or restore the occlusion are deemed to be optional and are not covered.

### **Prosthodontics**

*Partial dentures.* Covered dental expenses will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. This limit applies even if you and the Dentist choose a more elaborate or precision appliance.

*Complete dentures.* Covered dental expenses will be limited to the charges for a standard procedure. This limit applies even if you and the Dentist choose personalized or specialized treatment.

*Replacement of existing dentures.* This will be covered only if the existing denture cannot be used or repaired. If it can be used or repaired, covered dental expenses will be limited to the charges for the services needed to make the denture usable.

### **WHAT THE DENTAL PLAN DOES NOT COVER**

The following expenses are not covered:

- Care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending Physician or Dentist. However, the Plan will cover some treatments by a licensed dental hygienist that are supervised by a Dentist. These are scaling of teeth, cleaning of teeth and topical application of fluoride.
- The replacement of a prosthetic device that is lost, missing or stolen.
- Any services or supplies which are for orthodontic treatment.
- Services or supplies to increase vertical dimension. These are dentures, crowns, inlays and onlays, bridgework or any other appliance or service.

- A drug, a device, a procedure, or treatment will be determined Experimental or Investigational if Aetna determines that:
  - 1) There are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
  - 2) If required by the FDA, approval has not been granted for marketing; or
  - 3) A recognized national medical or dental society or regulatory agency has determined, in writing, that it is Experimental, Investigational, or for research purposes; or
  - 4) The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is Experimental, Investigational, or for research purposes.
- Those for services of a resident Physician or intern rendered in that capacity.
- Those that a covered person is not legally obliged to pay.
- To the extent allowed by the law of the jurisdiction where the group contract is delivered, those for services and supplies furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government; furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to “no fault” auto insurance if it is required by law; is provided on other than a group basis; and is included in the definition of Other Plans in the section entitled If You or Your Dependents Have Other Coverage excluding Medicare. In addition, this exclusion will not apply to a plan established by government for its own employees or their dependents; or Medicaid.)
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter or enhance appearance, whether or not for psychological or emotional reasons (this includes charges for personalization or characterization of dentures); except to the extent needed to repair an injury. Surgery must be performed in the calendar year of the accident which causes the injury, or in the next calendar year.

For dental expenses covered under the Medical Plan, please see pages 16.

## **WHAT HAPPENS IF...**

### **...I Go On an Approved Leave of Absence?**

If you go on an approved leave of absence, with or without pay, you may be eligible to continue your coverage under the Plan. If you wish to continue coverage during your approved leave of absence, you must make arrangements with your Human Resources Representative to apply for coverage through COBRA. See pages 41 for details.

### **...I Become Totally Disabled and Can No Longer work?**

If you are unable to work because of injury or sickness, and the firm’s third party administrator has approved your disability claim, coverage may be continued (up to 180 consecutive days) during the period you are totally disabled. Totally disabled means that you are unable to perform your normal work responsibilities. The firm will continue to pay all required premiums for coverage under the Plan.

After 180 days, if you had elected Long Term Disability Insurance under the firm's group plan, and your disability has been approved by the carrier, the firm will pay all required premiums for coverage under the Plan as long as the carrier continues to consider you to be totally disabled, and you are under age 65 (under age 65 is contingent on age of covered employee when benefits were first approved).

#### **..I Take an Unpaid Family and Medical Leave (FML)?**

If you go on an unpaid FML, coverage under the Plan will continue.

#### **...I Get Married, or Meet the Requirements for Domestic Partnership?**

If you are eligible for Plan coverage when you get married or meet the requirements of a domestic partnership, your spouse or domestic partner is immediately eligible for Plan coverage. You must contact your HR Representative within 31 days of the event to enroll your spouse or domestic partner in the Plan. If you don't enroll within this period, you and your spouse or domestic partner can enroll during the next open enrollment. Coverage will become effective on January 1 of the following year.

#### **...I Gain/Lose a Dependent?**

Notify your local HR Representative right away if your dependent is no longer eligible for Plan coverage. If you gain a dependent, your dependent will be eligible for coverage. You have 31 days to enroll a newly eligible dependent. Newborns are automatically covered for the first 31 days following their birth. If you don't enroll within this period, you will not be able to enroll the dependent until the next open enrollment period. Coverage will become effective on January 1 of the following year.

#### **...I Retire?**

If you retire, your coverage will automatically change to the U.S. Retired Officer Plan effective on the date following your retirement date. Different coverage rules apply to the Retired Officer Plan.

Please contact your HR Representative for a copy of the Retired Officer Plan. The firm will continue to make full payment of any required contributions to the Retired Officer Plan. If you are under age 65, the Retired Officer Plan will be considered the primary payer of your insurance claims. If you are age 65 or older, Medicare will be considered the primary payer of your insurance claims. The primary payer of your spouse's or domestic partner's insurance claims is also dictated by age. The Plan will coordinate its coverage with Medicare using the standard coordination of benefits method. To qualify for retirement, you must meet certain age and length of service criteria. Please contact your HR Representative for details. Refer to pages 36 and 37 for information on Medicare.

#### **...I Leave the Firm?**

Coverage for you and your dependents (if any) ends on the day after you leave the firm unless you elect to continue coverage through COBRA. See pages 41 for details. If you leave the firm and later return, you will be eligible to enroll in accordance with Plan enrollment requirements.

### **IF YOU OR YOUR DEPENDENTS HAVE OTHER COVERAGE EXCLUDING MEDICARE**

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a coordination of benefits provision.

This Plan uses the Maintenance of Benefits (MOB) approach for coordinating benefits. Using the MOB provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by Other Plans. Other Plans mean any other plan of health expenses coverage under: group insurance; any other type of coverage for persons in a group (this includes plans that are insured

and those that are not); no-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

The following example illustrates the benefits that would be paid, if the Plan is the secondary payer:

Eligible Charge	\$100
Primary Plan Pays (70% coinsurance)	\$70
Secondary Plan Would Pay (100% coinsurance)	\$100
The Plan Pays under MOB	\$30
<b>Patient Pays</b>	<b>\$0</b>

If the primary coverage paid the same as the Plan would have paid in the absence of the primary coverage, no benefit would be paid under the Plan.

Coordination of coverage with Other Plans includes coordination of cost containment procedures. This means that the Plan will not pay for an eligible expense that is not covered by another plan because the covered person did not follow the Other Plan's cost containment procedures. For example, if you are covered under another plan that requires certification before receiving medical care, the Plan will not pay for charges the Other Plan does not cover due to your failure to follow its certification requirements.

When this and another health expense coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

- 1) A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.
- 2) A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is: secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent; the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which covers the person as other than a dependent and is secondary to Medicare.
- 3) Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

If the Other Plan does not have the rule described above but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the Other Plan will determine the order of benefits.

- 4) In the case of a dependent child whose parents are divorced or separated:
  - a) If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

- b) If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any Other Plan which covers the child as a dependent child.
  - c) If there is not such a court decree:
    - i) If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
    - ii) If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.
- 5) If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest time will be deemed to pay its benefits first except that:
- a) The benefits of a plan which covers the person on whose expenses claim is based as a laid-off or retired employee; or the dependent of such person; shall be determined after the benefits of any Other Plan which covers such person as an employee who is not laid-off or retired, or a dependent of such person. If the Other Plan does not have a provision regarding laid-off or retired employees and as a result, each plan determines its benefits after the other, then the above paragraph will not apply.
  - b) The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any Other Plan which covers the person other than under such right of continuation. If the Other Plan does not have a provision: regarding right of continuation pursuant to federal or state law and as a result, each plan determines its benefits after the other, then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses incurred in a calendar year will be reduced by all Other Plan benefits payable for those expenses. When the coordination of benefits rules of this Plan and an Other Plan both agree that this Plan determines its benefits before such Other Plan, the benefits of the Other Plan will be ignored in applying the general rule above to the claim involved.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

## **IF YOU ARE ELIGIBLE FOR MEDICARE**

### **About Medicare**

Medicare is divided into two distinct programs that are separately funded:

**Part A** (Hospital Insurance) pays some of the cost of hospitalization and provides benefits for skilled nursing facility care, home health care and hospice care.

**Part B** (Supplementary Medical Insurance) is a voluntary program for eligible enrollees who enroll and pay a monthly premium and covers doctor bills, most outpatient Hospital services, and certain related services.

### **Your Eligibility**

You are eligible for Medicare at the beginning of the month in which you turn 65. (This age is not scheduled to rise, even though the full retirement age for Social Security benefits gradually rises to 67.) Enrollment is not automatic—you must contact your local Social Security office to enroll. When you enroll in Part A, you also automatically enroll in Part B unless you tell the Social Security Administration you do not want it.

**If You Plan To work Past Age 65...** you can delay enrolling in Part B as long as you continue coverage under the group Plan. Contact your Social Security office three months before you turn 65. At age 65, you should enroll in Part A and delay enrolling in Part B. In this case, the Plan will remain the primary payer and Part A will be the secondary payer for Hospital charges; using the standard coordination of benefits for claims payment. The Plan will continue to be the primary payer for your spouse (regardless of age) until you retire.

**If You Retire at Age 65 or Later...** contact your Social Security office three months before you retire to enroll in Part B. If you meet the firm's age and length of service criteria for retirement, Medicare will be the primary payer for you and your spouse (if eligible), and the Retired Officer Plan will be your secondary payer. The Retired Officer Plan will continue to be primary payer for a dependent not Medicare eligible.

### **Coordination of Benefits with Medicare**

Once you are Medicare eligible and have enrolled in Medicare Part B, and Aetna is your secondary payer, you can enroll in Medicare Direct. Medicare Direct is an electronic service that connects Medicare and Aetna for claim coordination and eliminates your need to file claims for supplemental benefits. By checking your Explanation of Medicare Benefits (EOMB) statement, it should note that unpaid charges have been forwarded to Aetna. Once Aetna pays covered expenses, Aetna will send you an EOB. There is no charge for this service. Contact your HR Representative for details.

### **HOW TO FILE A CLAIM**

Complete a Medical Benefits Request claim form and submit it, along with the itemized bills for eligible medical expenses, to the address on the claim form. Claim forms are available at <http://people.bah.com> (accessible outside the firewall via <https://secure.bah.com>). To research claim status, visit [www.aetna.com](http://www.aetna.com) and register for Aetna Navigator (Please note, if you have already registered, EOBs are available for viewing 11 days following your Aetna Navigator registration date.) If there has been recent claim activity, an Explanation of Benefits (EOB) will be available for you to view.

If you or your dependents incur a claim outside of the U.S., you must pay for the services up front and then submit a claim to Aetna. Aetna's specially trained processors convert the claim (no matter what language or currency) to U.S. dollars based on the date of service.

All claims should be reported promptly. The deadline for filing a claim for benefits is 90 days after the date of the loss causing the claim. If, through no fault of your own, you are not able to meet the deadline for filing claims, your claim will still be accepted if you file as soon as possible. Otherwise, late claims will not be covered. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

## **Filing Health 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 physician 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 medical 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 physician 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).

### ***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.

### **If Your Claim Is Denied**

If your claim for benefits is denied, in whole or in part, you will receive a written explanation from Aetna within 60 days after receipt of your claim (120 days if special circumstances apply). This explanation will tell you:

- The specific reasons for the denial;
- The specific references to provisions of the Plan documents that support those reasons;
- Any additional information you must provide to improve your claim and the reasons why that information is necessary; and
- The procedures available to you for further review of the claim.

## Health Claims—Standard Appeals

As a member of the Plan, you have the right to file an appeal about coverage for service(s) you have received from your health care provider or Aetna if you are not satisfied with the outcome of the initial determination and the appeal is regarding a change in the decision for the following:

- Certification of health care services
- Claim payment
- Plan interpretation
- Benefit determination
- Eligibility

You may file an appeal in writing to Aetna. The denial notice will include the address where the appeal can be sent. If your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, Social Security Number or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

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. A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. 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 on a claim involving urgent care, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the final determination on review, you have the right to bring a civil action, if applicable.

### ***Exhaustion of Process***

You must exhaust the applicable Level one and Level two processes of the Appeal Procedure before you establish any: litigation; arbitration; or administrative proceeding; regarding an alleged breach of the policy terms by Aetna Life Insurance Company; or any matter within the scope of the Appeals Procedure.

### **Health Claims—Voluntary Appeals**

You may file a voluntary appeal for external review of any final standard appeal determination that qualifies.

You must complete all of the levels of standard appeal described above before you can appeal for external review. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal. You must request this voluntary level of review within 60 days after you receive the final denial notice under the standard appeal processes.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

**NOTE:** *Members are encouraged not to send appeals certified or overnight mail to Aetna's P.O. Box address as this may cause delay in receipt.*

### **External Review**

You may, at your option, obtain External Review of a claim denial provided that:

- You have exhausted the Aetna Life Insurance Company appeal process for denied claims and you have received a final denial.
- The final denial was based upon a lack of medical necessity, or the experimental or investigational nature of the proposed service or treatment; and
- The cost of the service or treatment at issue exceeds \$500.00.

If you meet the eligibility requirements listed above, you will receive written notice of your right to request an External Review at the time the final decision on your internal appeal has been rendered. Either you or an individual acting on your behalf will be required to submit to Aetna Life Insurance

Company the External Review Request Form (except under expedited review as described below), a copy of the Plan denial of coverage letter, and all other information you wish to be reviewed in support of your request. Your request for an External Review must be submitted, in writing, to Aetna Life Insurance Company within 180 calendar days after you receive the final decision on your internal appeal.

Aetna Life Insurance Company will contact the "External Review Organization" that will conduct your External Review. The External Review Organization will then select an independent physician with appropriate expertise in the area at issue for the purpose of performing the External Review. In rendering a decision, the external reviewer may consider any appropriate credible information

submitted by you with the External Review Request Form, and must follow the applicable plan's contractual documents and plan criteria governing the benefits.

The External Review Organization will generally notify you of the decision within 30 calendar days of Aetna Life Insurance Company's receipt of a properly completed External Review Form. The notice will state whether the prior determination was upheld or reversed, and briefly explain the basis for the determination. The decision of the external reviewer will be binding on the Plan, except where Aetna Life Insurance Company or the Plan can show reviewer conflict of interest, bias or fraud. In such cases, notice will be given to you and a different reviewer will promptly resubmit the matter for consideration.

An expedited review is available when your treating physician certifies on a separate Request For Expedited External Review form (or by telephone with prompt written follow-up) the clinical urgency of the situation. "Clinical urgency" means that a delay (waiting the full 30 calendar day period) in receipt of the service or treatment would jeopardize your health. Expedited reviews will be decided within 5 calendar days of receipt of the request. In the case of such expedited reviews, you will initially be notified of the determination by telephone, followed immediately by a written notice delivered by expedited mail or fax.

You will be responsible for the cost of compiling and sending the information that you wish to be reviewed by the External Review Organization to Aetna Life Insurance Company. Aetna Life Insurance Company is responsible for the cost of sending this information to the External Review Organization. The professional fee for the External Review will be paid by Aetna Life Insurance Company.

In order for an individual to act on your behalf in connection with an External Review, you will need to specifically consent to the representation by signing the appropriate line on the External Review Request Form.

You may obtain more information about the External Review process by calling the toll-free Member Services telephone number listed on your ID card.

## **GENERAL NOTICE OF COBRA CONTINUATION COVERAGE RIGHTS**

### **Your Right To Continue Coverage**

The Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") gives you and your covered dependents the right to a temporary extension of coverage under the Plan ("COBRA continuation coverage") when coverage would otherwise end. This notice contains important information about your COBRA rights.

### **COBRA Continuation Coverage**

Under COBRA, the Plan must offer continuation coverage at group rates (the full premium including employee and employer portions, plus a 2% administrative fee) when coverage would otherwise end because of a life event known as a "qualifying event." COBRA continuation coverage must be offered to each person who is a "qualified beneficiary."\*<sup>1</sup> For purposes of the Plan, a qualified beneficiary is a

\* COBRA applies to "qualified beneficiaries" which does not include domestic partners. However, Booz Allen voluntarily offers the same continuation coverage to domestic partners who are eligible to participate in the Plan. References in this notice to "qualified beneficiaries" and "qualifying events" are intended to pertain to domestic partners covered under the Plan. A "domestic partner" will be treated identically to a "spouse" for all relevant purposes, including notice requirements given by the HR Representative.

A child born to, or placed for adoption with, the employee during the period of COBRA coverage is also considered a "qualified beneficiary" under COBRA. There may be extra cost in electing this additional coverage. You must also give notice to the HR Representative within 30 days of the birth or adoption placement.

spouse, domestic partner or dependent child who would otherwise lose Plan coverage because of a qualifying event. COBRA continuation coverage is the same as the coverage under the Plan of similarly situated employees and/or covered dependents who have not had a qualifying event. Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan, including special enrollment rights, as other participants or beneficiaries covered under the Plan.

This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. If COBRA continuation coverage is elected, proof of insurability is not required. The employee or qualified beneficiaries pay the full premium (both employee and employer portions, plus a 2% administrative fee) for COBRA continuation coverage.

The Plan Administrator is Booz Allen Hamilton, 8283 Greensboro Drive, McLean, VA 22102, (703) 902-5514. COBRA continuation coverage for the Plan is administered by Aetna Inc., 151 Farmington Ave. MB1K, Hartford, CT 06156-7622, (800) 429-9526.

### Qualifying Events

**Employees.** If you are an employee of Booz Allen Hamilton (“Booz Allen”) covered by this Plan, you have a right to elect COBRA continuation coverage if you lose your group health care coverage because of *either* of the following reasons:

- 1) A reduction in your hours of employment; or
- 2) The termination of your employment (for reasons other than your gross misconduct).\*\*

**Spouses and Domestic Partners.** If you are the spouse or domestic partner of an employee covered by this Plan, you have the right to elect COBRA continuation coverage for yourself if you lose group health coverage for *any* of the following reasons:

- 1) The death of your spouse or domestic partner;
- 2) The termination of your spouse’s or domestic partner’s employment (for reasons other than the employee’s gross misconduct);
- 3) A reduction in your spouse’s or domestic partner’s hours of employment;
- 4) Your divorce or legal separation or the end of your domestic partnership; or
- 5) Your spouse’s or domestic partner’s entitlement to Medicare (Part A, Part B, or both).

**Dependent Children.** In the case where a dependent child of an employee or domestic partner is covered by the Plan, he or she has the right to elect COBRA continuation coverage if group health care coverage under the Plan is lost for *any* of the following reasons:

- 1) The death of a parent employed by Booz Allen;
- 2) The termination of a parent’s employment with Booz Allen (for reasons other than parent’s gross misconduct);
- 3) A reduction in a parent’s hours of employment;

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\*\* The termination may be voluntary or involuntary.

- 4) The parents' divorce or legal separation or the end of the parent's domestic partnership;
- 5) The child ceases to be a "dependent child" as defined by the Plan; or
- 6) The parent who is employed by Booz Allen becomes entitled to Medicare (under Part A, Part B, or both.)

A qualified beneficiary who elects COBRA continuation coverage has the same rights as the covered employee. For example, a former dependent child of a covered employee could elect COBRA continuation coverage as a qualified beneficiary, marry, cover the new spouse, have a child and cover the child by paying a separate premium for the coverage elected. However, the new spouse and child are not considered "qualified beneficiaries" and have no separate rights to elect COBRA continuation coverage. Their COBRA continuation coverage ends when the former dependent child's coverage ends.

### **Notice Obligations**

Under the law, as a qualified beneficiary, you must notify the HR Representative of a divorce, legal separation, end of domestic partnership, or a child losing dependent status under the Plan. This notification must be made within 60 days after the later of: (i) the date of the qualifying event or (ii) the date that coverage would be lost under the Plan provisions because of the qualifying event.

Failure to give notice within the time limits can result in COBRA continuation coverage being forfeited. Be sure to check the Plan carefully to determine when a child loses dependent status.

### **Election Period**

When the employee's HR Representative is notified that a qualifying event has occurred, the HR Representative will in turn notify the employee, spouse, domestic partner, or dependent child of his or her right to elect COBRA continuation coverage. Election of COBRA continuation coverage must take place during the election period, which will end 60 days from the later of the date group health care coverage would otherwise terminate or the date the notification of COBRA continuation coverage rights is provided to the qualified beneficiary.

If an employee, spouse, domestic partner, or dependent child does not elect COBRA continuation coverage prior to the expiration of the election period, his or her rights to continue group health care coverage will terminate. If COBRA continuation coverage is elected, Booz Allen will provide COBRA continuation coverage which, as of the time such coverage is being provided, is identical to the group health care coverage provided under the Plan to similarly situated employees and/or covered dependents.

### **Duration of COBRA Coverage**

COBRA generally provides a maximum continuation period of 18, 29, or 36 months of COBRA continuation coverage depending on the type of qualifying event(s). The continuation period is measured from the date of the qualifying event.

**18 Month Coverage.** If group health care coverage was lost because of the employee's termination of employment (other than for reasons of gross misconduct) or reduction in hours, the required COBRA continuation coverage period is generally 18 months from the date of the qualifying event. Booz Allen voluntarily extends this period by up to an additional 6 months, for a maximum of 24 months from the date of the qualifying event, if the qualifying event is an educational leave of absence granted by Booz Allen to the employee.

**Secondary Events.** The 18-month COBRA continuation period may also be extended up to 18 additional months, for a maximum of 36 months from the date of the original qualifying event, if a second

qualifying event (divorce, legal separation, death, entitlement to Medicare, ceasing to be a dependent child) takes place during the original 18-month period. This extension applies only if the secondary event would have caused the spouse, domestic partner, or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Upon the occurrence of a second event it is the qualified beneficiary's obligation to notify the HR Representative of the second qualifying event within 60 days of the second qualifying event and within the original 18-month COBRA continuation coverage period. COBRA continuation coverage does not last beyond 36 months from the original qualifying event, no matter how many qualifying events occur.

**Disability Extension.** The 18-month COBRA continuation coverage period may be extended up to 11 additional months, for a maximum of 29 months from the date of the qualifying event, if the employee, spouse, domestic partner or dependent child is determined by the Social Security Administration to be disabled, the disability began during the first 60 days of COBRA continuation coverage and the disability lasts at least until the end of the original 18-month period of COBRA continuation coverage. The COBRA continuation coverage of the disabled qualified beneficiary and all other qualified beneficiaries (including those not deemed disabled) may be continued for up to an additional 11 months. The extended coverage is applicable provided the HR Representative is notified of the disabled status before the end of the original 18-month COBRA continuation coverage period and within 60 days after the date the qualified beneficiary is determined to be disabled.

The qualified beneficiaries who are receiving COBRA continuation coverage are responsible for providing the HR Representative with notice of a determination by the Social Security Administration that a qualified beneficiary is disabled. If this notice is not provided to the HR Representative, Booz Allen is not required to extend COBRA continuation coverage. If there is a final determination that the disability has ended, the formerly disabled person must notify the HR Representative within 30 days after the date the disability ends. The COBRA continuation coverage will end on the first of the month following 30 days after the determination that the disability has ended. If the COBRA continuation coverage period is extended under this provision, Booz Allen may increase the premium charged for each additional month of COBRA continuation coverage from the standard COBRA premium (102% of the full premium) to 150% of the full premium.

**36 Month Coverage.** The following events entitle qualified beneficiaries to 36 months of continuation coverage:

- 1) The death of the employee;
- 2) The dependent ceases to be a "dependent child" as defined by the Plan;
- 3) The employee's entitlement to Medicare (Part A, Part B, or both); or
- 4) Divorce or legal separation or end of domestic partnership.

#### **COBRA Termination**

The law permits COBRA continuation coverage to be terminated for any of the following reasons:

- 1) Booz Allen no longer provides group health care coverage to any of its employees;
- 2) The premium for COBRA continuation coverage is not paid in a timely manner;
- 3) The person receiving COBRA continuation coverage becomes covered under another group health care plan that does not contain any exclusion or limitation with respect to a pre-existing condition (other than an exclusion or limitation with respect to any pre-existing condition that may be disregarded under the law);

- 4) The person receiving COBRA continuation coverage becomes entitled to Medicare;
- 5) If COBRA continuation coverage was extended to up to 29 months due to a Social Security disability determination and a final determination is made that the qualified beneficiary is no longer disabled; or
- 6) The end of the COBRA continuation coverage period.

If you have any questions about COBRA continuation coverage, you should contact your HR Representative or the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's Web site at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

## **OTHER IMPORTANT INFORMATION**

### **Conversion Privileges**

If your COBRA coverage ends for any reason other than your failure to pay any required contributions, and you want to continue medical coverage for you and/or your dependents, you have the right to convert your medical coverage to an individual basic health care policy provided by Aetna. This "right to convert" applies to U.S. residents only and only if the firm's medical coverage under this Plan is not terminated.

If you want to convert to an individual health care policy, you must apply to do so, and pay the first premium to Aetna within 45 days after your COBRA coverage ends. This application period will be extended for 45 days, from the date you receive written notice of your conversion privilege, but not beyond 90 days from the date coverage ceases. This applies even if the covered person is still eligible for benefits because he/she is totally disabled. Evidence of insurability will not be required.

*Aetna may decline to issue a personal policy* if it is applied for in a jurisdiction in which Aetna cannot issue or deliver the policy; or if a person is eligible for or has benefits available under any other group contract or medical plan that would result in overinsurance or match benefits.

The coverage you receive under the individual contract may be lower than the regular Plan coverage, and certain covered services may not be included in this contract. You will be required to pay the entire cost of your and your dependents' medical premiums. Premiums will be determined by Aetna.

*There is no conversion privilege for the dental Plan.*

### **Special Rights for Mothers and Newborn Children**

The Plan may not, under federal law, restrict 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 provider, after consulting with the mother, from discharging the mother or her newborn child earlier than 48 hours (or 96 hours as applicable). Under federal law, the Plan may not require that a provider obtain authorization for prescribing a length of stay less than 48 hours (or 96 hours as applicable).

### **Women's Health and Cancer Rights Act**

Solely to the extent required under the Women's Health and Cancer Rights Act, the Plan will provide certain benefits related to services received in connection with a mastectomy. The Plan shall include coverage for reconstructive surgery following a mastectomy.

If you or your eligible dependent(s) are receiving benefits under the Plan related to mastectomy and you or your eligible dependent(s) elect breast reconstruction, the coverage will be provided, in a manner determined in consultation with the attending physician and you or your dependent(s), for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Reconstructive benefits are subject to annual Plan co-payments, deductibles and co-insurance provisions similar to other medical and surgical benefits covered under the Plan.

### **Type of Coverage**

Coverage under this Plan is non-occupational. Only non-occupational accidental injuries and non- occupational diseases are covered.

### **Who Pays for Your Benefits**

If you are an active Officer, the firm pays the cost of coverage under the Plan.

### **Recovery of Benefits Paid (Reimbursement Provision)**

If a person suffers a loss or an injury caused by the act or omission of a third party, the Health Expense Benefits in this Plan for such loss or injury will be paid only if that person, or his or her legally authorized representative, agrees in writing:

- To pay Aetna to the extent the person recovers from a third party via settlement or judgment an amount, which includes an amount or part thereof, already paid by Aetna. The amount recovered from a third party must be for the same services or benefits for which the person incurred expenses, which were already paid by Aetna. The foregoing notwithstanding, however, if the amount recovered through a settlement or judgment is not sufficient to cover all amounts paid by Aetna and the person, the person's obligation to pay Aetna shall begin only when the person has fully recovered from the third party all amounts paid by the person for the related medical claims and not paid or reimbursed by Aetna.
- To provide Aetna a lien in the amount of the benefit paid. This lien may be filed with: the third party; his or her agent; or a court that has jurisdiction in the matter.

The payment and the lien referred to above shall be made or provided to Aetna in its capacity as the provider of administrative services to the Plan.

### **Recovery of Overpayment**

If a benefit payment is made by the Plan, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, the Plan has the right to require the return of the overpayment on request; or to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family. Such right does not affect any other right of recovery the Plan may have with respect to such overpayment.

**Legal Action**

No legal action can be brought to recover any benefit after three years from the deadline for filing claims.

**Amending or Terminating the Plan**

This Plan may be amended or terminated at any time by a written resolution of an Officer of the firm who has been duly authorized to act on behalf of the firm with respect to the Plan pursuant to a written resolution adopted by the Board of Directors of the firm.

## ABOUT THE PLAN

**Plan Name:** U.S. Officer Medical and Dental Insurance Plan

**Employer Identification Number:**

**Plan Administrator and Plan Sponsor:** Booz Allen Hamilton Inc.  
8283 Greensboro Drive  
McLean, Virginia 22102-3838

**Plan Benefits Provided by:** Aetna, inc. under contract form number 800105 and underwritten by the Aetna Life Insurance Company, of Hartford Connecticut (called Aetna).

## HIPAA PRIVACY RULE

**The Health Insurance Portability and Accountability Act (HIPAA)** imposes numerous requirements on employer health plans concerning the use and disclosure of individual health information. Under the Privacy Rule, health information is private and protected and can only be disclosed for certain purposes with permission from the participant. If privacy rights are violated, the participant can file a complaint.

This information, known as protected health information, includes virtually all individually identifiable health information held by the Plan. Under the HIPAA Privacy Rule, the Plan must enable members to exercise specific health privacy rights. Aetna, as claims administrator, has established procedures that you and your dependents may use to exercise those rights. Aetna's procedures address members' rights to:

- Access their "Protected Health Information" (PHI);
- Make certain amendments to their PHI;
- Receive an accounting of certain disclosures of their PHI; and
- Request restrictions on use or disclosure of their PHI and/or have their PHI communicated through confidential means.

If you or your dependents wish to exercise your HIPAA Privacy rights, you should contact Aetna directly at the toll-free number provided on your ID card (it is especially critical that you refer any request for restrictions and/or confidential communications to Aetna, as not all such requests can be accommodated, and the HIPAA Privacy Rule does not require that all such requests be accepted).

Aetna's response to the member will contain instructions for the member to contact the firm directly if he/she wishes to exercise any HIPAA privacy rights with regard to PHI maintained by Aetna.

If you believe your HIPAA privacy rights have been violated, you may contact Aetna Member Services and/or the Secretary of Health and Human Services (HHS) 1-877-696-6775. Additionally, you may contact the Booz Allen Ethics Hotline at 1-800-501-8755.

## GLOSSARY

### **Behavioral Health Provider**

A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

### **Birthing Center**

This is a freestanding facility that meets licensing standards; is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care; makes charges; is directed by at least one Physician who is a specialist in obstetrics and gynecology; has a Physician or certified nurse midwife present at all births and during the immediate postpartum period; extends staff privileges to Physicians who practice obstetrics and gynecology in an area Hospital; has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery; provides, during labor, delivery and the immediate postpartum period, full-time skilled nursing services directed by an R.N. or certified nurse midwife; provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child; has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear; is equipped and has trained staff to handle medical emergencies and provide immediate support measures to sustain life if complications arise during labor, and if a child is born with an abnormality which impairs function or threatens life; accepts only patients with low risk pregnancies; and has a written agreement with a Hospital in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them; and provides an ongoing quality assurance program. This includes reviews by Physicians who do not own or direct the facility; and keeps a medical record on each patient and child.

**Board and Room Charges** Charges made by an institution for board and room and other **necessary** services and supplies. They must be regularly made at a daily or weekly rate.

### **Brand Name Drug**

A prescription drug which is protected by trademark registration.

### **Companion**

This is a person whose presence as a Companion or caregiver is necessary to enable an NME Patient:

- To receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- To travel to and from the facility where treatment is given.

### **Convalescent Facility**

This is an institution that is licensed to provide, and does provide the following, on an inpatient basis, for persons convalescing from disease or injury: professional nursing care by an R.N. or by an

L.P.N. directed by a full-time R.N., and physical restoration services to help patients to meet a goal of self-care in daily living activities. The Convalescent Facility also provides 24 hour a day nursing care by licensed nurses directed by a full-time R.N.; is supervised full-time by a Physician or an R.N.; keeps a complete medical record on each patient; has a utilization review plan; is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders; and makes charges.

### **Custodial Care**

This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- By whom they are prescribed; or
- By whom they are recommended; or
- By whom or by which they are performed.

### **Dentist**

This means a legally qualified Dentist. Also, a Physician who is licensed to do the dental work he or she performs.

### **Effective Treatment of Alcoholism or Drug Abuse**

This means a program of alcoholism or drug abuse therapy that is prescribed and supervised by a **physician** and either:

- Has a follow-up therapy program directed by a physician on at least a monthly basis; or
- Includes meetings at least twice a month with organizations devoted to the treatment of alcoholism or drug abuse.

These are not effective treatment:

- Detoxification. This means mainly treating the aftereffects of a specific episode of alcoholism or drug abuse.
- Maintenance care. This means providing an environment free of alcohol or drugs.

### **Generic Drug**

A drug product which is pharmaceutically equivalent and bioequivalent to another drug product that is customarily recognized as the brand name product throughout the pharmacist's profession. A drug is pharmaceutically equivalent to another drug if it contains identical amounts of the same active drug ingredients in the same dosage form. A drug is bioequivalent to another drug if it has demonstrated comparable bioavailability when tested under similar conditions.

### **Home Health Agency**

This is an agency that mainly provides skilled nursing and other therapeutic services and is associated with a professional group which makes policy. This group must have at least one Physician and one R.N.; full-time supervision by a Physician or an R.N.; keeps complete medical records on each person; has a full-time administrator; and meet licensing standards.

### **Home Health Care Plan**

This is a plan that provides for care and treatment of a disease or injury. The care and treatment must be: prescribed in writing by the attending Physician; and an alternative to confinement in a Hospital or Convalescent Facility.

## **Hospice Care**

This is care given to a Terminally Ill person by or under arrangements with a Hospice Care Agency. The care must be part of a Hospice Care Program.

## **Hospice Care Agency**

This is an agency or organization which has Hospice Care available 24 hours a day and meets any licensing or certification standards set forth by the jurisdiction where it is located. It provides skilled nursing services; medical social services; and psychological and dietary counseling. It provides or arranges for other services which will include services of a Physician; and physical and occupational therapy; and part-time home health aide services which mainly consist of caring for Terminally Ill persons; and inpatient care in a facility when needed for pain control and acute and chronic symptom management. It has personnel which include at least: one Physician; and one R.N.; and one licensed or certified social worker employed by the Agency. It establishes policies governing the provision of Hospice Care; assesses the patient's medical and social needs; develops a Hospice Care Program to meet those needs; and provides an ongoing quality assurance program. This includes reviews by Physicians, other than those who own or direct the Agency; permits all area medical personnel to utilize its services for their patients; keeps a medical record on each patient; utilizes volunteers trained in providing services for non-medical needs; and has a full-time administrator.

## **Hospice Care Program**

This is a written plan of Hospice Care which is established by, and reviewed from time to time by, a Physician attending the person and appropriate personnel of a Hospice Care Agency. It is designed to provide palliative and supportive care to Terminally Ill persons and supportive care to their families. It includes an assessment of the person's medical and social needs and a description of the care to be given to meet those needs.

## **Hospice Facility**

This is a facility, or distinct part of one, which mainly provides inpatient Hospice Care to Terminally Ill persons; charges its patients; meets any licensing or certification standards set forth by the jurisdiction where it is located; keeps a medical record on each patient; and provides an ongoing quality assurance program. The program includes reviews by Physicians other than those who own or direct the facility; is run by a staff of Physicians, at least one such Physician must be on call at all times; provides 24 hours a day nursing services under the direction of an R.N.; and has a full-time administrator.

## **Hospital**

A place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons;
- Is supervised by a staff of Physicians;
- Provides 24 hour a day R.N. service;
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, or a nursing home.

## **L.P.N.**

A Licensed Practical Nurse.

## **Medicare**

Title XVIII (Health Insurance for the Aged and Disabled) of the U.S. Social Security Act, as amended from time to time.

## **Mental Disorder**

This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

- Alcoholism and drug abuse.
- Schizophrenia.
- Bipolar disorder.
- Pervasive Mental Developmental Disorder (Autism).
- Panic disorder.
- Major depressive disorder.
- Psychotic depression.
- Obsessive compulsive disorder.

For the purposes of benefits under this Plan, mental disorder will include alcoholism and drug abuse only if any separate benefit for a particular type of treatment does not apply to alcoholism and drug abuse.

## **Necessary**

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternate service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- Information provided on the affected person's health status;
- Reports in peer reviewed medical literature;
- Reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- The opinion of health professionals in the generally recognized health specialty involved; and
- Any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- Those that do not require the technical skills of a medical, mental health or dental professional; or
- Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office or other less costly setting.

### **Negotiated Charge**

This is the maximum charge a PCP, specialist or facility has agreed to make as to any service or supply for the purpose of the benefits under the Plan.

### **Non-Occupational Disease**

A non-occupational disease is a disease that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that disease under such law.

### **Non-Occupational Injury**

A non-occupational injury is an accidental bodily injury that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an injury which does.

**Officer**

CEO, Executive Vice President, Senior Vice President of Booz Allen Hamilton. Certain Vice Presidents of Booz Allen Hamilton who held the position of Senior Director prior to October 1, 2009 are also considered to be Officers for purposes of the Plan.

**Physician**

A licensed practitioner of the healing arts acting within the scope of the license.

**Preferred Pharmacy**

A pharmacy, including a mail order pharmacy, which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:

- While the contract remains in effect;
- While such a pharmacy dispenses a prescription drug under the terms of its contract with Aetna.

**Residential Treatment Facility—Alcoholism and Drug Abuse**

This is an institution that meets all of the following requirements:

- On-site licensed Behavioral Health Provider 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a Physician.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires detoxification services, must have the availability of on-site medical treatment 24 hours per day/7 days a week, which must be actively supervised by an attending Physician.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a Psychiatrist or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed Behavioral Health Provider who, while not needing to be individually contracted, needs to (1) meet the Aetna credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).

- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.
- 24 hours per day/7 days a week supervision by a Physician with evidence of close and frequent observation.
- On-site, licensed Behavioral Health Provider, medical or substance abuse professionals 24 hours per day/7 days a week.

**R.N.**

A Registered Nurse.

**Semiprivate Rate**

This is the charge for room and board which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

**Temporomandibular Joint Dysfunction**

A Temporomandibular Joint Dysfunction (TMJ), a disorder in the relationship between the jaws or jaw joints and muscles and nerves.

**Terminally Ill**

This is a medical prognosis of six months or less to live.

**Totally Disabled**

You will be considered totally disabled if, because of an injury or a sickness, you are unable to perform all of the substantial and material duties of your regular employment or occupation. Your dependent will be considered totally disabled if, because of an injury or a sickness, he or she is unable to perform the normal activities of a person of like age and sex.

**Urgent Admission**

One where the **physician** admits the person to the **hospital** due to:

- The onset of or change in a disease; or
- The diagnosis of a disease; or

- An injury caused by an accident;

which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

### **Urgent Care Provider**

This is a freestanding medical facility which:

- Provides unscheduled medical services to treat an urgent condition if the person's physician is not reasonably available.
- Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
- Makes charges.
- Is licensed and certified as required by any state or federal law or regulation.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**. At least one **physician** must be on call at all times.
- Has a full-time administrator who is a licensed **physician**.

A **physician's** office, but only one that has contracted with Aetna to provide urgent care; and is, with Aetna's consent, included in the Directory as a Preferred Urgent Care Provider.

It is not the emergency room or outpatient department of a **hospital**. **Urgent Condition**

This means a sudden illness; injury; or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of the covered person's health;
- Includes a condition which would subject the covered person to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a **hospital**; and
- Requires immediate outpatient medical care that cannot be postponed until the covered person's **physician** becomes reasonably available.

# **BENEFIT PLAN**

**Prepared Exclusively For Booz Allen Hamilton**

**Retired Officers Traditional Choice Medical  
Plan**

**Aetna Life Insurance Company Booklet-Certificate**

This Booklet-Certificate is part of the Group Insurance Policy between **Aetna** Life Insurance Company and the Policyholder

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\*Defines the Terms Shown in Bold Type in the Text of This Document.

## Preface (GR-9N-02-005-01 VA)

Aetna Life Insurance Company (ALIC) is pleased to provide you with this *Booklet-Certificate*. Read this *Booklet-Certificate* carefully. The plan is underwritten by Aetna Life Insurance Company of Hartford, Connecticut (referred to as **Aetna**).

This *Booklet-Certificate* is part of the *Group Insurance Policy* between Aetna Life Insurance Company and the Policyholder. The *Group Insurance Policy* determines the terms and conditions of coverage. **Aetna** agrees with the Policyholder to provide coverage in accordance with the conditions, rights, and privileges as set forth in this *Booklet-Certificate*. The Policyholder selects the products and benefit levels under the plan. A person covered under this plan and their covered dependents are subject to all the conditions and provisions of the *Group Insurance Policy*.

The *Booklet-Certificate* describes the rights and obligations of you and **Aetna**, what the plan covers and how benefits are paid for that coverage. It is your responsibility to understand the terms and conditions in this *Booklet-Certificate*. Your *Booklet-Certificate* includes the *Schedule of Benefits* and any amendments or riders.

If you become insured, this *Booklet-Certificate* becomes your *Certificate of Coverage* under the *Group Insurance Policy*, and it replaces and supersedes all certificates describing similar coverage that **Aetna** previously issued to you.

Group Policyholder:	Booz Allen Hamilton
Group Policy Number:	
Effective Date:	January 1, 2015
Issue Date:	February 9, 2015
Booklet-Certificate Number:	15



Mark T. Bertolini  
Chairman, Chief Executive Officer and President

Aetna Life Insurance Company (A Stock Company)

## **Important Information Regarding Availability of Coverage** (GR-9N-02-005-02 VA)

No services are covered under this *Booklet-Certificate* in the absence of payment of current premiums subject to the *Grace Period* and the *Premium* section of the *Group Insurance Policy*.

Unless specifically provided in any applicable termination or continuation of coverage provision described in this *Booklet-Certificate* or under the terms of the *Group Insurance Policy*, the plan does not pay benefits for a loss or claim for a health care, medical or dental care expense incurred before coverage starts under this plan.

This plan will not pay any benefits for any claims, or expenses incurred after the date this plan terminates.

This provision applies even if the loss, or expense, was incurred because of an **accident, injury** or **illness** that occurred, began or existed while coverage was in effect.

Please refer to the sections, “*Termination of Coverage (Extension of Benefits)*” and “*Continuation of Coverage*” for more details about these provisions.

Benefits may be modified during the term of this plan as specifically provided under the terms of the *Group Insurance Policy* or upon renewal. If benefits are modified, the revised benefits (including any reduction in benefits or elimination of benefits) apply to any expenses incurred for services or supplies furnished on or after the effective date of the plan modification. There is no vested right to receive any benefits described in the *Group Insurance Policy* or in this *Booklet-Certificate* beyond the date of termination or renewal including if the service or supply is furnished on or after the effective date of the plan modification, but prior to your receipt of amended plan documents.

## **Coverage for You and Your Dependents** (GR-9N-02-005-01 VA)

### **Health Expense Coverage** (GR-9N-02-020-01 VA)

Benefits are payable for covered health care expenses that are incurred by you or your covered dependents while coverage is in effect. An expense is “incurred” on the day you receive a health care service or supply.

Coverage under this plan is non-occupational. Only **non-occupational injuries** and **non-occupational illnesses** are covered.

Refer to the *What the Plan Covers* section of the *Booklet-Certificate* for more information about your coverage.

### **Treatment Outcomes of Covered Services** (GR-9N-02-020-01 VA)

**Aetna** is not a provider of health care services and therefore is not responsible for and does not guarantee any results or outcomes of the covered health care services and supplies you receive. Except for Aetna RX Home Delivery LLC, providers of health care services, including hospitals, institutions, facilities or agencies, are independent contractors and are neither agents nor employees of **Aetna** or its affiliates.

# When Your Coverage Begins

(GR-9N-29-005-01 VA)

**Who Can Be Covered How and When to Enroll  
When Your Coverage Begins**

Throughout this section you will find information on who can be covered under the plan, how to enroll and what to do when there is a change in your life that affects coverage. In this section, “you” means the employee.

## Who Can Be Covered

### Employees

To be covered by this plan, the following requirements must be met:

- You will need to be in an “eligible class”, as defined below; and
- You will need to meet the “eligibility date criteria” described below.

### Determining if You Are in an Eligible Class (GR-9N-29-005-01 VA)

You are in an eligible class if:

- You are a retired employee of an employer participating in this plan, and you:
  - Retired before the effective date of this plan and were covered under the prior plan for health care coverage on the day before you retired; or
  - Were covered under this plan or another plan sponsored by your employer on the day before you retired; and
  - Retire under your employer’s IRS-qualified retirement plan.

### Determining When You Become Eligible (GR-9N-29-005-02 VA)

You become eligible for the plan on your eligibility date, which is determined as follows.

#### On the Effective Date of the Plan

If you are in an eligible class on the effective date of your plan, your eligibility date is the effective date of the plan.

#### After the Effective Date of the Plan

If you are in an eligible class on the date of retirement, your eligibility date is the date you retire.

If you enter an eligible class after your date of retirement, your eligibility date is the date you enter the eligible class.

### Obtaining Coverage for Dependents (GR-9N-29-010-02 VA)

Your dependents can be covered under your plan. You may enroll the following dependents:

- Your legal spouse; or
- Your domestic partner who meets the rules set by your employer; and
- Your dependent children; and
- Dependent children of your domestic partner.

**Aetna** will rely upon your employer to determine whether or not a person meets the definition of a dependent for coverage under the plan. This determination will be conclusive and binding upon all persons for the purposes of this plan.

### **Coverage for Domestic Partner** (GR-9N-29-010-01 VA)

To be eligible for coverage, you and your domestic partner will need to complete and sign a Declaration of Domestic Partnership.

### **Coverage for Dependent Children** (GR-9N-29-010-06 VA)

To be eligible for coverage, a dependent child must be under 26 years of age. An eligible dependent child includes:

- Your biological children;
- Your stepchildren;
- Your legally adopted children;
- Your foster children, including any children placed with you for adoption;
- Any children for whom you are responsible under court order;
- Your grandchildren in your court-ordered custody; and
- Any other child who lives with you in a parent-child relationship.

Coverage for a handicapped child may be continued past the age limits shown above. See *Handicapped Dependent Children* for more information.

### **Important Reminder**

Keep in mind that you cannot receive coverage under this Plan as:

- Both an employee and a dependent; or
- A dependent of more than one employee.

## **How and When to Enroll** (GR-9N 29-015 02 VA)

### **Initial Enrollment in the Plan**

You will be provided with plan benefit and enrollment information when you first become eligible to enroll. You will need to enroll in a manner determined by **Aetna** and your employer. To complete the enrollment process, you will need to provide all requested information for yourself and your eligible dependents.

You will need to enroll within 31 days of your eligibility date.

Newborns are automatically covered for 31 days after birth. To continue coverage after 31 days, you will need to complete a change form and return it to your employer before the end of the enrollment period.

### **Special Enrollment Periods** (GR-9N 29-015 02 VA)

#### **If You Adopt a Child**

Your plan will cover a child who is placed for adoption. This means you have taken on the legal obligation for total or partial support of a child whom you plan to adopt.

Your plan will provide coverage for a child who is placed with you for adoption if:

- The child meets the plan's definition of an eligible dependent on the date he or she is placed for adoption; and
- You request coverage for the child in writing within 31 days of the placement.
- Proof of placement will need to be presented to **Aetna** prior to the dependent enrollment.
- Any coverage limitations for a pre-existing condition will not apply to a child placed with you for adoption provided that the placement occurs on or after the effective date of your coverage.

## **When You Receive a Qualified Child Support Order**

A Qualified Medical Child Support Order (QMCSO) is a court order requiring a parent to provide health care coverage to one or more children. A Qualified Domestic Relations Support Order (QDRSO) is a court order requiring a parent to provide dependent's life insurance coverage to one or more children. Your plan will provide coverage for a child who is covered under a QMCSO or a QDRSO, if:

- The child meets the plan's definition of an eligible dependent; and
- You request coverage for the child in writing within 31 days of the court order.

Coverage for the dependent will become effective on the date of the court order. Any coverage limitations for a pre-existing condition will not apply, as long as you submit a written request for coverage within the 31-day period.

If you do not request coverage for the child within the 31-day period, you will need to wait until the next annual enrollment period.

Under a QMCSO or QDRSO, if you are the non-custodial parent, the custodial parent may file claims for benefits. Benefits for such claims will be paid to the custodial parent.

## **When Your Coverage Begins** (GR-9N-29-025-01 VA)

### **Your Effective Date of Coverage**

Your coverage takes effect on:

- The date you are eligible for coverage

### **Your Dependent's Effective Date of Coverage** (GR-9N-29-025-01 VA)

Your dependent's coverage takes effect on the same day that your coverage becomes effective, if you have enrolled them in the plan.

# How Your Medical Plan Works

(GR-9N-08-005-01)

## Common Terms Accessing Providers

It is important that you have the information and useful resources to help you get the most out of your **Aetna** medical plan. This Booklet-Certificate explains:

- § Definitions you need to know;
- § How to access care, including procedures you need to follow;
- § What expenses for services and supplies are covered and what limits may apply;
- § What expenses for services and supplies are not covered by the plan;
- § How you share the cost of your covered services and supplies; and
- § Other important information such as eligibility, complaints and appeals, termination, continuation of coverage, and general administration of the plan.

### Important Notes

- Unless otherwise indicated, “you” refers to you and your covered dependents.
- Your health plan pays benefits only for services and supplies described in this Booklet-Certificate as **covered expenses** that are **medically necessary**.
- This Booklet-Certificate applies to coverage only and does not restrict your ability to receive health care services that are not or might not be covered benefits under this health plan.
- Store this Booklet-Certificate in a safe place for future reference.

## Common Terms (GR-9N-08-010-01)

Many terms throughout this Booklet-Certificate are defined in the *Glossary* section at the back of this document. Defined terms appear in bolded print. Understanding these terms will also help you understand how your plan works and provide you with useful information regarding your coverage.

## About Your Comprehensive Medical Plan (GR-9N-08-015-02)

This **Aetna** medical plan is designed to cover a range of medical services and supplies for the treatment of **illness** and **injury** and other preventive and routine medical expenses. It does not provide benefits for all medical care.

The plan will pay for **covered expenses** up to the maximum benefits shown in this Booklet-Certificate. Coverage is subject to all the terms, policies and procedures outlined in this Booklet-Certificate. Not all medical expenses are covered under the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. Refer to the *What the Plan Covers*, *Exclusions* and *Schedule of Benefits* sections to determine if medical services are covered, excluded, or limited.

### Using the Plan (GR-9N-08-015-02)

- § When you need medical care, you can directly access **physicians, hospitals** and other health care providers of your choice for covered services and supplies under the plan.
- § You may have to pay the provider or facility and submit a claim to receive reimbursement from the plan. You will be responsible for completing and submitting claim forms for reimbursement of covered expenses you paid directly to the provider. **Aetna** will reimburse you for a covered expense up to the **recognized charge**, less any cost sharing required by you.

- You will receive notification of what the plan has paid toward your **covered expenses**. It will indicate any amounts you owe towards your **deductible, payment percentage** or other non-covered expenses you have incurred. You may elect to receive this notification by e-mail, or through the mail. Call or e-mail Member Services if you have questions regarding your statement.

### Important Note

Please refer to the *Understanding Precertification* section for information on how to request precertification.

## Cost Sharing

### Important Note:

**You share in the cost of your care. Cost Sharing amounts and provisions are described in the *Schedule of Benefits*.**

- You must satisfy any applicable **deductibles** before the plan begins to pay benefits.
- The plan contains a **deductible carryover** feature. Refer to your *Schedule of Benefits* section for details.
- After you satisfy any applicable **deductible**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. You will be responsible for your **coinsurance** up to the **coinsurance limit** applicable to your plan.
- Your **coinsurance** will be based on the **recognized charge**. If the health care provider you select charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.
- Once you satisfy the **coinsurance limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the Calendar Year. Certain designated out-of-pocket expenses may not apply to the **coinsurance limit**. Refer to your *Schedule of Benefits* section for information on what expenses do not apply to the limit and specific dollar limits that apply to your plan.
- The plan will pay for **covered expenses**, up to the maximums shown in the *What the Plan Covers* or *Schedule of Benefit* sections. You are responsible for any expenses incurred over the maximum limits outlined in the *What the Plan Covers* or *Schedule of Benefits* sections.

## Understanding Precertification

### Precertification

Inpatient **stays** require **precertification** by **Aetna**. **Precertification** is a process that helps you and your **physician** determine whether the services being recommended are **covered expenses** under the plan. It also allows **Aetna** to help your provider coordinate your transition from an inpatient setting to an outpatient setting (called discharge planning), and to register you for specialized programs or case management when appropriate.

### Important Note

Please read the following sections in their entirety for important information on the **precertification** process, and any impact it may have on your coverage.

### The Precertification Process

Prior to being **hospitalized** there are certain **precertification** procedures that must be followed.

You are responsible for obtaining **precertification**. You or a member of your family, a **hospital** staff member, or the attending **physician**, must notify **Aetna** to **precertify** the admission prior to receiving any of the services or supplies that require **precertification** pursuant to this Booklet-Certificate in accordance with the following timelines:

**Precertification** should be secured within the timeframes specified below. To obtain **precertification**, call **Aetna** at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	It is your responsibility to call and request <b>precertification</b> at least 14 days before the date you are scheduled to be admitted
For an <b>emergency admission</b> :	You, your <b>physician</b> or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an <b>urgent admission</b> :	You, your <b>physician</b> or the facility will need to call before you are scheduled to be admitted. An urgent admission is a <b>hospital admission</b> by a <b>physician</b> due to the onset of or change in an <b>illness</b> ; the diagnosis of an <b>illness</b> ; or an <b>injury</b> .

**Aetna** will provide a written notification to you and your **physician** of the **precertification** decision. If your **precertified** expenses are approved the approval is good for 60 days as long as you remain enrolled in the plan.

When you have an inpatient admission to a facility, **Aetna** will notify you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that your **stay** be extended, additional days will need to be certified. You, your **physician**, or the facility will need to call **Aetna** at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. **Aetna** will review and process the request for an extended **stay**. You and your **physician** will receive a notification of an approval or denial.

If **precertification** determines that the **stay** is not a **covered expense**, the notification will explain why and how **Aetna**'s decision can be appealed. You or your provider may request a review of the **precertification** decision pursuant to the Appeals Amendment included with this Booklet-Certificate.

## **Services and Supplies Which Require Precertification** (GR-9N-08-065-04 VA)

**Precertification** is requested for the following types of medical expenses:

### **Inpatient Care**

- Stays in a **hospital**

## **Emergency and Urgent Care** (GR-9N-27-005-01)

You have coverage 24 hours a day, 7 days a week for:

- An **emergency medical condition**; or
- An **urgent condition**.

### **In Case of a Medical Emergency**

When **emergency care** is necessary, please follow the guidelines below:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your **physician** provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your **physician** to obtain your medical history to assist the emergency **physician** in your treatment.
- If you are admitted to an inpatient facility, notify your **physician** as soon as reasonably possible.

- If you seek care in an emergency room for a non-emergency condition, your benefits will be reduced. Please refer to the *Schedule of Benefits* for specific details about the plan. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the plan.

## Coverage for Emergency Medical Conditions

Refer to **Coverage for Emergency Medical Conditions** in the *What the Plan Covers* section.

### Important Reminder

If you visit a **hospital** emergency room for a non-emergency condition, the plan will pay a reduced benefit, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room unless otherwise specified under the Plan.

## In Case of an Urgent Condition (GR-9N-27-010-01)

Call your **physician** if you think you need urgent care. **Physicians** usually provide coverage 24 hours a day, including weekends and holidays for urgent care. You may contact any **physician** or **urgent care provider**, for an **urgent care condition** if you cannot reach your **physician**.

If it is not feasible to contact your **physician**, please do so as soon as possible after urgent care is provided. If you need help finding an **urgent care provider** you may call Member Services at the toll-free number on your I.D. card, or you may access **Aetna's** online provider directory at [www.aetna.com](http://www.aetna.com).

## Coverage for an Urgent Condition

Refer to **Coverage for Urgent Medical Conditions** in the *What the Plan Covers* section.

## Follow-Up Care After Treatment of an Emergency or Urgent Medical Condition

Follow-up care is not considered an emergency or **urgent condition** and is not covered as part of any emergency or urgent care visit. Once you have been treated and discharged, you should contact your **physician** for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for **illness** or **injury**. If you access a **hospital** emergency room for follow-up care, your coverage will be reduced and you will be responsible for more of the cost of your treatment. Refer to your *Schedule of Benefits* for cost sharing information applicable to your plan.

To keep your out-of-pocket costs lower, your follow-up care should be provided by a **physician**.

### Important Notice

Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as x-rays, should **not** be provided by an emergency room facility.

# Requirements for Coverage (GR-9N-09-005-01 VA)

To be covered by the plan, services and supplies and **prescription drugs** must meet all of the following requirements:

1. The service or supply or **prescription drug** must be covered by the plan. For a service or supply or **prescription drug** to be covered, it must:
  - § Be included as a covered expense in this Booklet-Certificate;
  - § Not be an excluded expense under this Booklet-Certificate. Refer to the *Exclusions* sections of this Booklet- Certificate for a list of services and supplies that are excluded;
  - § Not exceed the maximums and limitations outlined in this Booklet-Certificate. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for information about certain expense limits; and
  - § Be obtained in accordance with all the terms, policies and procedures outlined in this Booklet-Certificate.
2. The service or supply or **prescription drug** must be provided while coverage is in effect. See the *Who Can Be Covered, How and When to Enroll, When Your Coverage Begins, When Coverage Ends* and *Continuation of Coverage* sections for details on when coverage begins and ends.
3. The service or supply or **prescription drug** must be **medically necessary**. To meet this requirement, the medical services, supply or **prescription drug** must be provided by a **physician**, or other health care provider, exercising prudent clinical judgment, to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms. The provision of the service or supply must be:
  - (a) In accordance with generally accepted standards of medical practice;
  - (b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease; and
  - (c) Not primarily for the convenience of the patient, **physician** or other health care provider;
  - (d) And not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

For these purposes “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, or otherwise consistent with **physician** specialty society recommendations and the views of **physicians** practicing in relevant clinical areas and any other relevant factors.

## Important Note

Not every service, supply or **prescription drug** that fits the definition for **medical necessity** is covered by the plan. Exclusions and limitations apply to certain medical services, supplies and expenses. For example some benefits are limited to a certain number of days, visits or a dollar maximum. Refer to the *What the Plan Covers* section and the *Schedule of Benefits* for the plan limits and maximums.

# What The Plan Covers

(GR-9N 11-005-01 VA)

Wellness

Physician Services

Hospital Expenses

Other Medical Expenses

## Comprehensive Medical Plan

Many preventive and routine medical expenses as well as expenses incurred for a serious **illness** or **injury** are covered. This section describes which expenses are **covered expenses**. Only expenses incurred for the services and supplies shown in this section are **covered expenses**. Limitations and exclusions apply.

## Preventive Care

This section on Preventive Care describes the **covered expenses** for services and supplies provided when you are well.

### Routine Physical Exams

**Covered expenses** include charges made by your **physician** for routine physical exams. A routine exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified **illness** or **injury**, and also includes:

- § Radiological services, X-rays, lab and other tests given in connection with the exam; and
- § Immunizations for infectious diseases and the materials for administration of immunizations as recommended by the Advisory Committee on Immunization Practices of the Department of Health and Human Services, Center for Disease Control; and
- § Testing for Tuberculosis.

**Covered expenses** for children from birth to age 18 also include:

- § An initial **hospital** check up and well child visits in accordance with the prevailing clinical standards of the American Academy of Pediatric Physicians.

Unless specified above, not covered under this benefit are charges for:

- § Services which are covered to any extent under any other part of this plan;
- § Services which are for diagnosis or treatment of a suspected or identified **illness** or **injury**;
- § Exams given during your **stay** for medical care;
- § Services not given by a **physician** or under his or her direction;
- § Psychiatric, psychological, personality or emotional testing or exams.

### Important Reminder

Refer to the *Schedule of Benefits* for details about any applicable deductibles, coinsurance, benefit maximums and frequency and age limits for physical exams.

## **Routine Cancer Screenings**

**Covered expenses** include charges incurred for routine cancer screening as follows:

- 1 gynecological exam every 12 months

## **Family Planning Services** (GR-9N 11-005-01 VA)

**Covered expenses** include charges for certain contraceptive and family planning services, even though not provided to treat an **illness** or **injury**. Refer to the *Schedule of Benefits* for any frequency limits that apply to these services, if not specified below.

### **Contraception Services**

**Covered expenses** include charges for contraceptive services and supplies provided on an outpatient basis, including:

- Contraceptive drugs and contraceptive devices prescribed by a **physician** provided they have been approved by the Federal Drug Administration;
- Related outpatient services such as:
  - Consultations;
  - Exams;
  - Procedures; and
  - Other medical services and supplies.

Not covered are:

- Charges for services which are covered to any extent under any other part of the Plan or any other group plans sponsored by your employer; and
- Charges incurred for contraceptive services while confined as an inpatient.

### **Other Family Planning**

**Covered expenses** include charges for family planning services, including:

- Voluntary sterilization.
- Voluntary termination of pregnancy.

The plan does *not* cover the reversal of voluntary sterilization procedures, including related follow-up care. Also see section on pregnancy and infertility related expenses on a later page.

## **Vision Care Services** (GR-9N S-11-010-01)

**Covered expenses** include charges made by a legally qualified ophthalmologist or optometrist for the following services:

- **Routine** eye exam: The plan covers expenses for a complete routine eye exam that includes refraction and glaucoma testing. A routine eye exam does not include a contact lens exam. The plan covers charges for one routine eye exam in any 12 consecutive month period.

## **Limitations**

Coverage is subject to any applicable Calendar Year **deductibles**, **copays** and **coinsurance** percentages shown in your *Schedule of Benefits*.

## Hearing Exam (GR-9N 11-015-01)

**Covered expenses** include charges for an audiometric hearing exam if the exam is performed by:

- A **physician** certified as an otolaryngologist or otologist; or
- An audiologist who:
  - Is legally qualified in audiology; or
  - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association (in the absence of any applicable licensing requirements); and
  - Performs the exam at the written direction of a legally qualified otolaryngologist or otologist.

The plan will not cover expenses for charges for more than one hearing exam for any 12-month period.

All **covered expenses** for the hearing exam are subject to any applicable **deductible**, **copay** and **coinsurance** shown in your *Schedule of Benefits*.

## Physician Services (GR-9N-S-11-020-01)

### Physician Visits

Covered medical expenses include charges made by a **physician** during a visit to treat an **illness** or **injury**. The visit may be at the **physician's** office, in your home, in a **hospital** or other facility during your **stay** or in an outpatient facility. **Covered expenses** also include:

- Immunizations for infectious disease, but not if solely for your employment;
- Allergy testing, treatment and injections; and
- Charges made by the **physician** for supplies, radiological services, x-rays, and tests provided by the **physician**.

### Surgery

**Covered expenses** include charges made by a **physician** for:

- Performing your surgical procedure;
- Pre-operative and post-operative visits; and
- Consultation with another **physician** to obtain a second opinion prior to the surgery.

### Anesthetics

**Covered expenses** include charges for the administration of anesthetics and oxygen by a **physician**, other than the operating **physician**, or Certified Registered Nurse Anesthetist (C.R.N.A.) in connection with a covered procedure.

## Hospital Expenses (GR-9N-11-030 01)

Covered medical expenses include services and supplies provided by a **hospital** during your **stay**.

### Room and Board

**Covered expenses** include charges for **room and board** provided at a **hospital** during your **stay**. Private room charges that exceed the **hospital's semi-private room rate** are not covered unless a private room is required because of a contagious **illness** or immune system problem.

**Room and board** charges also include:

- Services of the **hospital's** nursing staff;
- Admission and other fees;

- General and special diets; and
- Sundries and supplies.

## Other Hospital Services and Supplies

**Covered expenses** include charges made by a **hospital** for services and supplies furnished to you in connection with your **stay**.

**Covered expenses** include hospital charges for other services and supplies provided, such as:

- **Ambulance** services.
- **Physicians** and surgeons.
- Operating and recovery rooms.
- Intensive or special care facilities.
- Administration of blood and blood products, but not the cost of the blood or blood products.
- Radiation therapy.
- Speech therapy, physical therapy and occupational therapy.
- Oxygen and oxygen therapy.
- Radiological services, laboratory testing and diagnostic services.
- Medications.
- Intravenous (IV) preparations.
- Discharge planning.

## Outpatient Hospital Expenses (GR-9N-11-030 01)

**Covered expenses** include **hospital** charges made for covered services and supplies provided by the outpatient department of a **hospital**.

### Important Reminders

The plan will only pay for nursing services provided by the **hospital** as part of its charge. The plan does *not* cover private duty nursing services as part of an inpatient **hospital** stay.

If a **hospital** or other health care facility does not itemize specific **room and board** charges and other charges, **Aetna** will assume that 40 percent of the total is for **room and board** charge, and 60 percent is for other charges.

In addition to charges made by the **hospital**, certain **physicians** and other providers may bill you separately during your stay.

Refer to the *Schedule of Benefits* for any applicable **deductible**, **copay** and **coinsurance** and maximum benefit limits.

## Coverage for Emergency Medical Conditions

**Covered expenses** include charges made by a **hospital** or a **physician** for services provided in an emergency room to evaluate and treat an **emergency medical condition**.

The **emergency care** benefit covers:

- Use of emergency room facilities;
- Emergency room **physicians** services;
- **Hospital** nursing staff services; and
- Radiologists and pathologists services.

Please contact your **physician** after receiving treatment for an **emergency medical condition**.

### Important Reminder

With the exception of Urgent Care described below, if you visit a **hospital** emergency room for a non-emergency condition, the plan will pay a reduced benefit, as shown in the *Schedule of Benefits*. No other plan benefits will pay for non-emergency care in the emergency room.

### Coverage for Urgent Conditions

**Covered expenses** include charges made by a **hospital** or **urgent care provider** to evaluate and treat an **urgent condition**.

Your coverage includes:

- Use of emergency room facilities;
- Use of urgent care facilities;
- **Physicians** services;
- Nursing staff services; and
- Radiologists and pathologists services.

Please contact your **physician** after receiving treatment of an **urgent condition**.

## Alternatives to Hospital Stays (GR-9N-11-040 01 VA)

### Outpatient Surgery and Physician Surgical Services

**Covered expenses** include charges for services and supplies furnished in connection with outpatient surgery made by:

- A **physician** or **dentist** for professional services;
- A **surgery center**; or
- The outpatient department of a **hospital**.

The surgery must meet the following requirements:

- The surgery can be performed adequately and safely only in a **surgery center** or **hospital** and
- The surgery is not normally performed in a **physician's** or **dentist's** office.

### Important Note

Benefits for surgery services performed in a **physician's** or **dentist's** office are described under Physician Services benefits in the previous section.

The following outpatient surgery expenses are covered:

- Services and supplies provided by the **hospital, surgery center** on the day of the procedure;
- The operating **physician's** services for performing the procedure, related pre- and post-operative care, and administration of anesthesia; and
- Services of another **physician** for related post-operative care and administration of anesthesia. This does not include a local anesthetic.

## Limitations

Not covered under this plan are charges made for:

- The services of a **physician** or other health care provider who renders technical assistance to the operating **physician**.
- A **stay** in a **hospital**.
- Facility charges for office based surgery.

## Birth Center

**Covered expenses** include charges made by a **birthing center** for services and supplies related to your care in a **birthing center** for:

- Prenatal care;
- Delivery; and
- Postpartum care within 48 hours after a vaginal delivery and 96 hours after a Cesarean delivery.

## Limitations

Unless specified above, not covered under this benefit are charges:

- In connection with a pregnancy for which pregnancy related expenses are not included as a covered expense.

See *Pregnancy Related Expenses* for information about other **covered expenses** related to maternity care.

## Home Health Care (GR-9N-11-050-01)

**Covered expenses** include charges made by a **home health care agency** for home health care, and the care:

- Is given under a **home health care plan**;
- Is given to you in your home while you are **homebound**.

Home health care expenses include charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aid services provided in conjunction with and in direct support of care by an **R.N.** or an **L.P.N.**
- Physical, occupational, and speech therapy.
- Part-time or intermittent medical social services by a social worker when provided in conjunction with, and in direct support of care by an **R.N.** or an **L.P.N.**
- Medical supplies, **prescription drugs** and lab services by or for a **home health care agency** to the extent they would have been covered under this plan if you had a **hospital stay**.

Benefits for home health care visits are payable up to the Home Health Care Maximum. Each visit by a nurse or therapist is one visit.

In figuring the Calendar Year Maximum Visits, each visit of up to 4 hours is one visit. This maximum will not apply to care given by an **R.N.**

or **L.P.N.** when:

- Care is provided within 10 days of discharge from a **hospital** or **skilled nursing facility** as a full-time inpatient; and
- Care is needed to transition from the **hospital** or **skilled nursing facility** to home care.

When the above criteria are met, **covered expenses** include up to 12 hours of continuous care by an **R.N.** or **L.P.N.** per day.

Coverage for Home Health Care services is not determined by the availability of caregivers to perform them. The absence of a person to perform a non-skilled or **custodial care** service does not cause the service to become covered. If the covered person is a minor or an adult who is dependent upon others for non-skilled care (e.g. bathing, eating, toileting), coverage for home health services will only be provided during times when there is a family member or caregiver present in the home to meet the person's non-skilled needs.

### Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Services or supplies that are not a part of the **Home Health Care Plan**.
- Services of a person who usually lives with you, or who is a member of your or your spouse's or your domestic partner's family.
- Services of a certified or licensed social worker.
- Services for Infusion Therapy.
- Transportation.
- Services or supplies provided to a minor or dependent adult when a family member or caregiver is not present.
- Services that are **custodial care**.

### Important Reminders

The plan does *not* cover **custodial care**, even if care is provided by a nursing professional, and family member or other caretakers cannot provide the necessary care.

Refer to the *Schedule of Benefits* for details about any applicable home health care visit maximums.

### Private Duty Nursing (GR-9N S-11-065-01)

**Covered expenses** include private duty nursing provided by a **R.N.** or **L.P.N.** if the person's condition requires **skilled nursing** care and visiting nursing care is not adequate. However, **covered expenses** will not include private duty nursing for any shifts during a Calendar Year in excess of the Private Duty Nursing Care Maximum Shifts. Each period of private duty nursing of up to 8 hours will be deemed to be one private duty nursing shift.

The plan also covers skilled observation for up to one four-hour period per day, for up to 10 consecutive days following:

- A change in your medication;
- Treatment of an urgent or **emergency medical condition** by a **physician**;
- The onset of symptoms indicating a need for emergency treatment;
- Surgery;
- An inpatient **stay**.

### Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Nursing care that does not require the education, training and technical skills of a **R.N.** or **L.P.N.**
- Nursing care assistance for daily life activities, such as:
  - Transportation;
  - Meal preparation;
  - Vital sign charting;
  - Companionship activities;
  - Bathing;
  - Feeding;
  - Personal grooming;
  - Dressing;

- Toileting; and
- Getting in/out of bed or a chair.
- Nursing care provided for skilled observation.
- Nursing care provided while you are an inpatient in a **hospital** or health care facility.
- A service provided solely to administer oral medicine, except where law requires a **R.N.** or **L.P.N.** to administer medicines.

### **Skilled Nursing Facility** (GR-9N-11-060-01)

**Covered expenses** include charges made by a **skilled nursing facility** during your **stay** for the following services and supplies, up to the maximums shown in the *Schedule of Benefits*, including:

- **Room and board**, up to the **semi-private room rate**. The plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational, or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a **skilled nursing facility** (this does not include charges made for private or special nursing, or **physician's** services); and
- Medical supplies.

You must meet the following conditions:

- You are currently receiving inpatient **hospital** care, or inpatient subacute care; and
- The **skilled nursing facility** admission will take the place of an admission to, or continued **stay** in, a **hospital** or subacute facility; or it will take the place of three or more skilled nursing care visits per week at home; and
- There is a reasonable expectation that your condition will improve sufficiently to permit discharge to your home within a reasonable amount of time; and
- The **illness** or **injury** is severe enough to require constant or frequent skilled nursing care on a 24-hour basis; and
- Your **stay** in a **skilled nursing facility**:
  - follows a **hospital stay** of at least three days in a row; and
  - begins within 14 days after your discharge from the **hospital**; and
  - is necessary to recover from the **illness** or **injury** that caused the **hospital stay**.

### **Important Reminder**

Refer to the *Schedule of Benefits* for details about any applicable **skilled nursing facility** maximums.

### **Limitations**

Unless specified above, *not* covered under this benefit are charges for:

- Charges made for the treatment of:
  - Drug addiction;
  - Alcoholism;
  - Senility;
  - Mental retardation; or
  - Any other mental illness; and
- Daily **room and board** charges over the **semi private rate**.

### **Hospice Care** (GR-9N 5-11-070-01 VA)

**Covered expenses** include charges made by the following furnished to you for **hospice care** when given as part of a **hospice care program**.

## Facility Expenses

The charges made by a **hospital, hospice** or **skilled nursing facility** for:

- **Room and Board** and other services and supplies furnished during a **stay** for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

## Outpatient Hospice Expenses

**Covered expenses** include charges made on an outpatient basis by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by a **R.N.** or **L.P.N.** for up to eight hours a day;
- Part-time or intermittent home health aide services to care for you up to eight hours a day.
- Medical social services under the direction of a **physician**. These include but are not limited to:
  - Assessment of your social, emotional and medical needs, and your home and family situation;
  - Identification of available community resources; and
  - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy; and
- Consultation or case management services by a **physician**;
- Medical supplies;
- Prescription drugs;
- Dietary counseling; and
- Psychological counseling.

Charges made by the providers below if they are not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for your care:

- A **physician** for a consultation or case management;
- A physical or occupational therapist;
- A **home health care agency** for:
  - Physical and occupational therapy;
  - Part time or intermittent home health aide services for your care up to eight hours a day;
  - Medical supplies;
  - **Prescription drugs**;
  - Psychological counseling; and
  - Dietary counseling.

## Limitations

Unless specified above, *not* covered under this benefit are charges for:

- Daily **room and board** charges over the **semi-private room rate**.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

## Important Reminders

Refer to the *Schedule of Benefits* for details about any applicable **hospice care** maximums.

## Other Covered Health Care Expenses (GR-9N-11-080-01)

### Acupuncture

The plan covers charges made for acupuncture services provided by a **physician**, if the service is performed:

- As a form of anesthesia in connection with a covered surgical procedure; and
- To treat an **illness, injury** or to alleviate chronic pain.

### Important Reminder

Refer to the *Schedule of Benefits* for details about any applicable acupuncture benefit maximum.

### Ambulance Service (GR-9N-11-080-01)

**Covered expenses** include charges made by a professional **ambulance**, as follows:

#### Ground Ambulance

**Covered expenses** include charges for transportation:

- To the first **hospital** where treatment is given in a medical emergency.
- From one **hospital** to another **hospital** in a medical emergency when the first **hospital** does not have the required services or facilities to treat your condition.
- From **hospital** to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to **hospital** for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition. Transport is limited to 100 miles.
- When during a covered inpatient **stay** at a **hospital, skilled nursing facility** or acute rehabilitation **hospital**, an **ambulance** is required to safely and adequately transport you to or from inpatient or outpatient **medically necessary** treatment.

#### Air or Water Ambulance

**Covered expenses** include charges for transportation to a **hospital** by air or water **ambulance** when:

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

### Limitations

*Not covered* under this benefit are charges incurred to transport you:

- If an **ambulance** service is not required by your physical condition; or
- If the type of **ambulance** service provided is not required for your physical condition; or
- By any form of transportation other than a professional **ambulance** service.

### Autism Spectrum Disorders (GR-9N 11-171 02 VA)

**Covered expenses** include charges for the diagnosis and treatment of Autism Spectrum Disorder in covered individuals from age two through age six. Treatment of autism spectrum disorder shall be identified in a treatment plan and includes the following care prescribed or ordered for a covered individual diagnosed with autism spectrum disorder by a licensed **physician** or a licensed psychologist who determines the care to be **medically necessary**: (i) behavioral health treatment, (ii) pharmacy care, (iii) psychiatric care, (iv) psychological care, (v) therapeutic care, and (vi) applied behavioral analysis when provided by or supervised by a board certified behavior analyst who shall be licensed by the Board of Medicine.

“Applied Behavioral Analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between the environment and behavior.

“Autism Spectrum Disorder” means any pervasive developmental disorder, including:

- Autistic Disorder;
- Asperger's Syndrome;
- Rett's Syndrome;
- Childhood Disintegrative Disorder; or
- Pervasive Developmental Disorder--Not Otherwise Specified;

as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

“Treatment plan” means a plan for the treatment of autism spectrum disorder developed by a licensed physician or licensed psychologist pursuant to a comprehensive evaluation or reevaluation performed in a manner consistent with the most recent clinical report or recommendation of the American Academy of Pediatrics or the American Academy of Child and Adolescent Psychiatry.

Coverage for Applied Behavioral Analysis for the diagnosis and treatment of Autism Spectrum Disorders is subject to the maximum benefit amount, if any, shown on the *Schedule of Benefits*.

## Diagnostic and Preoperative Testing (GR-9N-11-085-01)

### Diagnostic Complex Imaging Expenses

The plan covers charges made on an outpatient basis by a **physician, hospital** or a licensed imaging or radiological facility for complex imaging services to diagnose an **illness** or **injury**, including:

- C.A.T. scans;
- Magnetic Resonance Imaging (MRI);
- Positron Emission Tomography (PET) Scans; and
- Any other outpatient diagnostic imaging service costing over \$500.

Complex Imaging Expenses for preoperative testing will be payable under this benefit.

### Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

### Outpatient Diagnostic Lab Work and Radiological Services

**Covered expenses** include charges for radiological services (other than diagnostic complex imaging), lab services, and pathology and other tests provided to diagnose an **illness** or **injury**. You must have definite symptoms that start, maintain or change a plan of treatment prescribed by a **physician**. The charges must be made by a **physician, hospital** or licensed radiological facility or lab.

### Important Reminder

Refer to the *Schedule of Benefits* for details about any **deductible, coinsurance** and maximum that may apply to outpatient diagnostic testing, and lab and radiological services.

## Outpatient Preoperative Testing

Prior to a scheduled covered surgery, **covered expenses** include charges made for tests performed by a **hospital, surgery center, physician** or licensed diagnostic laboratory provided the charges for the surgery are **covered expenses** and the tests are:

- Related to your surgery, and the surgery takes place in a **hospital or surgery center**;
- Completed within 14 days before your surgery;
- Performed on an outpatient basis;
- Covered if you were an inpatient in a **hospital**;
- Not repeated in or by the **hospital or surgery center** where the surgery will be performed.
- Test results should appear in your medical record kept by the **hospital or surgery center** where the surgery is performed.

## Limitations

The plan does not cover diagnostic complex imaging expenses under this part of the plan if such imaging expenses are covered under any other part of the plan.

- If your tests indicate that surgery should not be performed because of your physical condition, the plan will pay for the tests, however surgery will **not** be covered.

## Important Reminder

Complex Imaging testing for preoperative testing is covered under the complex imaging section. Separate cost sharing may apply. Refer to your *Schedule of Benefits* for information on cost sharing amounts for complex imaging.

## Durable Medical and Surgical Equipment (DME) (GR-9N 11-090-01)

**Covered expenses** include charges by a **DME** supplier for the rental of equipment or, in lieu of rental: The initial purchase of **DME** if:

- Long term care is planned; and
- The equipment cannot be rented or is likely to cost less to purchase than to rent.

Repair of purchased equipment. Maintenance and repairs needed due to misuse or abuse are not covered. Replacement of purchased equipment if:

- The replacement is needed because of a change in your physical condition; and
- It is likely to cost less to replace the item than to repair the existing item or rent a similar item.

The plan limits coverage to one item of equipment, for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

Covered **Durable Medical Equipment** includes those items covered by Medicare unless excluded in the Exclusions section of this Booklet-Certificate. **Aetna** reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level of service or item which can be safely and effectively provided. The decision to rent or purchase is at the discretion of **Aetna**.

## Important Reminder

Refer to the *Schedule of Benefits* for details about **durable medical and surgical equipment deductible, coinsurance** and benefit maximums. Also refer to *Exclusions* for information about Home and Mobility exclusions.

## Experimental or Investigational Treatment

**Covered expenses** include charges made for **experimental or investigational** drugs, devices, treatments or procedures, provided **all** of the following conditions are met:

- You have been diagnosed with cancer or a condition likely to cause death within one year or less;
- Standard therapies have not been effective or are inappropriate;
- **Aetna** determines, based on at least two documents of medical and scientific evidence, that you would likely benefit from the treatment;
- There is an ongoing clinical trial. You are enrolled in a clinical trial that meets these criteria:
- The drug, device, treatment or procedure to be investigated has been granted investigational new drug (IND) or Group c/treatment IND status;
- The clinical trial has passed independent scientific scrutiny and has been approved by an Institutional Review Board that will oversee the investigation;
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar national organization (such as the Food & Drug Administration or the Department of Defense) and conforms to the NCI standards;
- The clinical trial is not a single institution or investigator study unless the clinical trial is performed at an NCI- designated cancer center; and
- You are treated in accordance with protocol.

## Pregnancy Related Expenses (GR-9N 11-100-01-VA)

**Covered expenses** include charges made by a **physician** for pregnancy and childbirth services and supplies at the same level as any **illness or injury**. This includes prenatal visits, delivery and postnatal visits.

For inpatient care of the mother and newborn child, **covered expenses** include charges made by a **Hospital** for a minimum of:

- 48 hours after a vaginal delivery; and
- 96 hours after a cesarean section.
- A shorter stay, if the attending **physician**, with the consent of the mother, discharges the mother or newborn earlier.

If the mother is discharged earlier, the plan will pay for 1 home health care visit scheduled to occur within 24 hours of discharge. An additional visit will be covered when prescribed by the provider. This benefit is in addition to the home health maximum number of visits, if any, shown on the *Schedule of Benefits*. No copayment or coinsurance will apply for these home health care visits.

**Covered expenses** also include charges made by a **birthing center** as described under Alternatives to **Hospital** Care.

**Note: Covered expenses** also include services and supplies provided for circumcision of the newborn during the stay.

## Prosthetic Devices (GR-9N-11-110-02 VA)

Prosthetic Device means: an artificial device to replace, in whole or in part, a limb.

Limb means: an arm, a hand, a leg, a foot or any portion of an arm, a hand, a leg or a foot.

Component means: the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

**Covered expenses** include charges made for medically necessary prosthetic devices, including their repair, fitting and replacement and special appliances, if the prosthetic device or appliance improves or restores body part function that has been lost or damaged by **illness, injury** or congenital defect. **Covered expenses** also include instruction and incidental supplies needed to use a covered prosthetic device.

The plan also covers the first prosthesis, other than a limb, you need that temporarily or permanently replaces all or part of a body part lost or impaired as a result of disease or injury or congenital defects as described in the list of covered devices below for an:

- Internal body part or organ; or
- External body part.

The list of covered devices and appliances includes but is not limited to:

- A limb or artificial eye;
- Eye lens;
- An external breast prosthesis and the first bra made solely for use with it after a mastectomy;
- A breast implant after a mastectomy;
- Ostomy supplies, urinary catheters and external urinary collection devices;
- Speech generating device;
- A cardiac pacemaker and pacemaker defibrillators; and
- A durable brace that is custom made for and fitted for you.

The plan will not cover expenses and charges for, or expenses related to:

- Orthopedic shoes, therapeutic shoes, foot orthotics, or other devices to support the feet, unless required for the treatment of or to prevent complications of diabetes; or if the orthopedic shoe is an integral part of a covered leg brace; or
- Trusses, corsets, and other support items; or
- The repair or replacement of any device due to neglect, misuse or abuse.
- any item listed in the *Exclusions* section.

## Hearing Aids (GR-9N-26-005-01)

Covered hearing care expenses include charges for electronic hearing aids (monaural and binaural), installed in accordance with a **prescription** written during a covered hearing exam.

Benefits are payable up to the hearing supply maximum listed in the *Schedule of Benefits*.

All **covered expenses** are subject to the hearing expense exclusions in this *Booklet-Certificate* and are subject to **deductible(s), copayments** or **coinsurance** listed in the *Schedule of Benefits*, if any.

## Benefits After Termination of Coverage

Expenses incurred for hearing aids within 30 days of termination of the person's coverage under this benefit section will be deemed to be covered hearing care expenses if during the 30 days before the date coverage ends:

- The **prescription** for the hearing aid was written; and
- The hearing aid was ordered.

## Short-Term Rehabilitation Therapy Services (GR-9N 11-120-01 VA)

**Covered expenses** include charges for short-term therapy services when prescribed by a **physician** as described below up to the benefit maximums listed on your *Schedule of Benefits*. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A **hospital, skilled nursing facility, or hospice facility**; or
- A **physician**.

Charges for the following short term rehabilitation expenses are covered:

### Cardiac and Pulmonary Rehabilitation Benefits.

- Cardiac rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. This course of treatment is limited to a maximum of 36 sessions in a 12 week period.
- Pulmonary rehabilitation benefits are available as part of an inpatient **hospital stay**. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. This course of treatment is limited to a maximum of 36 hours or a six week period.

### Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy Rehabilitation Benefits.

Coverage is subject to the limits, if any, shown on the *Schedule of Benefits*. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this **Booklet-Certificate**.

- Physical therapy is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness, injury** or surgical procedure. Physical therapy does not include educational training or services designed to develop physical function.
- Occupational therapy (except for vocational rehabilitation or employment counseling) is covered for non-chronic conditions and acute **illnesses** and **injuries**, provided the therapy expects to significantly improve, develop or restore physical functions lost or impaired as a result of an acute **illness, injury** or surgical procedure, or to relearn skills to significantly improve independence in the activities of daily living. Occupational therapy does not include educational training or services designed to develop physical function.
- Speech therapy is covered for non-chronic conditions and acute illnesses and injuries and expected to restore the speech function or correct a speech impairment resulting from **illness** or **injury**; or for delays in speech function development as a result of a gross anatomical defect present at birth. Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.
- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke, or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.

A “visit” consists of no more than one hour of therapy. Refer to the *Schedule of Benefits* for the visit maximum that applies to the plan. **Covered expenses** include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration; and
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate.

### **Important Reminder**

Refer to the *Schedule of Benefits* for details about the short-term rehabilitation therapy maximum benefit.

Unless specifically covered above, *not* covered under this benefit are charges for:

- Therapies for the treatment of delays in development, unless resulting from acute **illness** or **injury**, or congenital defects amenable to surgical repair (such as cleft lip/palate). Examples of non-covered diagnoses include Pervasive Developmental Disorders, Down's Syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature. This does not apply to physical therapy, occupational therapy or speech therapy provided for the treatment of Autism Spectrum Disorders. Physical therapy, occupational therapy and speech therapy services for the treatment of Autism Spectrum Disorder are not subject to the maximum benefits, if any shown in the *Schedule of Benefits* applicable to this coverage.
- Any services which are **covered expenses** in whole or in part under any other group plan sponsored by an employer;
- Any services unless provided in accordance with a specific treatment plan;
- Services provided during a **stay** in a **hospital, skilled nursing facility, or hospice facility** except as stated above;
- Services provided by a **home health care agency**;
- Services not performed by a **physician** or under the direct supervision of a **physician**;
- Treatment covered as part of the Spinal Manipulation Treatment. This applies whether or not benefits have been paid under that section;
- Services provided by a **physician** or physical, occupational or speech therapist who resides in your home; or who is a member of your family, or a member of your spouse's family; or your domestic partner;
- Special education to instruct a person whose speech has been lost or impaired, to function without that ability. This includes lessons in sign language.

## **Reconstructive or Cosmetic Surgery and Supplies**

Covered expenses include charges made by a **physician, hospital, or surgery center** for reconstructive services and supplies, including:

- Surgery needed to improve a significant functional impairment of a body part.
- Surgery to correct the result of an accidental injury, including subsequent related or staged surgery, provided that the surgery occurs no more than 24 months after the original injury. For a covered child, the time period for coverage may be extended through age 18.
- Surgery to correct the result of an injury that occurred during a covered surgical procedure provided that the reconstructive surgery occurs no more than 24 months after the original injury.

Note: Injuries that occur as a result of a medical (*i.e.*, non surgical) treatment are not considered accidental injuries, even if unplanned or unexpected.

- Surgery to correct a gross anatomical defect present at birth or appearing after birth (but not the result of an illness or injury) when
  - § the defect results in severe facial disfigurement, or
  - § the defect results in significant functional impairment and the surgery is needed to improve function

## **Reconstructive Breast Surgery**

**Covered expenses** include reconstruction of the breast on which a mastectomy was performed, including an implant and areolar reconstruction. Also included is surgery on a healthy breast to make it symmetrical with the reconstructed breast and physical therapy to treat complications of mastectomy, including lymphedema.

### **Important Notice**

A benefit maximum may apply to reconstructive or **cosmetic** surgery services. Please refer to the *Schedule of Benefits*.

## Transgender (Sex Change) Surgery (GR-9N 11-126 800105-1 VA 1213)

**Covered expenses** include charges in connection with Transgender (Sex Change) Surgery as long as you or a covered dependent have obtained **precertification** from **Aetna**; and have met the following conditions:

- You or your dependent is at least 18 years old; and
- You or your dependent have met criteria for the diagnosis of true transsexualism including:
  - A life-long sense of belonging to the opposite sex and of having been born into the wrong sex, often since childhood;
  - A sense of estrangement from one's own body; so that any evidence of one's own biological sex is regarded as repugnant;
  - A desire to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment;
  - A stable transsexual orientation evidenced by a desire to be rid of one's genitals; and to live in society as a member of the other sex for at least 2 years; (i.e. not limited to periods of stress);
  - There is no sexual arousal from cross-dressing;
  - There is an absence of physical inter-sex of genetic abnormality; and
  - This is not due to another biological, chromosomal or associated psychiatric disorder; such as schizophrenia.
- You or your dependent must have completed a recognized program of transgender identity treatment; as evidenced by all of the following:
  - Has successfully lived and worked within the desired gender role full-time for at least 12 months (so- called real-life experience); without periods of returning to the original gender;
  - Unless medically contraindicated, has received at least 12 months of continuous hormonal sex change therapy recommended by a **behavioral health provider**; and carried out by an endocrinologist (which can be simultaneous with the real-life experience);
  - A **behavioral health provider** who has been acquainted with you or your dependent for at least 18 months recommends sex change surgery documented in the form of a written comprehensive evaluation;
  - A second concurring recommendation by another qualified **behavioral health provider** must be documented in the form of a written expert opinion; as long as one of the two **behavioral health providers** possess a doctoral degree (e.g., Ph.D., Ed.D., D.Sc., D.S.W., Psy.D., or M.D.);
  - Psychotherapy is not an absolute requirement for surgery unless the **behavioral health provider's** initial assessment leads to a recommendation for psychotherapy that specifies the goals of treatment, estimates its frequency and duration throughout the real life experience (usually a minimum of 3 months);
  - For genital surgical sex change; you or your dependent has undergone a urological examination for the purpose of identifying and perhaps treating abnormalities of the genitourinary tract; since genital surgical sex change includes the invasion of, and the alteration of; the genitourinary tract (urological examination is not required for persons not undergoing genital change); and
- You or your dependent have demonstrated an understanding of the proposed male-to-female or female-to-male sex change surgery with its attendant costs, required lengths of hospitalization, likely complications, and post surgical rehabilitation requirements of the planned surgery.
- The covered person has obtained **precertification** from **Aetna**.

**Covered expenses** include:

- Charges made by a **physician** for:
  - Performing the surgical procedure; and
  - Pre-operative and post-operative **hospital**, office and home visits.
- Charges made by a **hospital** for inpatient and outpatient services (including outpatient surgery). **Room and board** charges in excess of the **hospital's semi-private** rate will not be covered; unless a private room is ordered by your **physician** and **precertification** has been obtained.
- Charges made by a **Skilled Nursing Facility** for inpatient services and supplies. **Room and board** charges in excess of the **hospital's semi-private** rate will not be covered.
- Charges made for the administration of anesthetics.
- Charges for outpatient diagnostic laboratory and x-rays.
- Charges for blood transfusion and the cost of unreplaced blood and blood products. Also included are the charges for collecting, processing and storage of self-donated blood after the surgery has been scheduled.

<b>Important Reminders</b>
No payment will be made for any <b>covered expenses</b> under this benefit unless they have been <b>precertified</b> by <b>Aetna</b> .
Refer to the <i>Schedule of Benefits</i> for details about <b>deductibles, coinsurance</b> , benefit maximums.

## Specialized Care (GR-9N 11-135-01 VA)

### Chemotherapy

**Covered expenses** include charges for chemotherapy treatment. Coverage levels depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. Inpatient **hospitalization** for chemotherapy is limited to the initial dose while **hospitalized** for the diagnosis of cancer and when a **hospital stay** is otherwise **medically necessary** based on your health status.

### Radiation Therapy Benefits

**Covered expenses** include charges for the treatment of **illness** by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

### Outpatient Infusion Therapy Benefits

**Covered expenses** include charges made on an outpatient basis for infusion therapy by:

- A free-standing facility;
- The outpatient department of a **hospital**; or
- A **physician** in his/her office or in your home.

Infusion therapy is the intravenous or continuous administration of medications or solutions that are a part of your course of treatment. Charges for the following outpatient Infusion Therapy services and supplies are **covered expenses**:

- The pharmaceutical when administered in connection with infusion therapy and any medical supplies, equipment and nursing services required to support the infusion therapy;
- Professional services;
- Total parenteral nutrition (TPN);
- Chemotherapy;
- Drug therapy (includes antibiotic and antivirals);
- Pain management (narcotics); and
- Hydration therapy (includes fluids, electrolytes and other additives).

Not included under this infusion therapy benefit are charges incurred for:

- Enteral nutrition;
- Blood transfusions and blood products;
- Dialysis; and
- Insulin.

Coverage is subject to the maximums, if any, shown in the *Schedule of Benefits*.

Coverage for inpatient infusion therapy is provided under the *Inpatient Hospital* and *Skilled Nursing Facility Benefits* sections of this *Booklet-Certificate*.

Benefits payable for infusion therapy will not count toward any applicable **Home Health Care** maximums.

### Important Reminder

Refer to the *Schedule of Benefits* for details about any applicable **deductible**, **coinsurance** and maximum benefit limits.

## Diabetic Supplies, Equipment, and Training Expenses (GR-9N 11-135-01 VA)

**Covered expenses** include charges for diabetic supplies, equipment and self-management training and education. Medically necessary diabetic equipment and supplies and diabetic outpatient self-management training and educational services, including medical nutrition therapy, for the treatment of diabetic conditions are covered when ordered or prescribed by and obtained through a provider for the treatment of:

- Insulin-dependent diabetes;
- Insulin-using diabetes;
- Gestational diabetes; and
- Non-insulin using diabetes

## Treatment of Infertility (GR-9N 11-135-01 VA)

### Basic Infertility Expenses

**Covered expenses** include charges made by a **physician** to diagnose and to surgically treat the underlying medical cause of **infertility**.

### Comprehensive Infertility and Advanced Reproductive Technology (ART) Expenses

To be an eligible covered female for benefits you must be covered under this *Booklet-Certificate* as an employee, or be a covered dependent who is the employee's spouse.

Even though not incurred for treatment of an **illness** or **injury**, **covered expenses** will include expenses incurred by an eligible covered female for **infertility** if all of the following tests are met:

- A condition that is a demonstrated cause of **infertility** which has been recognized by a gynecologist, or an infertility specialist, and your **physician** who diagnosed you as **infertile**, and it has been documented in your medical records.
- The procedures are done while not confined in a hospital or any other facility as an inpatient.
- Your FSH levels are less than, 19 mIU on day 3 of the menstrual cycle.
- The **infertility** is not caused by voluntary sterilization of either one of the partners (with or without surgical reversal); or a hysterectomy.
- A successful pregnancy cannot be attained through less costly treatment for which coverage is available under this *Booklet-Certificate*.

### Comprehensive Infertility Services Benefits

If you meet the eligibility requirements above, the following comprehensive infertility services expenses are payable when provided by an infertility specialist, subject to all the exclusions and limitations of this *Booklet-Certificate*:

- Ovulation induction with menotropins is subject to the maximum benefit, if any, shown in the *Schedule of Benefits* section of this *Booklet-Certificate* and has a maximum of 6 cycles per lifetime; (where lifetime is defined to include services received, provided or administered by **Aetna** or any affiliated company of **Aetna**); and
- Intrauterine insemination is subject to the maximum benefit, if any, shown in the *Schedule of Benefits* section of this *Booklet-Certificate* and has a maximum of 6 cycles per lifetime; (where lifetime is defined to include services received, provided or administered by **Aetna** or any affiliated company of **Aetna**).

### Advanced Reproductive Technology (ART) Benefits

ART is defined as:

- In vitro fertilization (IVF);
- Zygote intrafallopian transfer (ZIFT);
- Gamete intra-fallopian transfer (GIFT);

- Cryopreserved embryo transfers;
- Intracytoplasmic sperm injection (ICSI); or ovum microsurgery.

ART services for procedures that are **covered expenses** under this *Booklet-Certificate*.

## Eligibility for ART Benefits

To be eligible for ART benefits under this *Booklet-Certificate*, you must meet the requirements above and:

- First exhaust the comprehensive infertility services benefits. Coverage for ART services is available only if comprehensive infertility services do not result in a pregnancy in which a fetal heartbeat is detected;
- Be referred by your **physician** to **Aetna's** infertility case management unit.

## Covered ART Benefits

The following charges are covered benefits for eligible covered females when all of the above conditions are met, subject to the *Exclusions and Limitations* section of the *Booklet-Certificate*:

- Up to 3 cycles and subject to the maximum benefit, if any, shown in the *Schedule of Benefits* section of any combination of the following ART services per lifetime (where lifetime is defined to include all ART services received, provided or administered by **Aetna** or any affiliated company of **Aetna**) which only include: IVF; GIFT; ZIFT; or cryopreserved embryo transfers;
- IVF; Intra-cytoplasmic sperm injection (“ICSI”); ovum microsurgery; GIFT; ZIFT; or cryopreserved embryo transfers subject to the maximum benefit shown on the *Schedule of Benefits* section while covered under an **Aetna** plan;
- Payment for charges associated with the care of the an eligible covered person under this plan who is participating in a donor IVF program, including fertilization and culture; and
- Charges associated with obtaining the spouse's sperm for ART, when the spouse is also covered under this *Booklet-Certificate*.

## Exclusions and Limitations

Unless otherwise specified above, the following charges will not be payable as **covered expenses** under this *Booklet- Certificate*:

- ART services for a female attempting to become pregnant who has *not* had at least 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination (for covered persons under 35 years of age), or 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination (for covered persons 35 years of age or older) prior to enrolling in the **infertility** program;
- ART services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Reversal of sterilization surgery;
- **Infertility** services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.);
- Home ovulation prediction kits;
- Drugs related to the treatment of non-covered benefits;
- Injectable **infertility** medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
- **Infertility** Services that are not reasonably likely to result in success;
- Ovulation induction and intrauterine insemination services if you are not **infertile**;

## Exclusions and Limitations

Unless otherwise specified above, the following charges will not be payable as **covered expenses** under this *Booklet- Certificate*:

- **Infertility** services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Reversal of sterilization surgery;
- **Infertility** services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers (or surrogacy); all charges associated with a gestational carrier program for the covered person or the gestational carrier;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.);
- Home ovulation prediction kits;
- Drugs related to the treatment of non-covered benefits;
- Injectable **infertility** medications, including but not limited to, menotropins, hCG, GnRH agonists, and IVIG;
- **Infertility** Services that are not reasonably likely to result in success;
- Ovulation induction and intrauterine insemination services if you are not **infertile**;
- Any ART procedure or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”), and intra-cytoplasmic sperm injection (“ICSI”); or
- Any charges associated with care required to obtain ART services (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); and any charges associated with obtaining sperm for any ART procedures.

### Important Note

Refer to the *Schedule of Benefits* for details about the maximums that apply to **infertility** services. The **lifetime maximums** that apply to **infertility** services apply differently than other **lifetime maximums** under the plan.

## Spinal Manipulation Treatment (GR-9N 11-150-01-VA)

**Covered expenses** include charges made by a **physician** on an outpatient basis for manipulative (adjustive) treatment or other physical treatment for conditions caused by (or related to) biomechanical or nerve conduction disorders of the spine.

Your benefits are subject to the maximum shown in the *Schedule of Benefits*. However, this maximum does not apply to expenses incurred:

- During your **hospital stay**; or
- For surgery. This includes pre- and post-surgical care provided or ordered by the operating **physician**.

## Cleft Lip or Palate Treatment (GR-9N 11-155-01)

### (Dependent Children Under Age 18 only)

**Covered expenses** include charges made for the treatment of a congenital cleft lip or cleft palate, or of a condition related to the cleft lip or palate, including:

- Oral surgery and facial surgery, including pre and post-operative care provided by a **physician**;
- Oral prosthesis treatment, including obturators and orthotic devices, speech and feeding appliances;
- Initial installation of dentures, whether fixed or removable, partial or full;
- Replacement of dentures by dentures or fixed partial dentures when needed because of structural changes in the mouth or jaw due to growth;
- Cleft orthodontic therapy;
- Orthodontic, otolaryngology or prosthetic treatment and management;

- Installation of crowns;
- Diagnostic services provided by a **physician** to determine the extent of loss or impairment in your speaking or hearing ability;
- Speech therapy to treat delays in speech development given by a **physician**. Such therapy is expected to overcome congenital or early acquired handicaps;
- Speech therapy provided by a **physician**, if the therapy is expected to restore or improve your ability to speak. Coverage includes speech aids and training to use the speech aids;
- Psychological assessment and counseling;
- Genetic assessment and counseling;
- Hearing aids;
- Audiological assessment, treatment and management, including surgically implanted amplification devices; and
- Physical therapy assessment and treatment.

A legally qualified audiologist or speech therapist will be deemed a **physician** for purposes of this coverage. Unless specified above, *not* covered under this benefit are:

- Oral prostheses, dentures or fixed partial dentures that were ordered before your coverage became effective or ordered while you were covered, but installed or delivered more than 60 days after your coverage ended;
- Augmentative (assistive) communication systems and usage training. (These aids are used in the special education of a person whose ability to speak or hear has been impaired, including lessons in sign language.)

## Transplant Services (GR-9N 11-160-01 VA)

**Covered expenses** include charges incurred during a transplant occurrence. The following will be considered to be one transplant occurrence once it has been determined that you or one of your dependents may require an organ transplant. Organ means solid organ; stem cell; bone marrow; and tissue.

- Heart;
- Lung;
- Heart/Lung;
- Simultaneous Pancreas Kidney (SPK);
- Pancreas;
- Kidney;
- Liver;
- Intestine;
- Bone Marrow/Stem Cell;
- Multiple organs replaced during one transplant surgery;
- Tandem transplants (Stem Cell);
- Sequential transplants;
- Re-transplant of same organ type within 180 days of the first transplant;
- Any other single organ transplant, unless otherwise excluded under the plan.

The following will be considered to be *more than one* Transplant Occurrence:

- Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant);
- Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant);
- Re-transplant after 180 days of the first transplant;
- Pancreas transplant following a kidney transplant;

- A transplant necessitated by an additional organ failure during the original transplant surgery/process;
- More than one transplant when not performed as part of a planned tandem or sequential transplant, (e.g., a liver transplant with subsequent heart transplant).

The plan covers:

- Charges made by a **physician** or transplant team.
- Charges made by a **hospital**, outpatient facility or **physician** for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.
- Charges for activating the donor search process with national registries.
- Compatibility testing of prospective organ donors who are immediate family members. For the purpose of this coverage, an “immediate” family member is defined as a first-degree biological relative. These are your biological parents, siblings or children.
- Inpatient and outpatient expenses directly related to a transplant.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either 180 days from the date of the transplant; **or** upon the date you are discharged from the **hospital** or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one transplant occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant evaluation/screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program;
2. Pre-transplant/candidacy screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members;
3. Transplant event: Includes inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; **prescription drugs** provided during your inpatient **stay** or outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your inpatient **stay** or outpatient visit(s); cadaveric and live donor organ procurement; and
4. Follow-up care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

### **Important Reminders**

Refer to the *Schedule of Benefits* for details about transplant expense maximums, if applicable.

### **Limitations**

Unless specified above, *not* covered under this benefit are charges incurred for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services that are covered under any other part of this plan;
- Services and supplies furnished to a donor when the recipient is not covered under this plan;
- Home infusion therapy after the transplant occurrence;
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness;

- Harvesting and/or storage of bone marrow, tissue or stem cells, without the expectation of transplantation within 12 months for an existing illness;
- Cornea (Corneal Graft with Amniotic Membrane) or Cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by **Aetna**.

## Morbid Obesity Treatment (GR-9N 11-165VA)

**Covered expenses** for a covered person include charges made on an inpatient or outpatient basis by a **hospital** or a **physician** for gastric bypass surgery or other such methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of **morbid obesity**.

**Covered expenses** are payable to the same extent as any other illness.

### Limitations

Unless specified above, *not* covered under this benefit are charges incurred for:

- Weight control services including surgical procedures, medical treatments, weight control/loss programs, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications; exercise programs, exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including **morbid obesity**, or for the purpose of weight reduction, regardless of the existence of comorbid conditions; except as provided in this *Booklet-Certificate*.

## Treatment of Mental Disorders and Substance Abuse (GR-9N-11-172-01)

### Treatment of Mental Disorders

**Covered expenses** include charges made for the treatment of **mental disorders** by **behavioral health providers**.

#### Important Note

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Health Plan Exclusions and Limits* for more information.

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- The treatment must be **medically necessary**;
- There is a written treatment plan prescribed and supervised by a **behavioral health provider**; and
- This Plan includes follow-up treatment.

Benefits are payable for charges incurred in a **hospital, psychiatric hospital, residential treatment facility** or **behavioral health provider's** office for the treatment of **mental disorders** as follows:

#### Inpatient Treatment

**Covered expenses** include charges for **room and board** at the **semi-private room rate**, and other services and supplies provided during your stay in a **hospital, psychiatric hospital** or **residential treatment facility**. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

#### Partial Confinement Treatment

**Covered expenses** include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of a **mental disorder**. Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

#### Outpatient Treatment

**Covered expenses** include charges for treatment received while not confined as a full-time inpatient in a **hospital, psychiatric hospital** or **residential treatment facility**.

The plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment. The partial **hospitalization** will only be covered if you would need inpatient care if you were not admitted to this type of facility.

### Important Reminder

- Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums and **Coinsurance Limit** that may apply.

## Treatment of Substance Abuse

**Covered expenses** include charges made for the treatment of **substance abuse** by **behavioral health providers**.

### Important Note

Not all types of services are covered. For example, educational services and certain types of therapies are not covered. See *Health Plan Exclusions and Limits* for more information.

### Substance Abuse

In addition to meeting all other conditions for coverage, the treatment must meet the following criteria:

- There is a program of therapy prescribed and supervised by a **behavioral health provider**.
- The program of therapy includes either:
  - A follow up program directed by a **behavioral health provider** on at least a monthly basis; or
  - Meetings at least twice a month with an organization devoted to the treatment of alcoholism or **substance abuse**.

Please refer to the *Schedule of Benefits* for any **substance abuse deductibles**, maximums and **Coinsurance Limit** that may apply.

### Inpatient Treatment

This Plan covers **room and board** at the **semi-private room rate** and other services and supplies provided during your **stay** in a **psychiatric hospital** or **residential treatment facility**, appropriately licensed by the state Department of Health or its equivalent.

Coverage includes:

- Treatment in a **hospital** for the medical complications of **substance abuse**.
- “Medical complications” include **detoxification**, electrolyte imbalances, malnutrition, cirrhosis of the liver, delirium tremens and hepatitis.
- Treatment in a **hospital** is covered only when the **hospital** does not have a separate treatment facility section.

### Outpatient Treatment

**Outpatient treatment** includes charges for treatment received for **substance abuse** while not confined as a full-time inpatient in a **hospital, psychiatric hospital** or **residential treatment facility**.

This Plan covers partial **hospitalization** services (more than 4 hours, but less than 24 hours per day) provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of alcohol or drug abuse. The partial **hospitalization** will only be covered if you would need inpatient treatment if you were not admitted to this type of facility.

### Partial Confinement Treatment

**Covered expenses** include charges made for **partial confinement treatment** provided in a facility or program for the intermediate short-term or medically-directed intensive treatment of **substance abuse**.

Such benefits are payable if your condition requires services that are only available in a **partial confinement treatment** setting.

### Important Reminder

- Please refer to the *Schedule of Benefits* for any **copayments/deductibles**, maximums and **Coinsurance Limit** that may apply.

## Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)<sup>(GR-9N 11-180-01)</sup>

**Covered expenses** include charges made by a **physician**, a **dentist** and **hospital** for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.

Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues, (this includes bones, muscles, and nerves), for surgery needed to:

- Treat a fracture, dislocation, or wound.
- Cut out cysts, tumors, or other diseased tissues.
- Cut into gums and tissues of the mouth. This is only covered when **not** done in connection with the removal, replacement or repair of teeth.
- Alter the jaw, jaw joints, or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement.

**Hospital** services and supplies received for a **stay** required because of your condition.

Dental work, surgery and **orthodontic treatment** needed to remove, repair, restore or reposition:

- (a) Natural teeth damaged, lost, or removed; or
- (b) Other body tissues of the mouth fractured or cut due to **injury**.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the **injury**.

The treatment must be completed in the Calendar Year of the **accident** or in the next Calendar Year.

If crowns, dentures, bridges, or in-mouth appliances are installed due to **injury**, **covered expenses** only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of **orthodontic treatment** after the **injury**.

## Other Services <sup>(GR-9N-11-195-01-VA)</sup>

### Routine Screening for Cancer

Even though not incurred in connection with a disease or **injury**, **covered expenses** include charges incurred by a covered person:

- age 35 but less than 40 for one screening mammogram.
- age 40 and over for one screening mammogram every calendar year.
- for an annual Pap smear and for annual testing using any FDA-approved gynecologic cytology screening technologies.

- age 50 and over; and persons age 40 and over who are at high risk for prostate cancer according to the most recent published guidelines of the American Cancer Society, and that occur in connection with an annual exam for screening for cancer of the prostate:
  - a digital rectal exam; and
  - a prostate specific antigen (PSA) test.
- in connection with an annual exam for screening of colorectal cancer and provided in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations:
  - fecal occult blood test; and
  - flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging.

#### **General Anesthesia for Dental Care**

**Covered expenses** include general anesthesia and associated **hospital** or ambulatory facility charges in conjunction with dental care provided to a covered person, if the person is determined by a licensed **dentist** in consultation with the person's **physician** to require these services to effectively and safely provide dental care; and

- i. is under 5 years of age;
- ii. is severely disabled; or
- iii. has a medical condition that requires admission to a **hospital** or outpatient **surgery center** and general anesthesia for dental care treatment.

Coverage is NOT provided for dental services associated with general anesthesia and associated **hospital** or ambulatory facility charges, except as otherwise provided in this Plan.

#### **Childhood Immunization Expenses**

**Covered expenses** include charges incurred by a covered dependent child between the ages of birth and 36-months for all routine and necessary immunizations administered on an outpatient basis.

Routine and necessary immunizations mean immunizations against diphtheria, pertussis, tetanus, polio, hepatitis B, measles, mumps, rubella, and other such immunizations as may be prescribed by the Virginia Commissioner of Health.

#### **Infant Hearing Screening Expenses**

**Covered expenses** include charges for infant hearing screenings and all necessary audiological examinations for newborn children that are provided pursuant to the Virginia Hearing Impairment Identification and Monitoring System and include the use of any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Coverage includes a follow-up audiological examination, recommended by a physician or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss, for those infants whose hearing screenings indicated the need for a diagnostic audiological examination.

#### **Bones or Joints of the Head, Neck, Face or Jaw Expenses**

**Covered expenses** include charges for diagnostic and surgical treatment involving any bone or joint of the head, neck, face or jaw if the treatment is required due to a medical condition or injury which prevents normal function of the joint or bone and is deemed **medically necessary** to attain functional capacity of the affected part. Treatment performed by prosthesis placed directly on the teeth is not covered.

#### **Blood Products and Blood Infusion Equipment Expenses**

**Covered expenses** include charges for blood products and blood infusion equipment for covered persons diagnosed with hemophilia or other congenital bleeding disorders.

## **Mastectomy and Hysterectomy Expenses**

**Covered expenses** following a mastectomy for the treatment of breast cancer include charges for:

- up to 48-hours of inpatient care in a hospital following a radical or modified mastectomy;
- up to 24-hours of inpatient care in a hospital following a total mastectomy or partial mastectomy with lymph node dissection.

**Covered expenses** following a hysterectomy include charges for:

- a minimum stay in a hospital of not less than 23-hours following a laparoscopy-assisted vaginal hysterectomy;
- a minimum stay in a hospital of not less than 48-hours following a vaginal hysterectomy; or
- a shorter hospital stay, if the attending provider, in consultation with the covered person, determines that a shorter length of stay is appropriate.

## **Treatment of Lymphedema**

**Covered expenses** include charges for equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, when provided by a provider legally authorized to provide such items under law.

## **Early Intervention Services**

**Covered expenses** include charges for speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for a covered person if:

- They are between the ages of birth and 3 years;
- They are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for the services under Part H of the Individuals with Disabilities Education Act; and
- The services are designed to attain or retain the capacity to function age-appropriately within their environment.

The benefit for these services is limited to \$5,000 per covered person per Calendar Year.

## **Cancer Clinical Trial Expenses**

**Covered expenses** include coverage for "Patient Costs" incurred by a covered person participating in clinical trials for treatment studies on cancer.

"Patient Cost" is defined as the cost of a **medically necessary** health care service incurred for treatment of a covered person for purposes of a clinical trial

NOTE: This definition excludes the cost of: (a) an investigational drug or device; (b) non-health services required as a result of treatment received in a clinical trial; (c) managing research associated with the clinical trial; and (d) services or items that would be excluded from coverage under the patient's policy, plan or contract for noninvestigational treatment.

Coverage of patient costs will be provided if:

- the treatment or studies are part of a Phase II-IV clinical trial for cancer;
- the treatment is being provided in a clinical trial approved by the National Cancer Institute (NCI), an NCI cooperative group or center, the FDA as part of an investigational new drug application, the Federal Department of Veterans Affairs, or an institutional review board which has a multiple project assurance contract approved by the office of protection from research risks of the National Cancer Institute;
- the treating facility and personnel have the expertise and capability to render the treatment as a result of their experience, training and volume of patients;
- there is no clearly superior, non-investigational treatment alternative; and
- available clinical or pre-clinical data provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.

The above coverage may be provided on a case-by-case basis if treatment is being provided in a Phase I clinical trial for cancer.

Benefits are payable on the same basis as any other illness.

# Medical Plan Exclusions (GR-9N-28-015-07)

Not every medical service or supply is covered by the plan, even if prescribed, recommended, or approved by your **physician** or **dentist**. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What The Plan Covers* section or by amendment attached to this Booklet-Certificate.

## **Important Note:**

You have medical and prescription drug insurance coverage. The exclusions listed below apply to all coverage under your plan. Additional exclusions apply to specific prescription drug coverage. Those additional exclusions are listed separately under the *What The Plan Covers* section for each of these benefits.

Acupuncture, acupressure and acupuncture therapy, except as provided in the *What the Plan Covers* section.

Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.

Any charges in excess of the benefit, dollar, day, visit or supply limits stated in this Booklet-Certificate.

Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain **prescription drugs** or supplies, even if otherwise covered under this Booklet-Certificate. This also includes **prescription drugs** or supplies if:

- such **prescription drugs** or supplies are unavailable or illegal in the United States; or
- the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Applied Behavioral Analysis, the LEAP, TEACCH, Denver and Rutgers programs. Behavioral Health Services:

- Alcoholism or **substance abuse** rehabilitation treatment on an inpatient or outpatient basis, except to the extent coverage for **detoxification** or treatment of alcoholism or **substance abuse** is specifically provided in the *What the Medical Plan Covers* Section.
- Treatment of a covered health care provider who specializes in the mental health care field and who receives treatment as a part of their training in that field.
- Treatment of impulse control disorders such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Treatment of mental retardation, defects, and deficiencies. This exclusion does not apply to mental health services or to medical treatment of mentally retarded in accordance with the benefits provided in the *What the Plan Covers* section of this Booklet-Certificate.

Blood, blood plasma, synthetic blood, blood derivatives or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered. For autologous blood donations, only administration and processing costs are covered.

Charges for a service or supply furnished by a **provider** in excess of the **recognized charge**.

Charges submitted for services that are not rendered, or rendered to a person not eligible for coverage under the plan.

Charges submitted for services by an unlicensed **hospital**, **physician** or other provider or not within the scope of the provider's license.

Contraception, except as specifically described in the *What the Plan Covers* Section:

- Over the counter contraceptive supplies including but not limited to condoms, contraceptive foams, jellies and ointments.

Cosmetic services and plastic surgery: any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:

- Face lifts, body lifts, tummy tucks, liposuctions, removal of excess skin, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
- Chemical peels, dermabrasion, laser or light treatments, bleaching, creams, ointments or other treatments or supplies to alter the appearance or texture of the skin;
- Insertion or removal of any implant that alters the appearance of the body (such as breast or chin implants);
- Removal of tattoos;
- Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
- Surgery to correct Gynecomastia;
- Breast augmentation; and
- Otoplasty.

Counseling: Services and treatment for marriage, religious, family, career, social adjustment, pastoral, or financial counselor.

Court ordered services, including those required as a condition of parole or release.

### **Custodial Care**

Dental Services: any treatment, services or supplies related to the care, filling, removal or replacement of teeth and the treatment of injuries and diseases of the teeth, gums, and other structures supporting the teeth. This includes but is not limited to:

- services of **dentists**, oral surgeons, dental hygienists, and orthodontists including apicoectomy (dental root resection), root canal treatment, soft tissue impactions, removal of bony impacted teeth, treatment of periodontal disease, alveolectomy, augmentation and vestibuloplasty and fluoride and other substances to protect, clean or alter the appearance of teeth;
- dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth; and
- non-surgical treatments to alter bite or the alignment or operation of the jaw, including treatment of malocclusion or devices to alter bite or alignment.

Disposable outpatient supplies: Any outpatient disposable supply or device, including sheaths, bags, elastic garments, support hose, bandages, bedpans, syringes, blood or urine testing supplies, and other home test kits; and splints, neck braces, compresses, and other devices not intended for reuse by another patient.

Drugs, medications and supplies:

- Over-the-counter drugs, biological or chemical preparations and supplies that may be obtained without a **prescription** including vitamins;
- Any services related to the dispensing, injection or application of a drug;
- Any prescription drug purchased illegally outside the United States, even if otherwise covered under this plan within the United States;
- Immunizations related to work;
- Needles, syringes and other injectable aids, except as covered for diabetic supplies;
- Drugs related to the treatment of **non-covered expenses**;
- Performance enhancing steroids;

- Injectable drugs if an alternative oral drug is available;
- Outpatient **prescription drugs**;
- Self-injectable **prescription drugs** and medications;
- Any **prescription drugs**, injectables, or medications or supplies provided by the policyholder or through a third party vendor contract with the policyholder; and
- Any expenses for prescription drugs, and supplies covered under an Aetna Pharmacy plan will not be covered under this medical expense plan. Prescription drug exclusions that apply to the Aetna Pharmacy plan will apply to the medical expense coverage; and
- Charges for any prescription drug for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy.

Educational services:

- Any services or supplies related to education, training or retraining services or testing, including: special education, remedial education, job training and job hardening programs;
- Evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders, behavioral disorders, (including pervasive developmental disorders) training or cognitive rehabilitation, regardless of the underlying cause; and
- Services, treatment, and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills.

Examinations:

- Any health examinations required:
  - by a third party, including examinations and treatments required to obtain or maintain employment, or which an employer is required to provide under a labor agreement;
  - by any law of a government;
  - for securing insurance, school admissions or professional or other licenses;
  - to travel;
  - to attend a school, camp, or sporting event or participate in a sport or other recreational activity; and

Any special medical reports not directly related to treatment except when provided as part of a covered service.

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *What the Plan Covers* section.

**Experimental or investigational** drugs, devices, treatments or procedures, except as described in the *What the Plan Covers* section.

Facility charges for care services or supplies provided in:

- rest homes;
- assisted living facilities;
- similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- health resorts;
- spas, sanitariums; or
- infirmaries at schools, colleges, or camps.

Food and nutritional items: Any food item, including but not limited to infant formulas, nutritional supplements, vitamins, including but not limited to **prescription** vitamins, medical foods and other nutritional items, even if it is the sole source of nutrition.

Foot care: Except as specifically covered for diabetics, any services, supplies, or devices to improve comfort or appearance of toes, feet or ankles, including but not limited to:

- Treatment of calluses, bunions, toenails, hammer-toes, subluxations, fallen arches, weak feet, chronic foot pain or conditions caused by routine activities such as walking, running, working or wearing shoes; and
- Shoes (including but not limited to orthopedic shoes), foot orthotics, arch supports, shoe inserts, ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies, even if required following a covered treatment of an **illness** or **injury**.

Growth/Height: Any treatment, device, drug, service or supply (including surgical procedures, devices to stimulate growth and growth hormones), solely to increase or decrease height or alter the rate of growth.

Hearing:

- Any hearing service or supply that does not meet professionally accepted standards;
- Hearing exams given during a **stay** in a **hospital** or other facility; except as specifically provided in the *What the Plan Covers* section;
- Replacement parts or repairs for a hearing aid; and
- Any tests, appliances, and devices for the improvement of hearing (including but not limited to hearing aids and amplifiers), or to enhance other forms of communication to compensate for hearing loss or devices that simulate speech, except as specifically provided in the *What the Plan Covers* section.

Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as but not limited to:

- Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds, and swimming pools;
- Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths, or massage devices;
- Equipment or supplies to aid sleeping or sitting, including but not limited to non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs;
- Equipment installed in your home, workplace or other environment, including but not limited to stair-glides, elevators, wheelchair ramps, or equipment to alter air quality, humidity or temperature;
- Other additions or alterations to your home, workplace or other environment, including but not limited to room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems, or home monitoring;
- Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your **illness** or **injury**;
- Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or **illness**; and
- Transportation devices, including but not limited to stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks, or alterations to any vehicle or transportation device.

Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.

Infertility: except as specifically described in the *What the Plan Covers* Section, any services, treatments, procedures or supplies that are designed to enhance fertility or the likelihood of conception, including but not limited to:

- Drugs related to the treatment of non-covered benefits;
- Injectable infertility medications, including but not limited to menotropins, hCG, GnRH agonists, and IVIG;
- Any advanced reproductive technology (“ART”) procedures or services related to such procedures, including but not limited to in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), zygote intra-fallopian transfer (“ZIFT”), and intra-cytoplasmic sperm injection (“ICSI”); Artificial Insemination for covered females attempting to become pregnant who are not infertile as defined by the plan;

- Infertility services for couples in which 1 of the partners has had a previous sterilization procedure, with or without surgical reversal;
- Procedures, services and supplies to reverse voluntary sterilization;
- Infertility services for females with FSH levels 19 or greater mIU/ml on day 3 of the menstrual cycle;
- The purchase of donor sperm and any charges for the storage of sperm; the purchase of donor eggs and any charges associated with care of the donor required for donor egg retrievals or transfers or gestational carriers or surrogacy; donor egg retrieval or fees associated with donor egg programs, including but not limited to fees for laboratory tests;
- Charges associated with cryopreservation or storage of cryopreserved eggs and embryos (e.g., office, **hospital**, ultrasounds, laboratory tests, etc.); any charges associated with a frozen embryo or egg transfer, including but not limited to thawing charges;
- Home ovulation prediction kits or home pregnancy tests;
- Any charges associated with care required to obtain ART Services (e.g., office, **hospital**, ultrasounds, laboratory tests); and any charges associated with obtaining sperm for any ART procedures; and
- Ovulation induction and intrauterine insemination services if you are not infertile.

### **Maintenance Care.**

Medicare: Payment for that portion of the charge for which Medicare or another party is the primary payer. Miscellaneous charges for services or supplies including:

- Annual or other charges to be in a **physician's** practice;
- Charges to have preferred access to a **physician's** services such as boutique or concierge **physician** practices;
- Cancelled or missed appointment charges or charges to complete claim forms;
- Charges the recipient has no legal obligation to pay; or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
  - Care in charitable institutions;
  - Care for conditions related to current or previous military service;
  - Care while in the custody of a governmental authority;
  - Any care a public **hospital** or other facility is required to provide; or
  - Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.

Nursing and home health aide services provided outside of the home (such as in conjunction with school, vacation, work or recreational activities).

Non-**medically necessary** services, including but not limited to, those treatments, services, **prescription drugs** and supplies which are not **medically necessary**, as determined by **Aetna**, for the diagnosis and treatment of **illness, injury**, restoration of physiological functions, or covered preventive services. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Personal comfort and convenience items: Any service or supply primarily for your convenience and personal comfort or that of a third party, including: Telephone, television, internet, barber or beauty service or other guest services; housekeeping, cooking, cleaning, shopping, monitoring, security or other home services; and travel, transportation, or living expenses, rest cures, recreational or diversional therapy.

Private duty nursing during your **stay** in a **hospital**, and outpatient private duty nursing services, except as specifically described in the *Private Duty Nursing* provision in the *What the Plan Covers* Section.

Prosthetics or prosthetic devices unless specifically covered under *What the Plan Covers* Section.

Sex change: Any treatment, drug, service or supply related to changing sex or sexual characteristics, including:

- Surgical procedures to alter the appearance or function of the body;
- Hormones and hormone therapy;
- Prosthetic devices; and
- Medical or psychological counseling.

Services provided by a spouse, domestic partner, parent, child, step-child, brother, sister, in-law or any household member.

Services of a resident **physician** or intern rendered in that capacity.

Services provided where there is no evidence of pathology, dysfunction, or disease; except as specifically provided in connection with covered routine care and cancer screenings.

Sexual dysfunction/enhancement: Any treatment, drug, service or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Surgery, drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or alter the shape or appearance of a sex organ; and
- Sex therapy, sex counseling, marriage counseling or other counseling or advisory services.

Smoking: Any treatment, drug, service or supply to stop or reduce smoking or the use of other tobacco products or to treat or reduce nicotine addiction, dependence or cravings, including counseling, hypnosis and other therapies, medications, nicotine patches and gum.

Services, including those related to pregnancy, rendered before the effective date or after the termination of coverage, unless coverage is continued under the *Continuation of Coverage* section of this Booklet-Certificate.

Services that are not covered under this Booklet-Certificate.

Services and supplies provided in connection with treatment or care that is not covered under the plan.

Speech therapy for treatment of delays in speech development, except as specifically provided in *What the Plan Covers* section. For example, the plan does not cover therapy when it is used to improve speech skills that have not fully developed.

Spinal disorder, including care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or dislocation in the human body or other physical treatment of any condition caused by or related to biomechanical or nerve conduction disorders of the spine including manipulation of the spine treatment, except as specifically provided in the *What the Plan Covers* section.

Strength and performance: Services, devices and supplies to enhance strength, physical condition, endurance or physical performance, including:

- Exercise equipment, memberships in health or fitness clubs, training, advice, or coaching;
- Drugs or preparations to enhance strength, performance, or endurance; and
- Treatments, services and supplies to treat **illnesses, injuries** or disabilities related to the use of performance- enhancing drugs or preparations.

Therapies for the treatment of delays in development, unless resulting from acute illness or injury, or congenital defects amenable to surgical repair (such as cleft lip/palate), are not covered. Examples of non-covered diagnoses include Pervasive Developmental Disorders, Down syndrome, and Cerebral Palsy, as they are considered both developmental and/or chronic in nature. This exclusion does not apply to coverage for Pervasive Developmental Disorders as provided under the Treatment of a Biologically-Based Mental Illness section of the Booklet-Certificate.

Therapies and tests: Any of the following treatments or procedures:

- Aromatherapy;
- Bio-feedback and bioenergetic therapy;
- Carbon dioxide therapy;
- Chelation therapy (except for heavy metal poisoning);
- Computer-aided tomography (CAT) scanning of the entire body;
- Educational therapy;
- Gastric irrigation;
- Hair analysis;
- Hyperbaric therapy, except for the treatment of decompression or to promote healing of wounds;
- Hypnosis, and hypnotherapy, except when performed by a **physician** as a form of anesthesia in connection with covered surgery;
- Lovaas therapy;
- Massage therapy;
- Megavitamin therapy;
- Primal therapy;
- Psychodrama;
- Purging;
- Recreational therapy;
- Rolfing;
- Sensory or auditory integration therapy;
- Sleep therapy;
- Thermograms and thermography.

Transplant-The transplant coverage does not include charges for:

- Outpatient drugs including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence;
- Services and supplies furnished to a donor when recipient is not a covered person;
- Home infusion therapy after the transplant occurrence;
- Harvesting and/or storage of organs, without the expectation of immediate transplantation for an existing **illness**;
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing **illness**;
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise **precertified** by **Aetna**.

Transportation costs, including **ambulance** services for routine transportation to receive outpatient or inpatient services except as described in *What the Plan Covers* section.

Unauthorized services, including any service obtained by or on behalf of a you or your covered dependent without Precertification by Aetna when required. This exclusion does not apply in a Medical Emergency or in an Urgent Care situation.

Vision-related services and supplies, except as described in the *What the Plan Covers* section. The plan does not cover:

- Special supplies such as non-**prescription** sunglasses and subnormal vision aids;
- Vision service or supply which does not meet professionally accepted standards;
- Eye exams during your **stay** in a **hospital** or other facility for health care;
- Eye exams for contact lenses or their fitting;
- Eyeglasses or duplicate or spare eyeglasses or lenses or frames;
- Replacement of lenses or frames that are lost or stolen or broken;
- Acuity tests;

- Eye surgery for the correction of vision, including radial keratotomy, LASIK and similar procedures;
- Services to treat errors of refraction.

Weight: Any treatment, drug service or supply intended to decrease or increase body weight, control weight or treat obesity, including **morbid obesity**, regardless of the existence of comorbid conditions; except as provided by this Booklet-Certificate, including but not limited to:

- Liposuction, banding, gastric stapling, gastric by-pass and other forms of bariatric surgery; surgical procedures medical treatments, weight control/loss programs and other services and supplies that are primarily intended to treat, or are related to the treatment of obesity, including **morbid obesity**;
- Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, appetite suppressants and other medications;
- Counseling, coaching, training, hypnosis or other forms of therapy; and
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement.

Work related: Any **illness** or **injury** related to employment or self-employment including any **illness** or **injury** that arises out of (or in the course of) any work for pay or profit, unless no other source of coverage or reimbursement is available to you for the services or supplies. Sources of coverage or reimbursement may include your employer, workers' compensation, or an occupational illness or similar program under local, state or federal law. A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. If you are also covered under a workers' compensation law or similar law, and submit proof that you are not covered for a particular illness or **injury** under such law, that illness or **injury** will be considered "non-occupational" regardless of cause.

# Your Pharmacy Benefit (GR-9N-12-005-02)

## How the Pharmacy Plan Works

It is important that you have the information and useful resources to help you get the most out of your **Aetna prescription drug** plan. This Booklet-Certificate explains:

- Definitions you need to know;
- How to access **network pharmacies** and procedures you need to follow;
- What **prescription drug** expenses are covered and what limits may apply;
- What **prescription drug** expenses are not covered by the plan;
- How you share the cost of your covered **prescription drug** expenses; and
- Other important information such as eligibility, complaints and appeals, termination, and general administration of the plan.

### A few important notes to consider before moving forward:

- Unless otherwise indicated, “you” refers to you and your covered dependents.
- Your **prescription drug** plan pays benefits only for **prescription drug** expenses described in this Booklet- Certificate as covered expenses that are **medically necessary**.
- This Booklet-Certificate applies to coverage only and does not restrict your ability to receive **prescription drugs** that are not or might not be covered benefits under this **prescription drug** plan.
- Store this Booklet-Certificate in a safe place for future reference.

(GR-9N 12-005 01 VA)

### Notice

The plan does not cover all **prescription drugs**, medications and supplies. Refer to the Limitations section of this coverage and *Exclusions* section of your Booklet-Certificate.

- **Covered expenses** are subject to cost sharing requirements as described in the Cost Sharing sections of this coverage and in your Schedule of Benefits.
- **Injectable prescription drug** refills will only be covered when obtained through **Aetna’s specialty pharmacy network**.

## Getting Started: Common Terms

You will find the terms below used throughout this Booklet-Certificate. They are described within the sections that follow, and you can also refer to the *Glossary* at the back of this document for helpful definitions. Words in bold print throughout the document are defined in the *Glossary*.

**Brand-Named Prescription Drug** is a **prescription drug** with a proprietary name assigned to it by the manufacturer and so indicated by Medispan or any other similar publication designated by **Aetna**.

**Generic Prescription Drug** is a **prescription drug**, whether identified by its chemical, proprietary, or non- proprietary name, that is accepted by the U.S. Food and Drug Administration as therapeutically equivalent and interchangeable with drugs having an identical amount of the same active ingredient. These drugs are identified by Medispan or any other publication designated by **Aetna**.

**Network pharmacy** is a description of a **retail, mail order or specialty pharmacy** that has entered into a contractual agreement with **Aetna**, an affiliate, or a third party vendor, for the provision of **covered services** to you and your covered dependents. The appropriate **pharmacy** type may also be substituted for the word **pharmacy**. (E.g. **network retail pharmacy, network mail order pharmacy or specialty pharmacy network**).

**Non-Preferred Drug (Non-Formulary)** is a **brand-named prescription drug** or **generic prescription drug** that does not appear on the **preferred drug guide**.

**Out-of-network pharmacy** is a description of a **pharmacy** that has not contracted with **Aetna**, an affiliate, or a third party vendor, and does not participate in the pharmacy network.

Preferred Drug (Formulary) is a **brand-named prescription drug** or **generic prescription drug** that appears on the **preferred drug guide**.

**Preferred Drug Guide** is a listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand-named prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and changes by **Aetna**. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at [www.aetna.com/formulary](http://www.aetna.com/formulary).

**Prescription Drug** is a drug, biological, or compounded **prescription** which, by State or Federal Law, may be dispensed only by **prescription** and which is required by Federal Law to be labeled “Caution: Federal Law prohibits dispensing without prescription.” This includes an injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.

**Provider** is any recognized health care professional, pharmacy or facility providing services with the scope of their license.

**Self-injectable Drug(s)**. Prescription drugs that are intended to be self-administered by injection to a specific part of the body to treat certain chronic medical conditions.

**Specialty Pharmacy Network**. **Aetna’s** network of participating pharmacies designated to fill **Self-injectable Drug** prescriptions.

## **Accessing Pharmacies and Benefits** (GR-9N 12-015 01 VA)

This plan provides access to **covered benefits** through a network of pharmacies, vendors or suppliers. **Aetna** has contracted for these **network pharmacies** to provide **prescription drugs** and other supplies to you.

Obtaining your benefits through **network pharmacies** has many advantages. Your out-of-pocket costs may vary between **network** and **out-of-network benefits**. Benefits and cost sharing may also vary by the type of **network pharmacy** where you obtain your **prescription drug** and whether or not you purchase a brand-name or generic drug. **Network pharmacies** include retail, mail order and specialty pharmacies.

Read your *Schedule of Benefits* carefully to understand the cost sharing charges applicable to you

To better understand the choices that you have with your plan, please carefully review the following information.

## **Accessing Network Pharmacies and Benefits** (GR-9N-12-015-02-VA)

You may select a **network pharmacy** from the **Aetna** Network Pharmacy Directory or by logging on to **Aetna’s** website at [www.aetna.com](http://www.aetna.com). You can search **Aetna’s** online directory, DocFind, for names and locations of **network pharmacies**. If you cannot locate a **network pharmacy** in your area call Member Services.

You must present your ID card to the **network pharmacy** every time you get a **prescription** filled to be eligible for network **benefits**. The **network pharmacy** will calculate your claim online. You will pay any deductible, copayment or coinsurance directly to the **network pharmacy**.

You do not have to complete or submit claim forms. The **network pharmacy** will take care of claim submission.

## Emergency Prescriptions (GR-9N 12-015 01 VA)

When you need a **prescription** filled in an emergency or urgent care situation, or when you are traveling, you can obtain network benefits by filling your **prescription** at any **network retail pharmacy**. The **network pharmacy** will fill your **prescription** and only charge you your plan's cost sharing amount. If you access an **out-of-network pharmacy** you will pay the full cost of the **prescription** and will need to file a claim for reimbursement. You will be reimbursed for your **covered expenses** up to the cost of the **prescription** less your plan's cost sharing for **network** benefits.

## Availability of Providers

**Aetna** cannot guarantee the availability or continued network participation of a particular **pharmacy**. Either **Aetna** or any **network pharmacy** may terminate the provider contract.

## Cost Sharing for Network Benefits

*You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.*

- You will be responsible for the **copayment** for each **prescription** or refill as specified in the *Schedule of Benefits*. The **copayment** is payable directly to the **network pharmacy** at the time the **prescription** is dispensed.
- After you pay the applicable **copayment**, you will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** amount is determined by applying the applicable **coinsurance** percentage to the **negotiated charge** if the **prescription** is filled at a **network pharmacy**. When you obtain your **prescription drugs** through a **network pharmacy**, you will not be subject to balance billing.

## When You Use an Out-of-Network Pharmacy (GR-9N 12-020 02 VA) (GR-9N 13-005 01 VA)

You can directly access an **out-of-network pharmacy** to obtain covered outpatient **prescription drugs**. You will pay the **pharmacy** for your **prescription drugs** at the time of purchase and submit a claim form to receive reimbursement from the plan. You are responsible for completing and submitting claim forms for reimbursement of **covered expenses** you paid directly to an out-of-network **pharmacy**. **Aetna** will reimburse you for a **covered expense** up to the **recognized charge**, less any cost sharing required by you.

## Cost Sharing for Out-of-Network Benefits (GR-9N 12-020 02 VA)

*You share in the cost of your benefits. Cost Sharing amounts and provisions are described in the Schedule of Benefits.*

- You will be responsible for any applicable **coinsurance** for **covered expenses** that you incur. Your **coinsurance** share is based on the **recognized charge**. If the **out-of-network pharmacy** charges more than the **recognized charge**, you will be responsible for any expenses above the **recognized charge**.

## Pharmacy Benefit (GR-9N 13-005 01 VA)

## What the Plan Covers

The plan covers charges for outpatient **prescription drugs** for the treatment of an **illness** or injury, subject to the Limitations section of this coverage and the Exclusions section of the Booklet-Certificate. Prescriptions must be written by a **prescriber** licensed to prescribe federal legend prescription drugs.

**Generic prescription drugs** may be substituted by your pharmacist for **brand-name prescription drugs**. You may minimize your out-of-pocket expenses by selecting a **generic prescription drug** when available.

Coverage of **prescription drugs** may, in **Aetna's** sole discretion, be subject to **Aetna** requirements or limitations. **Prescription drugs** covered by this plan are subject to drug utilization review by **Aetna** and/or your provider and/or your **network pharmacy**.

Coverage for **prescription drugs** and supplies is limited to the supply limits as described below.

## Retail Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network retail pharmacy**. Each **prescription** is limited to a maximum 30 day supply when filled at a **network retail pharmacy**. **Prescriptions** for more than a 30 day supply are not eligible for coverage when dispensed by a **network retail pharmacy**.

All prescriptions and refills over a 30 day supply must be filled at a **mail order pharmacy**.

## Mail Order Pharmacy Benefits

Outpatient **prescription drugs** are covered when dispensed by a **network mail order pharmacy**. Each **prescription** is limited to a maximum 90 day supply when filled at a **network mail order pharmacy**. **Prescriptions** for less than a 30 day supply or more than a 90 day supply are not eligible for coverage when dispensed by a **network mail order pharmacy**.

## Network Benefits for Specialty Care Drugs

**Specialty care drugs** are covered at the network level of benefits only when dispensed through a **network retail pharmacy** or **Aetna's specialty pharmacy network**. Refer to **Aetna's** website, [www.aetna.com](http://www.aetna.com) to review the list of **specialty care drugs** required to be dispensed through a **network retail pharmacy** or **Aetna's specialty pharmacy network**. The list may be updated from time to time.

The initial prescription for **specialty care drugs** must be filled at a **network retail pharmacy** or at **Aetna's specialty pharmacy network**.

You are required to obtain **specialty care drugs** at **Aetna's specialty pharmacy network** for all prescription drug refills after the initial fill.

## Other Covered Expenses (GR-9N 13-005 01 VA)

The following **prescription drugs**, medications and supplies are also **covered expenses** under this Coverage.

### Off-Label Use (GR-9N 13-005 01 VA)

FDA approved **prescription drugs** may be covered when the off-label use of the drug has not been approved by the FDA for that indication. The drug must be recognized for treatment of the indication in one of the standard compendia (the United States Pharmacopoeia Drug Information, the American Medical Association Drug Evaluations, or the American Hospital Formulary Service Drug Information). Or, the safety and effectiveness of use for this indication has been adequately demonstrated by at least one study published in a nationally recognized peer review journal. Coverage of off label use of these drugs may, in **Aetna's** sole discretion, be subject to **Aetna** requirements or limitations.

## Contraceptives

The following contraceptives and contraceptive devices:

- Oral Contraceptives.
- Diaphragms, 1 per 365 consecutive day period
- Injectable contraceptives.
- Contraceptive patches.
- Contraceptive rings.
- Implantable contraceptives and IUDs are covered when obtained from a **physician**. The **physician** will provide insertion and removal of the drugs or device.

## Oral and Self-Injectable Infertility Drugs

The following **prescription drugs** used for the purpose of treating infertility including, but not limited to:

- Urofollitropin, menotropin, human chorionic gonadotropin and progesterone.

## Lifestyle/Performance Drugs

The following lifestyle/performance drugs:

- Sildenafil Citrate, phentolamine, apomorphine and alprostadil in oral, injectable and topical (including but not limited to gels, creams, ointments and patches) forms or any other form used internally or externally. Expenses include any prescription drug in oral or topical form that is similar or identical class, has a similar or identical mode of action or exhibits similar or identical outcomes.
- Coverage is limited to 6 pills or other form, determined cumulatively among all forms, for unit amounts as determined by **Aetna** to be similar in cost to oral forms, per 30 day supply. Mail order and 60 to 90 day supplies are not covered.

## Pharmacy Benefit Limitations (GR-9N-S-13-15-01)

A **network pharmacy** may refuse to fill a prescription order or refill when in the professional judgment of the pharmacist the prescription should not be filled.

The plan will not cover expenses for any **prescription drug** for which the actual charge to you is less than the required **copayment** or **deductible**, or for any **prescription drug** for which no charge is made to you.

You will be charged the **out-of-network prescription drug cost sharing** for **prescription drugs** recently approved by the FDA, but which have not yet been reviewed by the Aetna Health Pharmacy Management Department and Therapeutics Committee.

**Aetna** retains the right to review all requests for reimbursement and in its sole discretion make reimbursement determinations subject to the Complaint and Appeals section(s) of the Booklet-Certificate.

The number of **copayments/deductibles** you are responsible for per vial of Depo-Provera, an injectable contraceptive, or similar type contraceptive dispensed for more than a 30 day supply, will be based on the 90 day supply level. Coverage is limited to a maximum of 5 vials per calendar year.

The plan will not pay charges for any **prescription drug** dispensed by a **mail order pharmacy** for the treatment of erectile dysfunction, impotence or sexual dysfunction or inadequacy.

## Pharmacy Benefit Exclusions (GR-9N 28-020 01 VA)

Not every health care service or supply is covered by the plan. Even if prescribed, recommended, or approved by your **physician** or **dentist** it may not be covered. The plan covers only those services and supplies that are **medically necessary** and included in the *What the Plan Covers* section. Charges made for the following are not covered except to the extent listed under the *What the Plan Covers* section or by amendment attached to this Booklet-Certificate. In addition, some services are specifically limited or excluded. This section describes expenses that are not covered or subject to special limitations.

These **prescription drug** exclusions are in addition to the exclusions listed under your medical coverage. The plan does not cover the following expenses:

- Administration or injection of any drug;
- Any charges in excess of the benefit, dollar, day, or supply limits stated in this Booklet-Certificate;
- Allergy sera and extracts.

Any non-emergency charges incurred outside of the United States 1) if you traveled to such location to obtain **prescription drugs**, or supplies, even if otherwise covered under this Booklet-Certificate, or 2) such drugs or supplies

are unavailable or illegal in the United States, or 3) the purchase of such **prescription drugs** or supplies outside the United States is considered illegal.

Any drugs or medications, services and supplies that are not **medically necessary**, as determined by **Aetna**, for the diagnosis, care or treatment of the **illness** or **injury** involved. This applies even if they are prescribed, recommended or approved by your **physician** or **dentist**.

Biological sera, blood, blood plasma, blood products or substitutes or any other blood products. Contraception:

- Over the counter contraceptive supplies including but not limited to:
  - § condoms;
  - § contraceptive foams;
  - § jellies; and
  - § ointments;
- Services associated with the prescribing, monitoring and/or administration of contraceptives.

**Cosmetic** drugs, medications or preparations used for **cosmetic** purposes or to promote hair growth, including but not limited to:

- § health and beauty aids;
- § chemical peels;
- § dermabrasion;
- § treatments;
- § bleaching;
- § creams;
- § ointments or other treatments or supplies, to remove tattoos, scars or to alter the appearance or texture of the skin.

Drugs given or entirely consumed at the time and place it is prescribed or dispensed.

Drugs which do not, by federal or state law, need a **prescription** order (i.e. over-the-counter (OTC) drugs), even if a **prescription** is written.

Drugs given by, or while the person is an inpatient in, any healthcare facility; or for any drugs provided on an outpatient basis in any such institution to the extent benefits are payable for it.

Drugs used primarily for the treatment of infertility, or for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures, except as described in the *What the Plan Covers* section.

Drugs used for the purpose of weight gain or reduction, including but not limited to:

- stimulants;
- preparations;
- foods or diet supplements;
- dietary regimens and supplements;
- food or food supplements;
- appetite suppressants; and
- other medications.

Drugs used for the treatment of obesity.

All drugs or medications in a **therapeutic drug class** if one of the drugs in that **therapeutic drug class** is not a **prescription drug**.

**Durable medical equipment**, monitors and other equipment.

**Experimental or investigational** drugs or devices, except as described in the *What the Plan Covers* section. This exclusion will **not** apply

with respect to drugs that:

- Have been granted treatment investigational new drug (IND); or Group c/treatment IND status; or
- Are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute; and
- **Aetna** determines, based on available scientific evidence, are effective or show promise of being effective for the **illness**.

Food items: Any food item, including:

- infant formulas;
- nutritional supplements;
- vitamins;
- medical foods and other nutritional items, even if it is the sole source of nutrition.

Genetics: Any treatment, device, drug, or supply to alter the body's genes, genetic make-up, or the expression of the body's genes. The one is exception for the correction of congenital birth defects.

Immunization or immunological agents. Implantable drugs and associated devices. Injectables:

- Any charges for the administration or injection of **prescription drugs** or injectable insulin and other injectable drugs covered by **Aetna**;
- Needles and syringes, except for diabetic needles and syringes;
- Injectable drugs if an alternative oral drug is available;
- For any refill of a designated self-injectable drug not dispensed by or obtained through the **specialty pharmacy network**. An updated copy of the list of self-injectable drugs designated by this plan to be refilled by or obtained through the **specialty pharmacy network** is available upon request. You may also get a copy of the list on **Aetna's** website at [www.aetna.com](http://www.aetna.com).

Insulin pumps or tubing or other ancillary equipment and supplies for insulin pumps.

**Prescription drugs** for which there is an over-the-counter (OTC) product which has the same active ingredient and strength even if a **prescription** is written.

**Prescription drugs**, medications, injectables or supplies given through a third party vendor contract with the policyholder.

**Prescription** orders filled prior to the effective date or after the termination date of coverage under this Booklet- Certificate.

Prophylactic drugs for travel.

Refills over the amount specified by the **prescription** order. Before recognizing charges, **Aetna** may require a new **prescription** or proof as to need, if a **prescription** or refill appears excessive under accepted medical practice standards.

Refills dispensed more than one year from the date the latest **prescription** order was written, or as otherwise allowed by applicable law of the jurisdiction in which the drug is dispensed.

Replacement of lost or stolen **prescriptions**.

Drugs, services and supplies given in connection with treatment of an **occupational injury or occupational illness**.

Strength and performance: Drugs or preparations, devices and supplies to enhance strength, physical condition, endurance or physical performance, including performance enhancing steroids.

Sex change: Any treatment, drug or supply related to changing sex or sexual characteristics, including hormones and hormone therapy.

Sexual dysfunction/enhancement: Any drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- Drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity, or change the shape or appearance of a sex organ.

Supplies, devices or equipment of any type, except as specifically provided in the *What the Plan Covers* section. Test agents except diabetic test agents.

## When Coverage Ends (GR-9N-30-005-05 VA)

Coverage under your plan can end for a variety of reasons. In this section, you will find details on how and why coverage ends, and how you may still be able to continue coverage.

### When Coverage Ends for Retirees (GR-9N-30-005-05 VA)

Your coverage under the plan will end if:

- The plan is discontinued;
- You voluntarily stop your coverage;
- The group policy ends;
- You are no longer eligible for coverage;
- You do not make any required contributions;
- You become covered under another plan offered by your employer;
- You have exhausted your overall maximum lifetime benefit under your health plan, if your plan contains such a maximum benefit.

It is your employer's responsibility to let **Aetna** know when your coverage ends. The limits above may be extended only if **Aetna** and your employer agree, in writing, to extend them.

### Your Proof of Prior Medical Coverage (GR-9N-30-010-01)

Under the Health Insurance Portability and Accountability Act of 1996, your employer is required to give you a certificate of **creditable coverage** when your coverage ends. This certificate proves that you were covered. Ask your employer about the certificate of **creditable coverage**.

### When Coverage Ends for Dependents (GR-9N-30-015-02 VA)

Coverage for your dependents will end if:

- You are no longer eligible for dependents' coverage;
- You do not make your contribution for the cost of dependents' coverage;
- Your own coverage ends for any of the reasons listed under *When Coverage Ends* for Employees (This does not apply if you use up your lifetime maximum, if included);
- Your dependent is no longer eligible for coverage. Coverage ends at the end of the calendar month when your dependent does not meet the plan's definition of a dependent. However, when a dependent child is a full-time student who is on a medically necessary leave of absence from school, coverage under this plan will remain in force for up to 12 months from the date the dependent ceases to be a full-time student, or until the dependent does not meet the plan's definition of a dependent, whichever occurs first; or
- As permitted under applicable federal and state law, your dependent becomes eligible for like benefits under this or any other group plan offered by your employer.

In addition, a "domestic partner" will no longer be considered to be a defined dependent on the earlier to occur of:

- The date this plan no longer allows coverage for domestic partners.
- The date of termination of the domestic partnership. In that event, you should provide your Employer a completed and signed Declaration of Termination of Domestic Partnership.

Coverage for dependents may continue for a period after your death. Coverage for handicapped dependents may continue after they reach any limiting age. See *Continuation of Coverage* for more information.

## Continuation of Coverage (GR-9N-31-010-03 VA)

### Continuing Health Care Benefits (GR-9N-31-015-06)

### Handicapped Dependent Children (GR-9N-31-015-01 VA)

Health Expense Coverage for your fully handicapped dependent child may be continued past the maximum age for a dependent child. However, such coverage may not be continued if the child has been issued an individual medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children under your plan; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to **Aetna** no later than 31 days after the date your child reaches the maximum age under your plan.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age under your plan.

**Aetna** will have the right to require proof of the continuation of the handicap. **Aetna** also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age under your plan.

## Extension of Benefits (GR-9N 31-020 01)

### Coverage for Health Benefits

If your health benefits end while you are totally disabled, your health expenses will be extended as described below. To find out why and when your coverage may end, please refer to *When Coverage Ends*.

“Totally disabled” means that because of an **injury** or **illness**, a person is not able to engage in most normal activities of a healthy person of the same age and gender.

### Extended Health Coverage (GR-9N 31-020 01)

*Medical Benefits (other than Basic medical benefits):* Coverage will be available while you are totally disabled, for up to 12 months.

*Prescription Drug Benefits:* Coverage will be available while you are totally disabled for up to 12 months.

## When Extended Health Coverage Ends

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

(This does not apply if coverage ceased because the benefit section ceased for your eligible class.)

## COBRA Continuation of Coverage (GR-9N 31-025-02 VA)

If your employer is subject to COBRA requirements, the health plan continuation is governed by the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requirements. With COBRA you and your dependents can continue health coverage, subject to certain conditions and your payment of premiums. Continuation rights are available following a “qualifying event” that would cause you or family members to otherwise lose coverage. Qualifying events are listed in this section.

### Continuing Coverage through COBRA

When you or your covered dependents become eligible, your employer will provide you with detailed information on continuing your health coverage through COBRA.

You or your dependents will need to:

- Complete and submit an application for continued health coverage, which is an election notice of your intent to continue coverage.
- Submit your application within 60 days of the qualifying event, or within 60 days of your employer’s notice of this COBRA continuation right, if later.
- Agree to pay the required premiums.

### Who Qualifies for COBRA

You have 60 days from the qualifying event to elect COBRA. If you do not submit an application within 60 days, you will forfeit your COBRA continuation rights.

Below you will find the qualifying events and a summary of the maximum coverage periods according to COBRA requirements.

<b>Qualifying Event Causing Loss of Health Coverage</b>	<b>Covered Persons Eligible to Elect Continuation</b>	<b>Maximum Continuation Periods</b>
Your active employment ends for reasons other than gross misconduct	You and your dependents	18 months
Your working hours are reduced	You and your dependents	18 months
You divorce or legally separate and are no longer responsible for dependent coverage	Your dependents	36 months
You become entitled to benefits under Medicare	Your dependents	36 months
Your covered dependent children no longer qualify as dependents under the plan	Your dependent children	36 months

You die	Your dependents	36 months
You are a retiree eligible for health coverage and your former employer files for bankruptcy	You and your dependents	18 months

## Disability May Increase Maximum COBRA Continuation to 29 Months

*If You or Your Covered Dependents Are Disabled.*

If you or your covered dependent qualify for disability status under Title II or XVI of the Social Security Act during the 18 month continuation period, you or your covered dependent:

- Have the right to extend coverage beyond the initial 18 month maximum continuation period.
- Qualify for an additional 11 month period, subject to the overall COBRA conditions.
- Must notify your employer within 60 days of the disability determination status and before the 18 month continuation period ends.
- Must notify the employer within 30 days after the date of any final determination that you or a covered dependent is no longer disabled.
- Are responsible to pay the premiums after the 18<sup>th</sup> month, through the 29<sup>th</sup> month.

*If There Are Multiple Qualifying Events.*

A covered dependent could qualify for an extension of the 18 or 29 month continuation period by meeting the requirements of another qualifying event, such as divorce or death. The total continuation period, however, can never exceed 36 months.

## Determining Your Premium Payments for COBRA Continuation Coverage

Your premium payments are regulated by law, based on the following:

- For the 18 or 36 month periods, premiums may never exceed 102 percent of the plan costs.
- During the 18 through 29 month period, premiums for coverage during an extended disability period may never exceed 150 percent of the plan costs.

## When You Acquire a Dependent During a COBRA Continuation Period

If through birth, adoption or marriage, you acquire a new dependent during the continuation period, your dependent can be added to the health plan for the remainder of the continuation period if:

- He or she meets the definition of an eligible dependent,
- Your employer is notified about your dependent within 31 days of eligibility, and
- Additional premiums for continuation are paid on a timely basis.

### Important Note

For more information about dependent eligibility, see the *Eligibility, Enrollment and Effective Date* section.

## When Your COBRA Continuation Coverage Ends

Your COBRA coverage will end when the first of the following events occurs:

- You or your covered dependents reach the maximum COBRA continuation period – the end of the 18, 29 or 36 months. (Coverage for a newly acquired dependent who has been added for the balance of a continuation period would end at the same time your continuation period ends, if he or she is not disabled nor eligible for an extended maximum).
- You or your covered dependents do not pay required premiums.
- You or your covered dependents become covered under another group plan that does not restrict coverage for pre-existing conditions. If your new plan limits pre-existing condition coverage, the continuation coverage under

this plan may remain in effect until the pre-existing clause ceases to apply or the maximum continuation period is reached under this plan.

- The date your employer no longer offers a group health plan.
- The date you or a covered dependent becomes enrolled in benefits under Medicare. This does not apply if it is contrary to the Medicare Secondary Payer Rules or other federal law.
- You or your dependent dies.

## **Conversion from a Group to an Individual Plan**

You may be eligible to apply for an individual health plan without providing proof of good health:

- At the termination of employment.
- When loss of coverage under the group plan occurs.
- When loss of dependent status occurs.
- At the end of the maximum health coverage continuation period.

The individual policy will not provide the same coverage as the former group plan offered by your employer. Certain benefits may not be available. You will be required to pay the associated premium costs for the coverage. For additional information concerning this conversion option, please refer to the “*Converting to an Individual Health Insurance Plan*” section of your Booklet-Certificate, contact your employer or call the toll-free number on your member ID card.

## **Converting to an Individual Medical Insurance Policy** (GR-9N 31-040-02 VA)

### **Eligibility**

You and your covered dependents may apply for an individual Medical insurance policy if you lose coverage under the group medical plan because:

- You terminate your employment;
- You are no longer in an eligible class;
- Your dependent no longer qualifies as an eligible dependent;
- Any continuation coverage required under federal or state law has ended; or
- You retire and there is no medical coverage available.

You can only use the conversion option once. If your group plan allows retirees to continue medical coverage, and you wish to continue your plan, then the conversion privilege will not be available to you again.

The individual conversion policy may cover:

- You only; or
- You and all dependents who are covered under the group plan at the time your coverage ended; or
- Your covered dependents, if you should die before you retire.

### **Features of the Conversion Policy**

The individual policy and its terms will be the type:

- Required by law or regulation for group conversion purposes in your or your dependent’s states of residence; and
- Offered by **Aetna** when you or your dependents apply under your employer’s conversion plan.

However, coverage will not be the same as your group plan coverage. Generally, the coverage level may be less.

The individual policy may also:

- Reduce its benefits by any like benefits payable under your group plan after coverage ends (for example: if benefits are paid after coverage ends because of a disability extension of benefits);
- Not guarantee renewal under selected conditions described in the policy.

## **Limitations**

You or your dependents do not have a right to convert if:

- Medical coverage under the group contract has been discontinued.
- You or your dependents are eligible for Medicare. Covered dependents not eligible for Medicare may apply for individual coverage even if you are eligible for Medicare.
- Coverage under the plan has been in effect for less than three months.
- You or your covered dependents become eligible for any other medical coverage under this plan.
- You apply for individual coverage in a jurisdiction where **Aetna** cannot issue or deliver an individual conversion policy.
- You or your covered dependents are eligible for, or have benefits available under, another plan that, in addition to the converted policy, would either match benefits or result in over insurance. Examples include:
  - Any other hospital or surgical expense insurance policy;
  - Any hospital service or medical expense indemnity corporation subscriber contract;
  - Any other group contract; or
  - Any statute, welfare plan or program.

## **Electing an Individual Conversion Policy**

You or your covered dependents must apply for an individual policy within 31 days after issuance of the written notice required by your employer, but in no event beyond the 60 day period following the date of the termination of your coverage. You do not need to provide proof of good health if you apply within this period.

To apply for an individual medical insurance policy:

- Get a copy of the “Notice of Conversion Privilege and Request” form from your employer.
- Complete and send the form to **Aetna** at the specified address.

## **Your Premiums and Payments**

Your first premium payment will be due at the time you submit the conversion application to **Aetna**.

The amount of the premium will be **Aetna**'s normal rate for the policy that is approved for issuance in your or your dependent's state of residence.

## **When an Individual Policy Becomes Effective**

The individual policy will begin on the day after coverage ends under your group plan. Your policy will be issued once **Aetna** receives and processes your completed application and premium payment.

# Coordination of Benefits - What Happens When There is More Than One Health Plan

(GR-9N-33-005-02)

## When Coordination of Benefits Applies

Getting Started - Important Terms Which  
Plan Pays First  
How Coordination of Benefits Works

## When Coordination of Benefits Applies

This Coordination of Benefits (COB) provision applies to this plan when you or your covered dependent has health coverage under more than one plan. “Plan” and “This plan” are defined herein. The Order of Benefit Determination Rules below determines which plan will pay as the primary plan. The primary plan pays first without regard to the possibility that another plan may cover some expenses. A secondary plan pays after the primary plan and may reduce the benefits it pays so that payments from all group plans do not exceed 100% of the total allowable expense.

## Getting Started - Important Terms

When used in this provision, the following words and phrases have the meaning explained herein.

**Allowable Expense** means a health care service or expense, including, coinsurance and **copayments** and without reduction of any applicable deductible, that is covered at least in part by any of the **Plan** covering the person. When a **Plan** provides benefits in the form of services (for example an HMO), the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense or service that is not covered by any of the **Plans** is not an allowable expense. Any expense that a health care provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an **allowable expense**. The following are examples of expenses and services that are **not allowable expenses**:

1. If a covered person is confined in a private **hospital** room, the difference between the cost of a semi-private room in the **hospital** and the private room is not an **allowable expense**. This does not apply if one of the **Plans** provides coverage for a private room.
2. If a person is covered by 2 or more **Plans** that compute their benefit payments on the basis of reasonable or **recognized charges**, any amount in excess of the highest of the reasonable or **recognized charges** for a specific benefit is not an allowable expense.
3. If a person is covered by 2 or more **Plans** that provide benefits or services on the basis of negotiated charges, an amount in excess of the highest of the negotiated charges is not an **allowable expense**.
4. The amount a benefit is reduced or not reimbursed by the **primary plan** because a covered person does not comply with the **Plan** provisions is not an **allowable expense**. Examples of these provisions are second surgical opinions, **precertification** of admissions, and preferred provider arrangements.
5. If all **plans** covering a person are high deductible **plans** and the person intends to contribute to a health savings account established in accordance with section 223 of the Internal Revenue Code of 1986, the primary high deductible **plan's** deductible is not an **allowable expense**, except as to any health expense that may not be subject to the deductible as described in section 223(c)(2)(C) of the Internal Revenue Code of 1986.

If a person is covered by one **Plan** that computes its benefit payments on the basis of reasonable or **recognized charges** and another **Plan** that provides its benefits or services on the basis of **negotiated charges**, the **primary plan's** payment arrangements shall be the allowable expense for all the **Plans**. However, if the **secondary plan** has a negotiated fee or payment amount different from the **primary plan** and if the provider contract permits, that negotiated fee will be the **allowable expense** used by the **secondary plan** to determine benefits.

When a **plan** provides benefits in the form of services, the reasonable cash value of each service rendered shall be deemed an **allowable expense** and a benefit paid.

**Closed Panel Plan(s).** A plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the **plan**, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

**Custodial Parent.** A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

**Plan.** Any **Plan** providing benefits or services by reason of health care or treatment, which benefits or services are provided by one of the following:

- Group or nongroup, blanket, or franchise health insurance policies issued by insurers, including health care service contractors;
- Other prepaid coverage under service plan contracts, or under group or individual practice;
- Uninsured arrangements of group or group-type coverage;
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans;
- **Medicare** or other governmental benefits;
- Other group-type contracts. Group type contracts are those which are not available to the general public and can be obtained and maintained only because membership in or connection with a particular organization or group.

If the **Plan** includes medical, prescription drug, dental, vision and hearing coverage, those coverages will be considered separate **plans**. For example, Medical coverage will be coordinated with other Medical **plans**, and dental coverage will be coordinated with other dental **plans**.

**This Plan** is any part of the policy that provides benefits for health care expenses.

**Primary Plan / Secondary Plan.** The order of benefit determination rules state whether **This Plan** is a **Primary Plan** or **Secondary Plan** as to another **Plan** covering the person.

When **This Plan** is a **Primary Plan**, its benefits are determined before those of the other **Plan** and without considering the other **Plan's** benefits.

When **This Plan** is a **Secondary Plan**, its benefits are determined after those of the other **Plan** and may be reduced because of the other **Plan's** benefits.

When there are more than two **Plans** covering the person, **This Plan** may be a **Primary Plan** as to one or more other **Plans**, and may be a **Secondary Plan** as to a different **Plan** or **Plans**.

## **Which Plan Pays First** (GR-9N-33-010-01)

When two or more plans pay benefits, the rules for determining the order of payment are as follows:

- The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.
- A plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary. There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan **hospital** and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.
- A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

The first of the following rules that describes which plan pays its benefits before another plan is the rule to use:

1. **Non-Dependent or Dependent.** The plan that covers the person other than as a dependent, for example as an employee, member, subscriber or retiree is primary and the plan that covers the person as a dependent is secondary. However, if the person is a **Medicare** beneficiary and, as a result of federal law, **Medicare** is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.
2. **Child Covered Under More than One Plan.** The order of benefits when a child is covered by more than one plan is:
  - A. The primary plan is the plan of the parent whose birthday is earlier in the year if:
    - i. The parents are married or living together whether or not married;
    - ii. A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage or if the decree states that both parents are responsible for health coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
  - B. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health coverage for the dependent child's health care expenses, but that parent's spouse does, the plan of the parent's spouse is the primary plan.
  - C. If the parents are separated or divorced or are not living together whether or not they have ever been married and there is no court decree allocating responsibility for health coverage, the order of benefits is:
    - The plan of the custodial parent;
    - The plan of the spouse of the **custodial parent**;
    - The plan of the **noncustodial parent**; and then
    - The plan of the spouse of the **noncustodial parent**.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits should be determined as outlined above as if the individuals were the parents.

3. **Active Employee or Retired or Laid off Employee.** The plan that covers a person as an employee who is neither laid off nor retired or as a dependent of an active employee, is the primary plan. The plan covering that same person as a retired or laid off employee or as a dependent of a retired or laid off employee is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
4. **Continuation Coverage.** If a person whose coverage is provided under a right of continuation provided by federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person's dependent) is primary, and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule will not apply if the Non-Dependent or Dependent rules above determine the order of benefits.
5. **Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member, or subscriber longer is primary.
6. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this provision. In addition, This Plan will not pay more than it would have paid had it been primary.

## How Coordination of Benefits Works

When this plan is secondary, it may reduce its benefits so that total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. The difference between the benefit payments that this plan would have paid had it been the primary plan, and the benefit payments that it actually paid or provided shall be recorded as a benefit reserve for the covered person and used by this plan to pay any allowable expenses, not otherwise paid during the claim determination period.

In addition, a **secondary plan** will credit to its plan deductible any amounts that would have been credited in the absence of other coverage.

Under the COB provision of **This Plan**, the amount normally reimbursed for covered benefits or expenses under **This Plan** is reduced to take into account payments made by other plans. The general rule is that the benefits otherwise payable under **This Plan** for all covered benefits or expenses will be reduced by all other plan benefits payable for those expenses. When the COB rules of **This Plan** and another plan both agree that **This Plan** determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved. Such reduced amount will be charged against any applicable benefit limit of this coverage.

If a covered person is enrolled in two or more **closed panel plans** COB generally does not occur with respect to the use of panel providers. However, COB may occur if a person receives emergency services that would have been covered by both plans.

### **Right To Receive And Release Needed Information**

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits under this plan and other plans. **Aetna** has the right to release or obtain any information and make or recover any payments it considers necessary in order to administer this provision.

### **Facility of Payment**

Any payment made under another plan may include an amount, which should have been paid under this plan. If so, **Aetna** may pay that amount to the organization, which made that payment. That amount will then be treated as though it were a benefit paid under this plan. **Aetna** will not have to pay that amount again. The term “payment made” means reasonable cash value of the benefits provided in the form of services.

### **Right of Recovery**

If the amount of the payments made by **Aetna** is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

# When You Have Medicare Coverage

(GR-9N-33-020-01)

Which Plan Pays First

How Coordination with Medicare Works

What is Not Covered

This section explains how the benefits under **This Plan** interact with benefits available under **Medicare**.

**Medicare**, when used in this Booklet-Certificate, means the health insurance provided by Title XVIII of the Social Security Act, as amended. It includes Health Maintenance Organization (HMO) or similar coverage that is an authorized alternative to Parts A and B of **Medicare**.

You are eligible for **Medicare** if you are:

- Covered under it by reason of age, disability, or
- End Stage Renal Disease; or
- Not covered under it because you:
  1. Refused it;
  2. Dropped it; or
  3. Failed to make a proper request for it.

If you are eligible for **Medicare**, the plan coordinates the benefits it pays with the benefits that **Medicare** pays. Sometimes, the **plan** is the primary payor, which means that the **plan** pays benefits before **Medicare** pays benefits. Under other circumstances, the **plan** is the secondary payor, and pays benefits after **Medicare**.

## Which Plan Pays First

The plan is the primary payor when your coverage for the **plan**'s benefits is based on current employment with your employer. The **plan** will act as the primary payor for the **Medicare** beneficiary who is eligible for **Medicare**:

- Solely due to age if the **plan** is subject to the Social Security Act requirements for **Medicare** with respect to working aged (i.e., generally a plan of an employer with 20 or more employees);
- Due to diagnosis of end stage renal disease, but only during the first 30 months of such eligibility for **Medicare** benefits. This provision does not apply if, at the start of eligibility, you were already eligible for **Medicare** benefits, and the **plan**'s benefits were payable on a secondary basis;
- Solely due to any disability other than end stage renal disease; but only if the **plan** meets the definition of a large group health plan as outlined in the Internal Revenue Code (i.e., generally a plan of an employer with 100 or more employees).

The plan is the secondary payor in all other circumstances.

## How Coordination With Medicare Works

### When the Plan is Primary

The **plan** pays benefits first when it is the primary payor. You may then submit your claim to **Medicare** for consideration.

### When Medicare is Primary

Your health care expense must be considered for payment by **Medicare** first. You may then submit the expense to **Aetna** for consideration.

**Aetna** will calculate the benefits the **plan** would pay in the absence of **Medicare**:

The amount will be reduced so that when combined with the amount paid by **Medicare**, the total benefits paid or provided by all plans for the claim do not exceed 100 % of the total **allowable expense**.

This review is done on a claim-by-claim basis.

Charges used to satisfy your Part B deductible under **Medicare** will be applied under the **plan** in the order received by **Aetna**. **Aetna** will apply the largest charge first when two or more charges are received at the same time.

**Aetna** will apply any rule for coordinating health care benefits after determining the benefits payable.

**Right to Receive and Release Required Information** *(GR-9N-33-025-01)*

Certain facts about health care coverage and services are required to apply coordination of benefits (COB) rules to determine benefits under **This Plan** and other **plans**. **Aetna** has the right to obtain or release any information, and make or recover any payments it considers necessary, in order to administer this provision.

# General Provisions (GR-9N-32-005-02 VA)

## Type of Coverage

Coverage under the plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational illnesses** are covered. The plan covers charges made for services and supplies only while the person is covered under the plan.

## Physical Examinations

**Aetna** will have the right and opportunity to examine and evaluate any person who is the basis of any claim at all reasonable times while a claim is pending or under review. This will be done at no cost to you.

## Legal Action

No legal action can be brought to recover payment under any benefit after 3 years from the deadline for filing claims.

**Aetna** will not try to reduce or deny a benefit payment on the grounds that a condition existed before your coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

## Confidentiality

Information contained in your medical records and information received from any provider incident to the provider- patient relationship shall be kept confidential in accordance with applicable law. Information may be used or disclosed by **Aetna** when necessary for your care or treatment, the operation of the plan and administration of this Booklet- Certificate, or other activities, as permitted by applicable law. You can obtain a copy of **Aetna's** Notice of Information Practices by calling **Aetna's** toll-free Member Service telephone.

## Additional Provisions

The following additional provisions apply to your coverage.

- This Booklet-Certificate applies to coverage only, and does not restrict your ability to receive health care services that are not, or might not be, covered.
- You cannot receive multiple coverage under the plan because you are connected with more than one employer.
- In the event of a misstatement of any fact affecting your coverage under the plan, the true facts will be used to determine the coverage in force.
- This document describes the main features of the plan. Additional provisions are described elsewhere in the *group policy*. If you have any questions about the terms of the plan or about the proper payment of benefits, contact your employer or **Aetna**.
- Your employer hopes to continue the plan indefinitely but, as with all group plans, the plan may be changed or discontinued with respect to your coverage.

## Assignments (GR-9N-32-005-01)

Coverage may be assigned only with the written consent of **Aetna**. To the extent allowed by law, **Aetna** will not accept an assignment to a provider or facility including but not limited to, an assignment of:

- The benefits due under this group insurance policy;
- The right to receive payments due under this group insurance policy; or
- Any claim you make for damages resulting from a breach or alleged breach, of the terms of this group insurance policy.

## Misstatements (GR-9N-32-005-03)

If any fact as to the Policyholder or you is found to have been misstated, a fair change in premiums may be made. If the misstatement affects the existence or amount of coverage, the true facts will be used in determining whether coverage is or remains in force and its amount.

All statements made by the Policyholder or you shall be deemed representations and not warranties. No written statement made by you shall be used by **Aetna** in a contest unless a copy of the statement is or has been furnished to you or your beneficiary, or the person making the claim.

**Aetna's** failure to implement or insist upon compliance with any provision of this policy at any given time or times, shall not constitute a waiver of **Aetna's** right to implement or insist upon compliance with that provision at any other time or times. This includes, but is not limited to, the payment of premiums. This applies whether or not the circumstances are the same.

## Incontestability

As to Accident and Health Benefits:

Except as to a fraudulent misstatement, or issues concerning Premiums due:

- No statement made by the Policyholder or you or your dependent shall be the basis for voiding coverage or denying coverage or be used in defense of a claim unless it is in writing after it has been in force for 2 years from its effective date.
- No statement made by the Policyholder shall be the basis for voiding this Policy after it has been in force for 2 years from its effective date.
- No statement made by you, an eligible employee or your dependent shall be used in defense of a claim for loss incurred or starting after coverage as to which claim is made has been in effect for 2 years.

## Recovery of Overpayments (GR-9N-32-015-01 VA)

### Health Coverage

If a benefit payment is made by **Aetna**, to or on your behalf, which exceeds the benefit amount that you are entitled to receive, **Aetna** has the right:

- To require the return of the overpayment; or
- To reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery **Aetna** may have with respect to such overpayment.

## Reporting of Claims (GR-9N-32-020 01-VA)

A claim must be submitted to **Aetna** in writing. It must give proof of the nature and extent of the loss. Your employer or **Aetna** has claim forms. **Aetna** will supply you with a claim form within 15 days of your request.

All other claims should be reported promptly. Written notice of a claim must be given to **Aetna** within 20 days after the occurrence or commencement of any loss covered under this policy. Failure to give notice within that time shall not invalidate or reduce any claim if it can be shown that notice was given as soon as reasonably possible. The deadline for filing a claim is 90 days after the date of the loss.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims for health benefits will not be covered if they are filed more than 2 years after the deadline.

## Payment of Benefits (GR-9N-32-005-02-VA)

Benefits will be paid as soon as the necessary proof to support the claim is received. Written proof must be provided for all benefits.

All benefits are payable to you. However, **Aetna** has the right to pay any health benefits to the service provider. This will be done unless you have told **Aetna** otherwise by the time you file the claim.

Any unpaid balance will be paid within 30 days of receipt by **Aetna** of the due written proof.

**Aetna** may pay up to \$5,000 of any other benefit to any of your relatives whom it believes are fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

## Records of Expenses (GR-9N-32-030-02)

Keep complete records of the expenses of each person. They will be required when a claim is made. Very important are:

- Names of **physicians, dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

## Contacting Aetna

If you have questions, comments or concerns about your benefits or coverage, or if you are required to submit information to **Aetna**, you may contact **Aetna**'s Home Office at:

Aetna Life Insurance Company 151 Farmington Avenue  
Hartford, CT 06156

You may also use **Aetna**'s toll free Member Services phone number on your ID card or visit **Aetna**'s web site at [www.aetna.com](http://www.aetna.com).

## Effect of Benefits Under Other Plans (GR-9N 32-035-01)

### Effect of An Health Maintenance Organization Plan (HMO Plan) On Coverage

If you are in an eligible class and have chosen coverage under an HMO Plan offered by your employer, you will be excluded from medical expense coverage (except Vision Care), if any, on the date of your coverage under such HMO Plan.

If you are in an eligible class and are covered under an HMO Plan, you can choose to change to coverage for yourself and your covered dependents under this plan. If you:

- Live in an HMO Plan enrollment area and choose to change coverage during an open enrollment period, coverage will take effect on the group policy anniversary date after the open enrollment period. There will be no rules for waiting periods or preexisting conditions.
- Live in an HMO Plan enrollment area and choose to change coverage when there is not an open enrollment period, coverage will take effect only if and when **Aetna** gives its written consent.
- Move from an HMO Plan enrollment area or if the HMO discontinues and you choose to change coverage within 31 days of the move or the discontinuance, coverage will take effect on the date you elect such coverage. There will be no restrictions for waiting periods or preexisting conditions. If you choose to change coverage after 31 days, coverage will take effect only if and when **Aetna** gives its written consent.

Any extensions of benefits under this plan for disability or pregnancy will not always apply on and after the date of a change to an HMO Plan providing medical coverage. They will apply only if the person is not covered at once under the HMO Plan because he or she is in a **hospital** not affiliated with the HMO. If you give evidence that the HMO Plan provides an extension of benefits for disability or pregnancy, coverage under this plan will be extended. The extension will be for the same length of time and for the same conditions as the HMO Plan provides. It will not be longer than the first to occur of:

- The end of a 90 day period; and
- The date the person is not confined.

No benefits will be paid for any charges for services rendered or supplies furnished under an HMO Plan.

### Effect of Prior Coverage - Transferred Business (GR-9N 32-040 02 VA)

If your coverage under any part of this plan replaces any prior coverage for you, the rules below apply to that part.

"Prior coverage" is any plan of group coverage that has been replaced by coverage under part or all of this plan; it must have been sponsored by your employer (e.g., transferred business). The replacement can be complete or in part for the eligible class to which you belong. Any such plan is prior coverage if provided by another group contract or any benefit section of this plan.

Coverage under any other section of this plan will be in exchange for all privileges and benefits provided under any like prior coverage. Any benefits provided under such prior coverage may reduce benefits payable under this plan.

If:

- A dependent child's eligibility under the prior coverage is a result of his or her status as a full-time student at a postsecondary educational institution; and
- Such dependent child is in a period of coverage continuation pursuant to a medically necessary leave of absence from school (or change in full-time student status); and
- This plan provides coverage for eligible dependents;

coverage under any Major or Comprehensive Medical Expense Coverage section this plan will continue uninterrupted as to such dependent child for the remainder of the continuation period.

If part or all of your **deductible** under any section of a prior **Aetna** Major or Comprehensive Medical Expense Insurance Plan has been applied against covered medical expenses incurred by you, your **deductible** under any Comprehensive Medical Expense Coverage section of this plan will, for the calendar year in which you become covered, be reduced by the amount so applied. This will be done only if such expenses are incurred by you during:

- The calendar year in which you become covered under any Comprehensive Medical Expense Coverage section of this plan; or
- The last 3 months of the calendar year right before the year your coverage takes effect.

## **Discount Programs** (GR-9N-32-045-01 VA)

### **Discount Arrangements**

From time to time, we may offer, provide, or arrange for discount arrangements or special rates from certain service providers such as pharmacies, optometrists, **dentists**, alternative medicine, wellness and healthy living providers to you under this plan. Some of these arrangements may be made available through third parties who may make payments to **Aetna** in exchange for making these services available.

The third party service providers are independent contractors and are solely responsible to you for the provision of any such goods and/or services. We reserve the right to modify or discontinue such arrangements at any time. These discount arrangements are not insurance. There are no benefits payable to you nor do we compensate providers for services they may render through discount arrangements.

### **Incentives** (GR-9N-32-045-01 VA)

In order to encourage you to access certain medical services when deemed appropriate by you in consultation with your **physician** or other service providers, we may, from time to time, offer to waive or reduce a member's **copayment**, coinsurance, and/or a **deductible** otherwise required under the plan or offer coupons or other financial incentives. We have the right to determine the amount and duration of any waiver, reduction, coupon, or financial incentive and to limit the covered persons to whom these arrangements are available.

# Glossary

(GR-9N-34-005-01 VA)

In this section, you will find definitions for the words and phrases that appear in **bold type** throughout the text of this Booklet-Certificate.

## A (GR-9N-34-005-05)

### **Aetna**

**Aetna** Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

### **Ambulance**

A vehicle that is staffed with medical personnel and equipped to transport an ill or injured person.

### **Average Wholesale Price (AWP)**

The current **average wholesale price** of a **prescription drug** listed in the Facts and Comparisons weekly price updates (or any other similar publication designated by **Aetna**) on the day that a **pharmacy** claim is submitted for adjudication.

## B (GR-9N-34-010-01 VA)

### **Behavioral Health Provider/Practitioner**

A licensed organization or professional providing diagnostic, therapeutic or psychological services for behavioral health conditions.

### **Birthing Center**

A freestanding facility that meets **all** of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide prenatal care, delivery and immediate postpartum care.
- Charges for its services.
- Is directed by at least one **physician** who is a **specialist** in obstetrics and gynecology.
- Has a **physician** or certified nurse midwife present at all births and during the immediate postpartum period.
- Extends staff privileges to **physicians** who practice obstetrics and gynecology in an area **hospital**.
- Has at least 2 beds or 2 birthing rooms for use by patients while in labor and during delivery.
- Provides, during labor, delivery and the immediate postpartum period, full-time **skilled nursing services** directed by an **R.N.** or certified nurse midwife.
- Provides, or arranges with a facility in the area for, diagnostic X-ray and lab services for the mother and child.
- Has the capacity to administer a local anesthetic and to perform minor surgery. This includes episiotomy and repair of perineal tear.
- Is equipped and has trained staff to handle **emergency medical conditions** and provide immediate support measures to sustain life if:
  - Complications arise during labor; or
  - A child is born with an abnormality which impairs function or threatens life.
- Accepts only patients with low-risk pregnancies.
- Has a written agreement with a **hospital** in the area for emergency transfer of a patient or a child. Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. This includes reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient and child.

## Body Mass Index

This is a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

## Brand-Name Prescription Drug

A **prescription drug** with a proprietary name assigned to it by the manufacturer or distributor and so indicated by Medi-Span or any other similar publication designated by **Aetna** or an affiliate.

**C** (GR-9N-34-015-02 VA)

## Coinsurance

**Coinsurance** is both the percentage of **covered expenses** that the plan pays, and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as “plan **coinsurance**” and varies by the type of expense. Please refer to the *Schedule of Benefits* for specific information on **coinsurance** amounts.

## Coinsurance Limit

**Coinsurance limit** is the maximum out-of-pocket amount you are responsible to pay for **coinsurance** for **covered expenses** during your calendar year. Once you satisfy the **coinsurance limit**, the plan will pay 100% of the **covered expenses** that apply toward the limit for the rest of the calendar year.

## Copay or Copayment

The specific dollar amount or percentage required to be paid by you or on your behalf. The plan includes various **copayments**, and these **copayment** amounts or percentages are specified in the *Schedule of Benefits*.

## Cosmetic

Services or supplies that alter, improve or enhance appearance.

## Covered Expenses

Medical, dental, vision or hearing services and supplies shown as covered under this Booklet.

## Creditable Coverage

A person’s prior medical coverage as defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Such coverage includes:

- Health coverage issued on a group or individual basis;
- Medicare;
- Medicaid;
- Health care for members of the uniformed services;
- A program of the Indian Health Service;
- A state health benefits risk pool;
- The Federal Employees’ Health Benefit Plan (FEHBP);
- A public health plan (any plan established by a State, the government of the United States, or any subdivision of a State or of the government of the United States, or a foreign country);
- Any health benefit plan under Section 5(e) of the Peace Corps Act; and
- The State Children’s Health Insurance Program (S-CHIP).

## Custodial Care

Services and supplies that are primarily intended to help you meet personal needs. **Custodial care** can be prescribed by a **physician** or given by trained medical personnel. It may involve artificial methods such as feeding tubes, ventilators or catheters. Examples of **custodial care** include:

- Routine patient care such as changing dressings, periodic turning and positioning in bed, administering medications;
- Care of a stable tracheostomy (including intermittent suctioning);
- Care of a stable colostomy/ileostomy;
- Care of stable gastrostomy/jejunostomy/nasogastric tube (intermittent or continuous) feedings;
- Care of a stable indwelling bladder catheter (including emptying/changing containers and clamping tubing);
- Watching or protecting you;
- Respite care, adult (or child) day care, or convalescent care;
- Institutional care, including **room and board** for rest cures, adult day care and convalescent care;
- Help with the daily living activities, such as walking, grooming, bathing, dressing, getting in or out of bed, toileting, eating or preparing foods;
- Any services that a person without medical or paramedical training could be trained to perform; and
- Any service that can be performed by a person without any medical or paramedical training.

**D** (GR-9N-34-020-01 VA)

## Day Care Treatment

A **partial confinement treatment** program to provide treatment for you during the day. The **hospital, psychiatric hospital or residential treatment facility** does not make a room charge for **day care treatment**. Such treatment must be available for at least 4 hours, but not more than 12 hours in any 24-hour period.

## Deductible

The part of your **covered expenses** you pay before the plan starts to pay benefits. Additional information regarding **deductibles** and **deductible** amounts can be found in the *Schedule of Benefits*.

## Deductible Carryover

This allows you to apply any **covered expense** incurred during the last 3 months of a calendar year that is applied toward this year's **deductible** to also apply toward the following year's **deductible**.

## Dentist

A legally qualified **dentist**, or a **physician** licensed to do the dental work he or she performs.

## Detoxification

The process by which an alcohol-intoxicated or drug-intoxicated; or an alcohol-dependent or drug-dependent person is medically managed through the period of time necessary to eliminate, by metabolic or other means, the:

- Intoxicating alcohol or drug;
- Alcohol or drug-dependent factors; or
- Alcohol in combination with drugs;

as determined by a **physician**. The process must keep the physiological risk to the patient at a minimum, and take place in a facility that meets any applicable licensing standards established by the jurisdiction in which it is located.

## Directory

A listing of all **network providers** serving the class of employees to which you belong. The policyholder will give you a copy of this **directory**. **Network provider** information is available through **Aetna's** online provider **directory**, DocFind®. You can also call the Member Services phone number listed on your ID card to request a copy of this **directory**.

## Durable Medical and Surgical Equipment (DME)

Equipment, and the accessories needed to operate it, that is:

- Made to withstand prolonged use;
- Made for and mainly used in the treatment of an **illness** or **injury**;
- Suited for use in the home;
- Not normally of use to people who do not have an **illness** or **injury**;
- Not for use in altering air quality or temperature; and
- Not for exercise or training.

**Durable medical and surgical equipment** does not include equipment such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, over bed tables, elevators, communication aids, vision aids and telephone alert systems.

## E (GR-9N 34-025 04)

### Emergency Care

This means the treatment given in a **hospital's** emergency room to evaluate and treat an **emergency medical condition**.

### Emergency Medical Condition

A recent and severe medical condition, including (but not limited to) severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, **illness**, or **injury** is of such a nature that failure to get immediate medical care could result in:

- Placing your health in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of a body part or organ; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

### Experimental or Investigational

Except as provided for under the Clinical Trials benefit provision, a drug, a device, a procedure, or treatment will be determined to be **experimental or investigational** if:

- There is not enough outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the **illness** or **injury** involved; or
- Approval required by the FDA has not been granted for marketing; or
- A recognized national medical or dental society or regulatory agency has determined, in writing, that it is **experimental or investigational**, or for research purposes; or
- It is a type of drug, device or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of “phases” indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same:
  - drug;
  - device;
  - procedure; or

- treatment.

It also includes the written informed consent used by:

- the treating facility; or
- by another facility studying the same:
  - drug;
  - device;
  - procedure; or
  - treatment.

that states that it is **experimental or investigational**, or for research purposes.

## **G** (GR-9N 34-035 01)

### **Generic Prescription Drug**

A **prescription drug**, that is identified by its:

- chemical;
- proprietary; or
- non-proprietary name; and
- is accepted by the U.S. Food and Drug Administration as therapeutically the same; and
- can be replaced with drugs with the same amount of active ingredient; and
- so stated by Medispan or any other publication named by **Aetna** or consort.

## **H** (GR-9N-34-040-02 VA)

### **Homebound**

This means that you are confined to your place of residence:

- Due to an **illness** or **injury** which makes leaving the home medically contraindicated; or
- Because the act of transport would be a serious risk to your life or health.

Situations where you would not be considered **homebound** include (but are not limited to) the following:

- You do not often travel from home because of feebleness or insecurity brought on by advanced age (or otherwise); or
- You are wheelchair bound but could safely be transported via wheelchair accessible transportation.

### **Home Health Care Agency**

An agency that meets all of the following requirements.

- Mainly provides skilled nursing and other therapeutic services.
- Is associated with a professional group (of at least one **physician** and one **R.N.**) which makes policy.
- Has full-time supervision by a **physician** or an **R.N.**
- Keeps complete medical records on each person.
- Has an administrator.
- Meets licensing standards.

## Home Health Care Plan

This is a plan that provides for continued care and treatment of an **illness** or **injury**. The care and treatment must be:

- Prescribed in writing by the attending **physician**; and
- An alternative to a **hospital** or **skilled nursing facility stay**.

## Hospice Care

This is care given to a **terminally ill** person by or under arrangements with a **hospice care agency**. The care must be part of a **hospice care program**.

## Hospice Care Agency

An agency or organization that meets all of the following requirements:

- Has **hospice care** available 24 hours a day.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Provides:
  - **Skilled nursing services**;
  - Medical social services; and
  - Psychological and dietary counseling.
- Provides, or arranges for, other services which include:
  - **Physician** services;
  - Physical and occupational therapy;
  - Part-time home health aide services which mainly consist of caring for **terminally ill** people; and
  - Inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has at least the following personnel:
  - One **physician**;
  - One **R.N.**; and
  - One licensed or certified social worker employed by the agency.
- Establishes policies about how **hospice care** is provided.
- Assesses the patient's medical and social needs.
- Develops a **hospice care program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Uses volunteers trained in providing services for non-medical needs.
- Has a full-time administrator.

## Hospice Care Program

This is a written plan of **hospice care**, which:

- Is established by and reviewed from time to time by a **physician** attending the person, and appropriate personnel of a **hospice care agency**;
- Is designed to provide palliative and supportive care to **terminally ill** persons, and supportive care to their families; and
- Includes an assessment of the person's medical and social needs; and a description of the care to be given to meet those needs.

## Hospice Facility

A facility, or distinct part of one, that meets all of the following requirements:

- Mainly provides inpatient **hospice care** to **terminally ill** persons.
- Charges patients for its services.
- Meets any licensing or certification standards established by the jurisdiction where it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program including reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**. At least one staff **physician** must be on call at all times.
- Provides 24-hour-a-day nursing services under the direction of an **R.N.**
- Has a full-time administrator.

## Hospital

An institution that:

- Is primarily engaged in providing, on its premises, inpatient medical, surgical and diagnostic services;
- Is supervised by a staff of **physicians**;
- Provides twenty-four (24) hour-a-day **R.N.** service,
- Charges patients for its services;
- Is operating in accordance with the laws of the jurisdiction in which it is located; and
- Does not meet all of the requirements above, but does meet the requirements of the jurisdiction in which it operates for licensing as a **hospital** and is accredited as a **hospital** by the Joint Commission on the Accreditation of Healthcare Organizations.

**In no event** does **hospital** include a convalescent nursing home or any institution or part of one which is used principally as a convalescent facility, rest facility, nursing facility, facility for the aged, extended care facility, intermediate care facility, **skilled nursing facility**, hospice, rehabilitative **hospital** or facility primarily for rehabilitative or custodial services.

## Hospitalization

A continuous confinement as an inpatient in a **hospital** for which a **room and board** charge is made.

## I

(GR-9N 34-045 02)

## Illness

A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to the findings set the condition apart as an abnormal entity differing from other normal or pathological body states.

## Infertile or Infertility

The condition of a presumably healthy covered person who is unable to conceive or produce conception after:

- *For a woman who is under 35 years of age:* 1 year or more of timed, unprotected coitus, or 12 cycles of artificial insemination; or
- *For a woman who is 35 years of age or older:* 6 months or more of timed, unprotected coitus, or 6 cycles of artificial insemination.

## **Injury**

An accidental bodily **injury** that is the sole and direct result of:

- An unexpected or reasonably unforeseen occurrence or event; or
- The reasonable unforeseeable consequences of a voluntary act by the person.
- An act or event must be definite as to time and place.

## **J** (GR-9N 34-050 01)

### **Jaw Joint Disorder** (GR-9N 34-050 01)

This is:

- A Temporomandibular Joint (TMJ) dysfunction or any alike disorder of the jaw joint; or
- A Myofacial Pain Dysfunction (MPD); or
- Any alike disorder in the relationship of the jaw joint and the related muscles and nerves.

## **L** (GR-9N 34-055 01)

### **Late Enrollee**

This is an employee in an Eligible Class who asked for enrollment under this Plan after the Initial Enrollment Period. Also, this is an eligible dependent for whom the employee did not choose coverage for the Initial Enrollment Period, but for whom coverage is asked for at a later time.

An eligible employee or dependent may not be considered a **Late Enrollee** at certain times. See the Special Enrollment Periods section of the (Booklet-Certificate).

### **L.P.N.**

A licensed practical or vocational nurse.

## **M** (GR-9N-34-065-03 VA)

### **Mail Order Pharmacy**

An establishment where **prescription drugs** are legally given out by mail or other carrier.

### **Maintenance Care**

Care made up of services and supplies that:

- Are given mainly to maintain, rather than to improve, a level of physical, or mental function; and
- Give a surrounding free from exposures that can worsen the person's physical or mental condition.

## Medically Necessary or Medical Necessity

These are health care or dental services, and supplies or **prescription drugs** that a **physician**, other health care provider or **dental provider**, exercising prudent clinical judgment, would give to a patient for the purpose of:

- preventing;
- evaluating;
- diagnosing; or
- treating:
  - an **illness**;
  - an **injury**;
  - a disease; or
  - its symptoms.

The provision of the service, supply or **prescription drug** must be:

- a) In accordance with generally accepted standards of medical or dental practice;
- b) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease; and
- c) Not mostly for the convenience of the patient, **physician**, other health care or **dental provider**; and
- d) And do not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury**, or disease.

For these purposes “generally accepted standards of medical or dental practice” means standards that are based on credible scientific evidence published in peer-reviewed literature. They must be generally recognized by the relevant medical or dental community. Otherwise, the standards are consistent with **physician** or dental specialty society recommendations. They must be consistent with the views of **physicians** or **dentists** practicing in relevant clinical areas and any other relevant factors.

## Mental Disorder

An **illness** commonly understood to be a **mental disorder**, whether or not it has a physiological basis, and for which treatment is generally provided by or under the direction of a **behavioral health provider** such as a **psychiatric physician**, a psychologist or a psychiatric social worker.

Any one of the following conditions is a **mental disorder** under this plan:

- Anorexia/Bulimia Nervosa.
- Bipolar disorder.
- Major depressive disorder.
- Obsessive compulsive disorder.
- Panic disorder.
- Pervasive developmental disorder (including Autism).
- Psychotic disorders/Delusional disorder.
- Schizo-affective disorder.
- Schizophrenia.

Also included is any other mental condition which requires **Medically Necessary** treatment.

## Morbid Obesity

This means a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables; and a **Body Mass Index** that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; cardiopulmonary conditions; sleep apnea; or diabetes.

## Negotiated Charge

As to health expense coverage, other than Prescription Drug Expense Coverage:

The **negotiated charge** is the maximum charge a **network provider** has agreed to make as to any service or supply for the purpose of the benefits under this plan.

As to Prescription Drug Expense Coverage:

The **negotiated charge** is the amount **Aetna** has established for each **prescription drug** obtained from a **network pharmacy** under this plan. This **negotiated charge** may reflect amounts **Aetna** has agreed to pay directly to the **network pharmacy** or to a third party vendor for the **prescription drug**, and may include an additional service or risk charge set by **Aetna**.

The **negotiated charge** does not include or reflect any amount **Aetna**, an affiliate, or a third party vendor, may receive under a rebate arrangement between **Aetna**, an affiliate or a third party vendor and a drug manufacturer for any **prescription drug**, including **prescription drugs** on the **preferred drug guide**.

Based on its overall drug purchasing, **Aetna** may receive rebates from the manufacturers of **prescription drugs** and may receive or pay additional amounts from or to third parties under price guarantees. These amounts will not change the **negotiated charge** under this plan.

## Network Advanced Reproductive Technology (ART) Specialist

A specialist **physician** who has entered into a contractual agreement with **Aetna** for the provision of covered **Advanced Reproductive Technology (ART)** services.

## Network Provider

A **pharmacy** who has contracted to furnish services or supplies for this plan; but only if the provider is, with **Aetna's** consent, included in the **directory** as a **network provider** for:

- The service or supply involved; and
- The class of employees to which you belong.

## Night Care Treatment

A **partial confinement treatment** program provided when you need to be confined during the night. A room charge is made by the **hospital, psychiatric hospital** or **residential treatment facility**. Such treatment must be available at least:

- 8 hours in a row a night; and
- 5 nights a week.

## Non-Occupational Illness

A **non-occupational illness** is an **illness** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **illness** that does.

An **illness** will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- Is covered under any type of workers' compensation law; and
- Is not covered for that **illness** under such law.

## **Non-Occupational Injury**

A **non-occupational injury** is an accidental bodily **injury** that does not:

- Arise out of (or in the course of) any work for pay or profit; or
- Result in any way from an **injury** which does.

## **Non-Specialist**

A **physician** who is not a **specialist**.

## **Non-Urgent Admission**

An inpatient admission that is not an **emergency admission** or an **urgent admission**.

**O** (GR-9N-34-075-01 VA)

## **Occupational Injury or Occupational Illness**

An **injury** or **illness** that:

- Arises out of (or in the course of) any activity in connection with employment or self-employment whether or not on a full time basis; or
- Results in any way from an **injury** or **illness** that does.

## **Occurrence**

This means a period of disease or **injury**. An **occurrence** ends when 60 consecutive days have passed during which the covered person:

- Receives no medical treatment; services; or supplies; for a disease or **injury**; and
- Neither takes any medication, nor has any medication prescribed, for a disease or **injury**.

## **Orthodontic Treatment** (GR-9N-34-075-01 VA)

This is any:

- Medical service or supply; or
- Dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- Of the teeth; or
- Of the bite; or
- Of the jaws or jaw joint relationship; whether or not for the purpose of relieving pain.

The following are not considered **orthodontic treatment**:

- The installation of a space maintainer; or
- A surgical procedure to correct malocclusion.

## **Out-of-Network Provider**

A **pharmacy** who has not contracted with **Aetna**, an affiliate, or a third party vendor, to furnish services or supplies at a for this plan.

## **Partial Confinement Treatment**

A plan of medical, psychiatric, nursing, counseling, or therapeutic services to treat **substance abuse** or **mental disorders**. The plan must meet these tests:

- It is carried out in a **hospital; psychiatric hospital or residential treatment facility**; on less than a full-time inpatient basis.
- It is in accord with accepted medical practice for the condition of the person.
- It does not require full-time confinement.
- It is supervised by a **psychiatric physician** who weekly reviews and evaluates its effect.
- **Day care treatment** and **night care treatment** are considered **partial confinement treatment**.

## **Pharmacy**

An establishment where **prescription drugs** are legally dispensed. **Pharmacy** includes a retail **pharmacy**, **mail order pharmacy** and **specialty pharmacy network pharmacy**.

## **Physician**

A duly licensed member of a medical profession who:

- Has an M.D. or D.O. degree;
- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where the individual practices; and
- Provides medical services which are within the scope of his or her license or certificate.

This also includes a health professional who:

- Is properly licensed or certified to provide medical care under the laws of the jurisdiction where he or she practices;
- Provides medical services which are within the scope of his or her license or certificate;
- Under applicable insurance law is considered a "physician" for purposes of this coverage;
- Has the medical training and clinical expertise suitable to treat your condition;
- Specializes in psychiatry, if your **illness** or **injury** is caused, to any extent, by alcohol abuse, substance abuse or a mental disorder; and
- A physician is not you or related to you.

## **Precertification or Precertify**

A process where **Aetna** is contacted before certain services are provided, such as **hospitalization** or outpatient surgery, or **prescription drugs** are prescribed to determine whether the services being recommended or the drugs prescribed are considered **covered expenses** under the plan. It is not a guarantee that benefits will be payable.

## **Preferred Drug Guide**

A listing of **prescription drugs** established by **Aetna** or an affiliate, which includes both **brand name prescription drugs** and **generic prescription drugs**. This list is subject to periodic review and modification by **Aetna** or an affiliate. A copy of the **preferred drug guide** will be available upon your request or may be accessed on the **Aetna** website at [www.Aetna.com/formulary](http://www.Aetna.com/formulary).

## **Preferred Drug Guide Exclusions List**

A list of **prescription drugs** in the **preferred drug guide** that are identified as excluded under the plan. This list is subject to periodic review and modification by **Aetna**.

## Prescriber

Any **physician** or **dentist**, acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

## Prescription

An order for the dispensing of a **prescription drug** by a **prescriber**. If it is an oral order, it must be promptly put in writing by the pharmacy.

## Prescription Drug

A drug, biological, or compounded **prescription** which, by State and Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription." This includes:

- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include injectable insulin.

## Psychiatric Hospital

This is an institution that meets all of the following requirements.

- Mainly provides a program for the diagnosis, evaluation, and treatment of alcoholism, substance abuse or **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a **psychiatric physician** who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a **psychiatric physician** present during the whole treatment day.
- Provides, at all times, **psychiatric** social work and nursing services.
- Provides, at all times, **skilled nursing services** by licensed nurses who are supervised by a full-time **R.N.**
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a **psychiatric physician**.
- Makes charges.
- Meets licensing standards.

## Psychiatric Physician

This is a **physician** who:

- Specializes in psychiatry; or
- Has the training or experience to do the required evaluation and treatment of alcoholism, substance abuse or **mental disorders**.

**R** (GR-9N-34-090-01 VA)

## Recognized Charge

Only that part of a charge which is recognized is a **covered benefit**. The **recognized charge** for a service or supply is the amount billed by the **provider**.

## Rehabilitation Facility

A facility, or a distinct part of a facility which provides **rehabilitative services**, meets any licensing or certification standards established by the jurisdiction where it is located, and makes charges for its services.

## Rehabilitative Services

The combined and coordinated use of medical, social, educational and vocational measures for training or retraining if you are disabled by **illness or injury**.

## Residential Treatment Facility (Mental Disorders)

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

## Residential Treatment Facility (Substance Abuse)

This is an institution that meets all of the following requirements:

- On-site licensed **Behavioral Health Provider** 24 hours per day/7 days a week.
- Provides a comprehensive patient assessment (preferably before admission, but at least upon admission).
- Is admitted by a **Physician**.
- Has access to necessary medical services 24 hours per day/7 days a week.
- If the member requires **detoxification** services, must have the availability of on-site medical treatment 24 hours per day/7 days a week, which must be actively supervised by an attending **Physician**.
- Provides living arrangements that foster community living and peer interaction that are consistent with developmental needs.
- Offers group therapy sessions with at least an RN or Masters-Level Health Professional.
- Has the ability to involve family/support systems in therapy (required for children and adolescents; encouraged for adults).
- Provides access to at least weekly sessions with a **Psychiatrist** or psychologist for individual psychotherapy.
- Has peer oriented activities.
- Services are managed by a licensed **Behavioral Health Provider** who, while not needing to be individually contracted, needs to (1) meet the **Aetna** credentialing criteria as an individual practitioner, and (2) function under the direction/supervision of a licensed psychiatrist (Medical Director).
- Has individualized active treatment plan directed toward the alleviation of the impairment that caused the admission.
- Provides a level of skilled intervention consistent with patient risk.
- Meets any and all applicable licensing standards established by the jurisdiction in which it is located.
- Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.
- Ability to assess and recognize withdrawal complications that threaten life or bodily functions and to obtain needed services either on site or externally.

- 24-hours per day/7 days a week supervision by a **physician** with evidence of close and frequent observation.
- On-site, licensed **Behavioral Health Provider**, medical or **substance abuse** professionals 24 hours per day/7 days a week.

## R.N.

A registered nurse.

## Room and Board

Charges made by an institution for **room and board** and other **medically necessary** services and supplies. The charges must be regularly made at a daily or weekly rate.

## S (GR-9N 34-095-05)

## Self-injectable Drug(s)

**Prescription drugs** that are intended to be self-administered by injection to a specific part of the body to treat medical conditions.

## Semi-Private Room Rate

The **room and board** charge that an institution applies to the most beds in its semi-private rooms with 2 or more beds. If there are no such rooms, **Aetna** will figure the rate based on the rate most commonly charged by similar institutions in the same geographic area.

## Skilled Nursing Facility

An institution that meets all of the following requirements:

- It is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from **illness** or **injury**:
  - Professional nursing care by an **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  - Physical restoration services to help patients to meet a goal of self-care in daily living activities.
- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or an **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of **mental disorders**.
- Charges patients for its services.
- An institution or a distinct part of an institution that meets all of the following requirements:
  - It is licensed or approved under state or local law.
  - Is primarily engaged in providing skilled nursing care and related services for residents who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.
- Qualifies as a **skilled nursing facility** under Medicare or as an institution accredited by:
  - The Joint Commission on Accreditation of Health Care Organizations;
  - The Bureau of **Hospitals** of the American Osteopathic Association; or
  - The Commission on the Accreditation of Rehabilitative Facilities

**Skilled nursing facilities** also include rehabilitation **hospitals** (all levels of care, e.g. acute) and portions of a **hospital** designated for skilled or **rehabilitation services**.

**Skilled nursing facility** does not include:

- Institutions which provide only:
  - Minimal care;
  - Custodial care services;
  - Ambulatory; or
  - Part-time care services.
- Institutions which primarily provide for the care and treatment of alcoholism, **substance abuse** or **mental disorders**.

## **Skilled Nursing Services**

Services that meet all of the following requirements:

- The services require medical or paramedical training.
- The services are rendered by an **R.N.** or **L.P.N.** within the scope of his or her license.
- The services are not custodial.

## **Specialist**

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

## **Specialty Care**

Health care services or supplies that require the services of a **specialist**.

## **Specialty Care Drugs**

**Prescription drugs** include **injectable**, infusion and oral drugs prescribed to address complex, chronic diseases with associated comorbidities such as cancer, rheumatoid arthritis, hemophilia, multiple sclerosis which are listed in the **specialty care drug list**.

## **Specialty Pharmacy Network**

A network of pharmacies designated to fill **specialty care drugs**.

## **Stay**

A full-time inpatient confinement for which a **room and board** charge is made.

## **Step Therapy**

A form of **precertification** under which certain **prescription drugs** will be excluded from coverage, unless a first-line therapy drug(s) is used first by you. The list of step-therapy drugs is subject to change by **Aetna** or an affiliate. An updated copy of the list of drugs subject to **step therapy** shall be available upon request by you or may be accessed on the **Aetna** website at [www.Aetna.com/formulary](http://www.Aetna.com/formulary).

## **Substance Abuse**

This is a physical or psychological dependency, or both, on a controlled substance or alcohol agent (These are defined on Axis I in the Diagnostic and Statistical Manual of **Mental Disorders** (DSM) published by the American Psychiatric Association which is current as of the date services are rendered to you or your covered dependents.) This term does not include conditions not attributable to a **mental disorder** that are a focus of attention or treatment (the V codes on Axis I of DSM); an addiction to nicotine products, food or caffeine intoxication.

## **Surgery Center**

A freestanding ambulatory surgical facility that meets all of the following requirements:

- Meets licensing standards.
- Is set up, equipped and run to provide general surgery.
- Charges for its services.

- Is directed by a staff of **physicians**. At least one of them must be on the premises when surgery is performed and during the recovery period.
- Has at least one certified anesthesiologist at the site when surgery requiring general or spinal anesthesia is performed and during the recovery period.
- Extends surgical staff privileges to:
  - **Physicians** who practice surgery in an area **hospital**; and
  - **Dentists** who perform oral surgery.
- Has at least 2 operating rooms and one recovery room.
- Provides, or arranges with a medical facility in the area for, diagnostic x-ray and lab services needed in connection with surgery.
- Does not have a place for patients to **stay** overnight.
- Provides, in the operating and recovery rooms, full-time **skilled nursing services** directed by an **R.N.**
- Is equipped and has trained staff to handle **emergency medical conditions**.

Must have all of the following:

- A **physician** trained in cardiopulmonary resuscitation; and
- A defibrillator; and
- A tracheotomy set; and
- A blood volume expander.
- Has a written agreement with a **hospital** in the area for immediate emergency transfer of patients.
- Written procedures for such a transfer must be displayed and the staff must be aware of them.
- Provides an ongoing quality assurance program. The program must include reviews by **physicians** who do not own or direct the facility.
- Keeps a medical record on each patient.

## **T** (GR-9N 34-100-02)

### **Terminally Ill (Hospice Care)**

**Terminally ill** means a medical prognosis of 12 months or less to live.

### **Therapeutic Drug Class**

A group of drugs or medications that have a similar or identical mode of action or exhibit similar or identical outcomes for the treatment of a disease or **injury**.

## **U** (GR-9N-34-105-01)

### **Urgent Admission**

A **hospital** admission by a **physician** due to:

- The onset of or change in an **illness**; or
- The diagnosis of an **illness**; or
- An **injury**.
- The condition, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

## Urgent Care Provider

This is:

- A freestanding medical facility that meets all of the following requirements.
  - Provides unscheduled medical services to treat an **urgent condition** if the person's **physician** is not reasonably available.
  - Routinely provides ongoing unscheduled medical services for more than 8 consecutive hours.
  - Makes charges.
  - Is licensed and certified as required by any state or federal law or regulation.
  - Keeps a medical record on each patient.
  - Provides an ongoing quality assurance program. This includes reviews by **physicians** other than those who own or direct the facility.
  - Is run by a staff of **physicians**. At least one **physician** must be on call at all times.
  - Has a full-time administrator who is a licensed **physician**.
- A **physician**'s office, but only one that has contracted with **Aetna** to provide urgent care.

It is not the emergency room or outpatient department of a **hospital**.

## Urgent Condition

This means a sudden **illness; injury**; or condition; that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of your health;
- Includes a condition which would subject you to severe pain that could not be adequately managed without urgent care or treatment;
- Does not require the level of care provided in the emergency room of a hospital; and
- Requires immediate outpatient medical care that cannot be postponed until your physician becomes reasonably available.

## **Additional Information Provided by Booz Allen Hamilton**

The following information is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). It is not a part of your booklet-certificate. Your Plan Administrator has determined that this information together with the information contained in your booklet-certificate is the Summary Plan Description required by ERISA.

In furnishing this information, Aetna is acting on behalf of your Plan Administrator who remains responsible for complying with the ERISA reporting rules and regulations on a timely and accurate basis.

**Name of Plan:**

Booz Allen Hamilton's Welfare Plan

**Employer Identification Number:**

**Plan Number:**

504

**Type of Plan:**

Welfare

**Type of Administration:**

Group Insurance Policy with:

Aetna Life Insurance Company 151 Farmington Avenue  
Hartford, CT 06156

**Plan Administrator:** Booz Allen Hamilton 8283 Greensboro Dr.  
McLean, VA 22102

**Agent For Service of Legal Process:**

Booz Allen Hamilton 8283 Greensboro Dr.  
McLean, VA 22102

Service of legal process may also be made upon the Plan Administrator

**End of Plan Year:**

December 31

**Source of Contributions:**

Employer

**Procedure for Amending the Plan:**

The Employer may amend the Plan from time to time by a written instrument signed by Plan Administrator.

## **ERISA Rights**

As a participant in the group insurance plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974. ERISA provides that all plan participants shall be entitled to:

### **Receive Information about Your Plan and Benefits**

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

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

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

Receive a copy of the procedures used by the Plan for determining a qualified domestic relations order (QDRO) or a qualified medical child support order (QMCSO).

### **Continue Group Health Plan Coverage**

Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan for the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to preexisting condition exclusion for 12 months after your enrollment date in your coverage under this Plan. Contact your Plan Administrator for assistance in obtaining a certificate of creditable coverage.

### **Prudent Actions by Plan Fiduciaries**

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

### **Enforce Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain 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 materials from the 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 up to \$ 110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the 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. In addition, if you disagree with the Plan's decision or lack thereof concerning the 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 plan fiduciaries misuse the Plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If 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 Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA, 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.

### **Statement of Rights under the Newborns' and Mothers' Health Protection Act**

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section.

However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that you, your physician, or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). For information on precertification, contact your plan administrator.

### **Notice Regarding Women's Health and Cancer Rights Act**

Under this health plan, as required by the Women's Health and Cancer Rights Act of 1998, coverage will be provided to a person who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with the mastectomy for:

- (1) all stages of reconstruction of the breast on which a mastectomy has been performed;
- (2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
- (3) prostheses; and
- (4) treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be provided in accordance with the plan design, limitations, copays, deductibles, and referral requirements, if any, as outlined in your plan documents.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on your ID card.

For more information, you can visit this U.S. Department of Health and Human Services website, <http://www.cms.gov/home/regsguidance.asp>, and this U.S. Department of Labor website, [http://www.dol.gov/ebsa/consumer\\_info\\_health.html](http://www.dol.gov/ebsa/consumer_info_health.html).

## **Confidentiality Notice**

Aetna considers personal information to be confidential and has policies and procedures in place to protect it against unlawful use and disclosure. By "personal information," we mean information that relates to a member's physical or mental health or condition, the provision of health care to the member, or payment for the provision of health care or disability or life benefits to the member. Personal information does not include publicly available information or information that is available or reported in a summarized or aggregate fashion but does not identify the member.

When necessary or appropriate for your care or treatment, the operation of our health, disability or life insurance plans, or other related activities, we use personal information internally, share it with our affiliates, and disclose it to health care providers (doctors, dentists, pharmacies, hospitals and other caregivers), payors (health care provider organizations, employers who sponsor self-funded health plans or who share responsibility for the payment of benefits, and others who may be financially responsible for payment for the services or benefits you receive under your plan), other insurers, third party administrators, vendors, consultants, government authorities, and their respective agents. These parties are required to keep personal information confidential as provided by applicable law. In our health plans, participating network providers are also required to give you access to your medical records within a reasonable amount of time after you make a request.

Some of the ways in which personal information is used include claim payment; utilization review and management; medical necessity reviews; coordination of care and benefits; preventive health, early detection, vocational rehabilitation and disease and case management; quality assessment and improvement activities; auditing and anti-fraud activities; performance measurement and outcomes assessment; health, disability and life claims analysis and reporting; health services, disability and life research; data and information systems management; compliance with legal and regulatory requirements; formulary management; litigation proceedings; transfer of policies or contracts to and from other insurers, HMOs and third party administrators; underwriting activities; and due diligence activities in connection with the purchase or sale of some or all of our business. We consider these activities key for the operation of our health, disability and life plans. To the extent permitted by law, we use and disclose personal information as provided above without member consent. However, we recognize that many members do not want to receive unsolicited marketing materials unrelated to their health, disability and life benefits. We do not disclose personal information for these marketing purposes unless the member consents. We also have policies addressing circumstances in which members are unable to give consent.

To obtain a copy of our Notice of Privacy Practices, which describes in greater detail our practices concerning use and disclosure of personal information, please call the toll-free Member Services number on your ID card or visit our Internet site at [www.aetna.com](http://www.aetna.com).

## Group Personal Excess Liability Policy

CHUBB®

## Coverage Summary

**Chubb Group of Insurance  
Companies  
PO BOX 1600,  
Whitehouse Station, NJ  
08889-1600**

Name and address  
of Insured

Policy Number:

BOOZ  
ALLEN HAMILTON INC

Group Personal Excess  
Program

GREENSBORO DRIVE  
MCLEAN, VIRGINIA  
22102

Issued by the stock insurance  
company indicated below,  
herein called the company.

**FEDERAL INSURANCE  
COMPANY**

Producer No.: 0017811

Incorporated under the laws of  
INDIANA

Sponsoring Organization  
and Address

Booz Allen Hamilton Inc.  
8283 Greensboro Dr.  
McLean, VA 22102

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**Policy Period**

From: JANUARY 01, 2018 To: JANUARY 01, 2019  
12:01 A.M. Standard Time at the Named Insured' s mailing address.

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**Premium**

Amount  
\$156,652.00

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**Limit Of Liability**

SEE ENDT Each  
Occurrence  
\$2,000,000 Excess Uninsured / Underinsured  
Motorists Protection Each  
Occurrence

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**Required Primary Underlying Insurance**

Personal Liability (Homeowners) for personal injury and property damage in the minimum amount of \$300,000 each occurrence.

Registered vehicles in the minimum amount of \$250,000 / \$500,000 bodily injury and \$100,000 property damage; or \$300,000 single limit each occurrence.

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**Required Primary Underlying Insurance**

*(continued)*

Unregistered vehicles in the minimum amount of \$300,000 bodily injury and property damage each occurrence.

Registered vehicles with less than four wheels and motorhomes in the minimum amount \$250,000 / \$500,000 bodily injury and \$100,000 property damage; or \$300,000 single limit each occurrence.

Watercraft less than 26 feet and 50 engine rated horsepower or less for bodily and property damage in the minimum amount of \$300,000 each occurrence.

Watercraft 26 feet or longer or more than 50 engine rated horsepower for bodily injury and property damage in the minimum amount of \$500,000 each occurrence.

Uninsured motorists/underinsured motorists protection in the minimum amount of \$250,000 / \$500,000 bodily injury and \$100,000 property damage; or \$300,000 single limit occurrence.

**FAILURE TO COMPLY WITH THE REQUIRED PRIMARY UNDERLYING INSURANCE WILL RESULT IN A GAP IN COVERAGE.**

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Group Personal Excess Liability Policy

CHUBB®

Coverage Summary

Effective Date JANUARY 01,

2018

Policy Number

Authorization

In Witness Whereof, the company issuing this policy has caused this policy to be signed by its authorized officers and signed by a duly authorized representative of the company.

FEDERAL INSURANCE COMPANY



President



Secretary



Authorized Representative

Date

December 29, 2017

Producer's Name & Address

MARSH USA, INC. (SOUTHWEST)  
7201 W LK MEAD BLVD #400  
LAS VEGAS, NV 89128-0000

**Chubb. Insured**

Policy Number:  
 Insured: BOOZ ALLEN HAMILTON INC

Group Personal Excess Program

Policy Period From: JANUARY 01, 2018 to JANUARY 01, 2019

The following is a schedule of forms issued with the policy at inception:

<b>Form Name</b>	<b>Form Number</b>
PRIVACY NOTICE - GROUP MASTER POLICY	10-02-1058 (10/16)
IMPORTANT NOTICE - OFAC	99-10-0796 (09/04)
AOD POLICYHOLDER NOTICE	99-10-0872 (06/07)
COVERAGE SUMMARY/DECLARATIONS	10-02-0690 (08/07)
GROUP PERSONAL EXCESS - CONTRACT/POLICY TERMS	10-02-0691 (07/16)
ANNUAL PREMIUM ADJUSTMENT CLAUSE	10-02-0692 (08/96)
NAMED INSURED ENDORSEMENT	10-02-0692 (08/96)
UNDERLYING LIMITS ENDORSEMENT	10-02-0692 (08/96)

**GROUP PERSONAL  
EXCESS LIABILITY  
POLICY**

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## GROUP PERSONAL EXCESS LIABILITY POLICY

## INTRODUCTION

This is your Chubb Group Personal Excess Liability Policy. Together with your Coverage Summary, it explains your coverages and other conditions of your insurance in detail.

This policy is a contract between you and us. READ YOUR POLICY CAREFULLY and keep it in a safe place.

**Agreement**

We agree to provide the insurance described in this policy in return for the premium paid by you or the Sponsoring Organization and your compliance with the policy conditions.

**Definitions**

In this policy, we use words in their plain English meaning. Words with special meanings are defined in the part of the policy where they are used. The few defined terms used throughout the policy are defined here:

**You** means the individual who is a member of the Defined Group shown as the Insured named in the Coverage Summary.

**Spouse** means a partner in marriage or a partner in a civil union recognized under state law and who lives with you.

**We and us** mean the insurance company named in the Coverage Summary.

**Family member** means your spouse or domestic partner or other relative who lives with you, or any other person under 25 in your care or your relative's care who lives with you.

**Domestic partner** means a person in a legal or personal relationship with you, who lives with you and shares a common domestic life with you, and meeting all of the benefits eligibility criteria as defined by the Sponsoring Organization.

**Sponsoring Organization** means the entity, corporation, partnership or sole proprietorship sponsoring and defining the criteria for qualification as an Insured.

**Policy** means your entire Group Personal Excess Liability Policy, including the Coverage Summary.

**Coverage Summary** means the most recent Coverage Summary we issued to you, including any endorsements.

**Occurrence** means an accident or offense to which this insurance applies and which begins within the policy period. Continuous or repeated exposure to substantially the same general conditions unless excluded is considered to be one occurrence.

**Business** means any employment, trade, occupation, profession, or farm operation including the raising or care of animals or any activities intended to realize a benefit or financial gain engaged in on a full-time, part-time or occasional basis.

**Defined Group** means those individuals meeting the criteria for qualification as an Insured as defined by the Sponsoring Organization and accepted by us.

**Follow form** means we cover damages to the extent they are both covered under the Required Primary Underlying Insurance and, not excluded under this policy. Also, the amount of coverage, defense coverages, cancellation and "other insurance" provisions of this policy supersede and replace the similar provisions contained in such other policies. When this policy is called upon to pay losses in excess of required primary underlying policies exhausted by payment of claims, we do not provide broader coverage than provided by such policies. When no primary underlying coverage exists, the extent of coverage provided on a follow form basis will be determined as if the required primary underlying insurance had been purchased from us.

**Covered person** means:

- you or a family member;
- any person using a vehicle or watercraft covered under this policy with permission from you or a family member with respect to their legal responsibility arising out of its use;
- any other person who is a covered person under your Required Primary Underlying Insurance;
- any person or organization with respect to their legal responsibility for covered acts or omissions of you or a family member; or
- any combination of the above.

## Definitions

(continued)

**Damages** mean the sum that is paid or is payable to satisfy a claim settled by us or resolved by judicial procedure or by a compromise we agree to in writing.

**Personal injury** means the following injuries, and resulting death:

- bodily injury;
- shock, mental anguish, or mental injury;
- false arrest, false imprisonment, or wrongful detention;
- wrongful entry or eviction;
- malicious prosecution or humiliation; and
- libel, slander, defamation of character, or invasion of privacy.

**Bodily injury** means physical bodily harm, including sickness or disease that results from it, and required care, loss of services and resulting death.

**Property damage** means physical injury to or destruction of tangible property and the resulting loss of its use. Tangible property includes the cost of recreating or replacing stocks, bonds, deeds, mortgages, bank deposits, and similar instruments, but does not include the value represented by such instruments. Tangible property does not include the cost of recreating or replacing any software, data or other information that is in electronic form.

**Registered vehicle** means any motorized land vehicle not described in "unregistered vehicle."

**Unregistered vehicle** means:

- any motorized land vehicle not designed for or required to be registered for use on public roads;
- any motorized land vehicle which is in dead storage at your residence;
- any motorized land vehicle used solely on and to service your residence premises;
- any motorized land vehicle used to assist the disabled that is not designed for or required to be registered for use on public roads; or
- golf carts.

## GROUP PERSONAL EXCESS COVERAGE

This part of your Group Personal Excess Liability Policy provides you or a family member with liability coverage in excess of your underlying insurance anywhere in the world unless stated otherwise or an exclusion applies.

### Payment for a Loss

#### Amount of coverage

The amount of coverage for liability is shown in the Coverage Summary. We will pay on your behalf up to that amount for covered damages from any one occurrence, regardless of how many claims, homes, vehicles, watercraft, or people are involved in the occurrence.

Any costs we pay for legal expenses (see **Defense coverages**) are in addition to the amount of coverage.

#### Underlying Insurance

We will pay only for covered damages in excess of all underlying insurance covering those damages, even if the underlying coverage is for more than the minimum amount.

"Underlying insurance" includes all liability coverage that applies to the covered damages, except for other insurance purchased in excess of this policy.

#### Required primary underlying insurance

Regardless of whatever other primary underlying insurance may be available in the event of a claim or loss, it is a condition of your policy that you and your family members must maintain in full effect primary underlying liability insurance of the types and in at least the amounts set forth below unless a different amount is shown in your Coverage Summary, covering your personal liability and to the extent you or a family member have such liability exposures, all vehicles and watercraft you or your family members own, or rent for longer than 60 days, or have furnished for longer than 60 days, as follows:

Personal liability(homeowners) for personal injury and property damage in the minimum amount of \$300,000 each occurrence.

**Payment for a Loss***(continued)*

Registered vehicles in the minimum amount of:

- \$250,000/\$500,000 bodily injury and \$100,000 property damage;
- \$300,000/\$300,000 bodily injury and \$100,000 property damage; or
- \$300,000 single limit each occurrence.

Unregistered vehicles in the minimum amount of \$300,000 bodily injury and property damage each occurrence.

Registered vehicles with less than four wheels and motorhomes in the minimum amount of:

- \$250,000/\$500,000 bodily injury and \$100,000 property damage;
- \$300,000/\$300,000 bodily injury and \$100,000 property damage; or
- \$300,000 single limit each occurrence.

Watercraft less than 26 feet and 50 engine rated horsepower or less for bodily injury and property damage in the minimum amount of \$300,000 each occurrence.

Watercraft 26 feet or longer or more than 50 engine rated horsepower for bodily injury and property damage in the minimum amount of \$500,000 each occurrence.

Uninsured motorists/underinsured motorist protection in the minimum amounts of:

- \$250,000/\$500,000 bodily injury and \$100,000 property damage;
- \$300,000/\$300,000 bodily injury and \$100,000 property damage; or
- \$300,000 single limit each occurrence.

With respect to you and your family members residing outside of the United States, the required primary underlying insurance limits of liability shall be the same limits of liability as shown above, unless you and your family members reside in a country where the minimum required primary underlying insurance limits of liability are not available. In these countries, you and your family members must maintain in full effect primary underlying liability insurance limits equal to the maximum limits of liability available in that country for all coverages up to the minimum required primary underlying limits shown in the Coverage Summary under Required Primary Underlying Insurance.

Failure by you or your family members to comply with this condition, or failure of any of your primary underlying insurers due to insolvency or bankruptcy, shall not invalidate this policy. In the event of any such failure, we shall only be liable in excess of the foregoing minimum amounts and to no greater extent with respect to coverages, amounts and defense costs than we would have been had this failure not occurred.

You must also give notice of losses and otherwise cooperate and comply with the terms and conditions of such primary underlying insurance.

**Group Personal Excess Liability Coverage**

We cover damages a covered person is legally obligated to pay for personal injury or property damage, caused by an occurrence:

- in excess of damages covered by the underlying insurance; or
- from the first dollar of damage where no underlying insurance is required under this policy and no underlying insurance exists; or
- from the first dollar of damage where underlying insurance is required under this policy but no coverage is provided by the underlying insurance for a particular occurrence;

unless stated otherwise or an exclusion applies.

Exclusions to this coverage are described in **Exclusions**.

**Excess uninsured motorists/underinsured motorist protection**

This coverage is in effect only if excess uninsured motorists/underinsured motorists protection is shown in the Coverage Summary.

## **Group Personal Excess Liability Coverage**

(continued)

We cover damages for bodily injury and property damage a covered person is legally entitled to receive from the owner or operator of an uninsured motorized/underinsured motorized land vehicle. We cover these damages in excess of the underlying insurance or the Required Primary Underlying Insurance, whichever is greater, if they are caused by an occurrence during the policy period, unless otherwise stated.

**Amount of coverage.** The maximum amount of excess uninsured motorists/underinsured motorists protection available for any one occurrence is the excess uninsured motorists/underinsured motorists protection amount shown in the Coverage Summary regardless of the number of vehicles covered by the Required Primary Underlying Insurance. We will not pay more than this amount in any one occurrence for covered damages regardless of how many claims, vehicles or people are involved in the occurrence. This coverage will follow form.

### **Uninsured motorists/underinsured motorists protection arbitration**

If we and a covered person disagree whether that person is legally entitled to recover damages from the owner or operator of an uninsured motor vehicle/underinsured motor vehicle, or do not agree as to the amount of damages, either party may make a written demand for arbitration. In this event, each party will select an arbitrator. The two arbitrators will select a third. If they cannot agree on a third arbitrator within 45 days, either may request that the arbitration be submitted to the American Arbitration Association. When the covered person's recovery exceeds the minimum limit specified in the applicable jurisdiction's financial responsibility law, each party will pay the expenses it incurs, and bear the expenses of the third arbitrator equally. Otherwise, we will bear all the expenses of the arbitration.

Unless both parties agree otherwise, arbitration will take place in the county and state in which the covered person lives. Local rules of law as to procedure and evidence will apply. A decision agreed to by two arbitrators will be binding unless the recovery amount for bodily injury exceeds the minimum limit specified by the applicable jurisdiction's financial responsibility law. If the amount exceeds that limit, either party may demand the right to a trial. This demand must be made within 60 days of the arbitrator's decision. If this demand is not made, the amount of damages agreed to by the arbitrators will be binding.

### **Uninsured/underinsured liability coverage**

This coverage is in effect only if excess uninsured motorists/underinsured motorists protection is shown in the Coverage Summary.

We cover up to a maximum of \$1 million for bodily injury and personal injury you or a family member are legally entitled to receive from an uninsured or underinsured negligent person caused by an occurrence, unless stated otherwise or an exclusion applies. We will not pay more than this amount for covered damages from any one occurrence, regardless of how many claims or people are involved in the occurrence. This coverage is excess over the total of any other collectible insurance that covers damages from the occurrence.

All the exclusions under the Group Personal Excess Liability Coverage are applicable to this Uninsured/underinsured liability coverage, and where used, the definition of you or a family member is extended to include negligent person. This coverage also does not apply to damages from an occurrence arising out of any business activities; any activities involving business property or the sale or transfer of property; or the ownership, maintenance, use, loading, unloading, or towing of any motor vehicle, watercraft, or aircraft. In addition, this coverage does not apply to damages from an occurrence arising from any employment related harassment, termination, demotion, breach of an oral or written employment contract or agreement or violation of any state or federal wrongful employment practices act or similar law.

We also do not cover any fines, penalties, taxes, punitive, exemplary or multiplied damages, or any claim or suit seeking non monetary relief, including but not limited to, injunctive relief, declaratory relief or other equitable remedies.

"Negligent person" means an identifiable natural person by legal name who is not a family member, and who is legally responsible for damages sustained by you or a family member caused by an occurrence.

**Duplication of coverage.** We will not make a duplicate payment for any portion of damages for which payment has been made by or on behalf of persons who may be legally responsible, or otherwise covered by any other collectible insurance. Nor will we pay for any portion of damages if you or a family member is entitled to receive payment for the same portion of damages under any workers' compensation law, disability benefits law or similar law.

**Group Personal Excess Liability Coverage***(continued)***Defense coverages**

We will defend a covered person against any suit seeking covered damages for personal injury or property damage that is either:

- not covered by any underlying insurance; or
- covered by an underlying policy. This will apply to each Defense Coverage as it has been exhausted by payment of claims.

We provide this defense at our expense, with counsel of our choice, even if the suit is groundless, false, or fraudulent. We may investigate, negotiate, and settle any such claim or suit at our discretion.

As part of our investigation, defense, negotiation, or settlement, we will pay:

- all premiums on appeal bonds required in any suit we defend;
- all premiums on bonds to release attachments for any amount up to the amount of coverage (but we are not obligated to apply for or furnish any bond);
- all expenses incurred by us;
- all costs taxed against a covered person;
- all interest accruing after a judgment is entered in a suit we defend on only that part of the judgment we are responsible for paying. We will not pay interest accruing after we have paid the judgment up to the amount of coverage;
- all prejudgment interest awarded against a covered person on that part of the judgment we pay or offer to pay.

We will not pay any prejudgment interest based on that period of time after we make an offer to pay the amount of coverage;

- all earnings lost by each covered person at our request; up to \$25,000;
- other reasonable expenses incurred by a covered person at our request; and
- the cost of bail bonds required of a covered person because of a covered loss.

In jurisdictions where we may be prevented by local law from carrying out these Defense Coverages, we will pay only those defense expenses that we agree in writing to pay and that are incurred by you.

**Extra Coverages**

In addition to covering damages and defense costs, we also provide other related coverages. These coverages are in addition to the amount of coverage for damages and defense costs unless stated otherwise.

**Shadow defense coverage**

If we are defending you or a family member in a suit seeking covered damages, we will pay reasonable expenses you or a family member incur up to \$10,000 or the amount shown in the Coverage Summary for a law firm of your choice to review and monitor the defense. However, any recommendation by your persona attorney is not binding on us. We will pay these costs provided that you obtain prior approval from us before incurring any fees or expenses.

**Identity fraud**

We will pay for your or a family member's identity fraud expenses, up to a maximum of \$25,000, for each identity fraud occurrence.

"Identity fraud" means the act of knowingly transferring or using, without lawful authority, your or a family member's means of identity which constitutes a violation of federal law or a crime under any applicable state or local law.

"Identity fraud occurrence" means any act or series of acts of identity fraud by a person or group commencing in the policy period.

"Identity fraud expenses" means:

- the costs for notarizing affidavits or similar documents for law enforcement agencies, financial institutions or similar credit grantors, and credit agencies;
- the costs for sending certified mail to law enforcement agencies, financial institutions or similar credit grantors, and credit agencies;

## **Extra Coverages**

(continued)

- the loan application fees for reapplying for loan(s) due to the rejection of the original application because the lender received incorrect credit information;
- the telephone expenses for calls to businesses, law enforcement agencies, financial institutions or similar credit grantors, and credit agencies;
- earnings lost by you or a family member as a result of time off from work to complete fraud affidavits, meet with law enforcement agencies, credit agencies, merchants, or legal counsel;
- the reasonable attorney fees incurred with prior notice to us for:
- the defense of you or a family member against any suit(s) by businesses or their collection agencies;
- the removal of any criminal or civil judgements wrongly entered against you or a family member;
- any challenge to the information in your or a family member's consumer credit report; and
- the reasonable fees incurred with prior notice to us by an identity fraud mitigation entity to:
- provide services for the activities described above;
- restore accounts or credit standing with financial institutions or similar credit grantors and credit agencies; and
- monitor for up to one year the effectiveness of the fraud mitigation and to detect additional identity fraud activity after the first identity fraud occurrence.

However, such monitoring must begin no later than one year after you or a family member first report an identity fraud occurrence to us.

However, "identity fraud expenses" does not include expenses incurred due to any fraudulent, dishonest or criminal act by a covered person or any person acting with a covered person, or by any authorized representative of a covered person, whether acting alone or in collusion with others.

"Identity fraud mitigation entity" means a company that principally provides professional, specialized services to counter identity fraud for individuals or groups of individuals, or a financial institution that provides similar services.

In addition to the duties described in Policy Terms, Liability Conditions, Your duties after a loss, you shall notify an applicable law enforcement agency.

### **Kidnap expenses**

We will pay up to a maximum of \$100,000 for kidnap expenses you or a family member incurs solely and directly as a result of a kidnap and ransom occurrence. In addition, we also will pay up to \$25,000 to any person for information not otherwise available leading to the arrest and conviction of any person(s) who kidnaps you, a family member or a covered relative. The following are not eligible to receive this reward payment:

- you or a family member; or
- a covered relative who witnessed the occurrence.

"Kidnap and ransom occurrence" means the actual or alleged wrongful taking of:

- you;  
one or more family members; or  
one or more covered relatives while visiting or legally traveling with you or a family member;
- from anywhere in the world except those places listed on the United States State Department Bureau of Consular Affairs Travel Warnings list at the time of the occurrence. The occurrence must include a demand for ransom payment which would be paid by you or a family member in exchange for the release of the kidnapped person(s).

"Kidnap expenses" means the reasonable costs for:

- a professional negotiator;
- a professional security consultant;
- professional security guard services;
- a professional public relations consultant;
- travel, meals, lodging and phone expenses incurred by you or a family member;
- advertising, communications and recording equipment;
- related medical, cosmetic, psychiatric and dental expenses incurred by a kidnapped person within 12 months from that person's release;
- attorney's fees;
- a professional forensic analyst;
- earnings lost by you or a family member, up to \$25,000.

**Extra Coverages***(continued)*

However, "kidnap expenses" does not include expenses incurred due to any kidnap and ransom occurrence caused by:

- you or a family member;
  - a covered relative;
  - any guardian, or former guardian of you, a family member or covered relative;
  - any estranged spouse or domestic partner, or former spouse or domestic partner of you or a family member;
  - any person unrelated to you or a family member who lives with you or a family member or has ever lived with you or a family member for 6 or more months, other than a domestic employee, residential staff, or a person employed by you or a family member for farm work; or
  - a civil authority,
- or any person acting on behalf of any of the above, whether acting alone or in collusion with others.

"Covered relative" means the following relatives of you, or a spouse or domestic partner who lives with you, or any family member:

- children, their children or other descendants of theirs;
- parents, grandparents or other ancestors of theirs; or
- siblings, their children or other descendants of theirs;

who do not live with you, including spouses or domestic partners of all of the above. Parents, grandparents and other ancestors include adoptive parents, stepparents and step grandparents.

**Reputational injury.** If we are defending you or a family member in a suit seeking covered damages, we will pay reasonable and necessary fees or expenses that you or a family member incur for services provided by a reputation management firm to minimize potential injury to the reputation of you or a family member solely as a result of personal injury or property damage, caused by an occurrence if:

- the reputational injury is reported to us as soon as reasonably possible but not later than 30 days after the personal injury or property damage occurrence; and
- you obtain approval of the reputation management firm from us before incurring any fees or expenses, unless stated otherwise or an exclusion applies. There is no deductible for this coverage.

A Reputation management firm means a professional public relations consulting firm, a professional security consulting firm or a professional media management consulting firm.

The maximum amount of coverage for Reputational injury available for any one occurrence is \$25,000 or the amount shown in the Coverage Summary. We will not pay more than this amount in any one occurrence for covered damages regardless of how many claims or people are involved in the occurrence.

The maximum annual amount of coverage for Reputational injury shown in the Coverage Summary is the most we will pay for the sum of all covered damages you or a family member incur during the policy period regardless of the number of claims, people, or occurrences.

This coverage does not apply to loss caused by a wrongful employment act covered by Employment Practices Liability Insurance.

**Exclusions**

These exclusions apply to your Group Personal Excess Liability Coverage, unless stated otherwise.

**Aircraft.** We do not cover any damages arising out of the ownership, maintenance, use, loading, unloading, or towing of any aircraft, except aircraft chartered with crew by you. We do not cover any property damages to aircraft rented to, owned by, or in the care, custody or control of a covered person.

**Hovercraft.** We do not cover any damages arising out of the ownership, maintenance, use, loading, unloading or towing of any hovercraft. We do not cover any property damages to hovercraft rented to, owned by, or in the care, custody or control of a covered person.

## **Exclusions**

(continued)

Motorized land vehicle racing or track usage. We do not cover any damages arising out of the ownership, maintenance or use of any motorized land vehicle:

- during any instruction, practice, preparation for, or participation in, any competitive, prearranged or organized racing, speed contest, rally, gymkhana, sports event, stunting activity, or timed event of any kind; or
- on a racetrack, test track or other course of any kind.

Watercraft and aircraft racing or track usage. We do not cover any damages arising out of the ownership, maintenance or use of any watercraft or aircraft during any instruction, practice, preparation for, or participation in, any competitive, prearranged or organized racing, speed contest, rally, sports event, stunting activity or timed event of any kind. This exclusion does not apply to you or a family member for sailboat racing even if the sailboat is equipped with an auxiliary motor.

Motorized land vehicle-related jobs. We do not cover any damages arising out of the ownership, maintenance, or use of a motorized land vehicle by any person who is employed or otherwise engaged in the business of selling, repairing, servicing, storing, parking, testing, or delivering motorized land vehicles. This exclusion does not apply to you, a family member, or your employee or an employee of a family member for damages arising out of the ownership, maintenance or use of a motorized land vehicle owned by, rented to, or furnished to you or a family member.

**Watercraft related jobs.** We do not cover any damages arising out of the ownership, maintenance, or use of a watercraft by any person who is engaged by or employed by, or is operating a marina, boat repair yard, shipyard, yacht club, boat sales agency, boat service station, or other similar organization. This exclusion does not apply to damages arising out of the ownership, maintenance, or use of a watercraft by you, a family member, or your or a family member's captain or full time paid crew member maintaining or using this watercraft with permission from you or a family member.

**Motorized land vehicle and watercraft loading.** We do not cover any person or organization, other than you or a family member or your or a family member's employees, with respect to the loading or unloading of motorized land vehicles or watercraft.

**Workers' compensation or disability.** We do not cover any damages a covered person is legally:

- required to provide; or
- voluntarily provides

under any:

- workers' compensation;
- disability benefits;
- unemployment compensation; or
- other similar laws.

But we do provide coverage in excess over any other insurance for damages you or a family member is legally required to pay for bodily injury to a domestic employee of a residence covered under the Required Primary Underlying Insurance which are not compensable under workers' compensation, unless another exclusion applies.

**Director's liability.** We do not cover any damages for any covered person's actions or failure to act as an officer or member of a board of directors of any corporation or organization. However, we do cover such damages if you are or a family member is an officer or member of a board of directors of a:

- homeowner, condominium or cooperative association; or
- not for profit corporation or organization for which he or she is not compensated; unless another exclusion applies.

**Damage to covered person's property.** We do not cover any person for property damage to property owned by any covered person.

**Damage to property in your care.** We do not cover any person for property damage to property rented to, occupied by, used by, or in the care of any covered person, to the extent that the covered person is required by contract to provide insurance. But we do cover such damages for loss caused by fire, smoke, or explosion unless another exclusion applies.

**Wrongful employment act.** We do not cover any damages arising out of a wrongful employment act. A wrongful employment act means any employment discrimination, sexual harassment, or wrongful termination of any residential staff actually or allegedly committed or attempted by a covered person while acting in the capacity as an employer, that violates applicable employment law of any federal, state, or local statute, regulation, ordinance, or common law of the United States of America, its territories or possessions, or Puerto Rico.

**Exclusions***(continued)*

**Employment discrimination** as it relates solely to a wrongful employment act means a violation of applicable employment discrimination law protecting any residential staff based on his or her race, color, religion, creed, age, sex, disability, national origin or other status according to any federal, state, or local statute, regulation, ordinance, or common law of the United States of America, its territories or possessions, or Puerto Rico.

**Sexual harassment** as it relates solely to a wrongful employment act means unwelcome sexual advances, requests for sexual favors, or other conduct of a sexual nature that:

- is made a condition of employment of any residential staff;
- is used as a basis for employment decisions;
- interferes with performance of any residential staff's duties; or
- creates an intimidating, hostile, or offensive working environment.

**Wrongful termination** as it relates solely to a wrongful employment act means:

- the actual or constructive termination of employment of any residential staff by you or a family member in violation of applicable employment law; or
- breach of duty and care when you or a family member terminates an employment relationship with any residential staff.

**Residential staff** as it relates solely to a wrongful employment act means your or a family member's employee who is:

- employed by you or a family member, or through a firm under an agreement with you or a family member, to perform duties related only to a covered person's domestic, personal, or business pursuits covered under this part of your policy;
- compensated for labor or services directed by you or a family member; and
- employed regularly to work 15 or more hours per week.

Residential staff includes a temporary worker. Residential staff does not include an independent contractor or any covered person.

**Temporary worker** as it relates solely to a wrongful employment act means your or a family member's employee who is:

- employed by you or a family member, or through a firm under an agreement with you or a family member, to perform duties related only to a covered person's domestic, personal, or business pursuits covered under this part of your policy;
- compensated for labor or services directed by you or a family member; and
- employed to work 15 or more hours per week to substitute for any residential staff on leave or to meet seasonal or short-term workload demands for 30 consecutive days or longer during a 6 month period.

Temporary worker does not include an independent contractor or any covered person.

**Discrimination.** We do not cover any damages arising out of discrimination due to age, race, color, sex, creed, national origin, or any other discrimination.

**Intentional acts.** We do not cover any damages arising out of a willful, malicious, fraudulent or dishonest act or any act intended by any covered person to cause personal injury or property damage, even if the injury or damage is of a different degree or type than actually intended or expected. But we do cover such damages if the act was intended to protect people or property unless another exclusion applies. An intentional act is one whose consequences could have been foreseen by a reasonable person.

**Molestation, misconduct or abuse.** We do not cover any damages arising out of any actual, alleged or threatened:

- sexual molestation;
- sexual misconduct or harassment; or
- abuse.

**Nonpermissive use.** We do not cover any person who uses a motorized land vehicle or watercraft without permission from you or a family member.

## **Exclusions**

(continued)

**Business pursuits.** We do not cover any damages arising out of a covered person's business pursuits, investment or other for-profit activities, for the account of a covered person or others, or business property except on a follow form basis.

But we do cover damages arising out of volunteer work for an organized charitable, religious or community group, an incidental business away from home, incidental business at home, incidental business property, incidental farming, or residence premises conditional business liability unless another exclusion applies. We also cover damages arising out of your or a family member's ownership, maintenance, or use of a private passenger motor vehicle in business activities other than selling, repairing, servicing, storing, parking, testing, or delivering motorized land vehicles.

Unless stated otherwise in your Coverage Summary:

"Incidental business away from home" is a self-employed sales activity, or a self-employed business activity normally undertaken by person under the age of 18 such as newspaper delivery, babysitting, caddying, and lawn care. Either of these activities must:

- not yield gross revenues in excess of \$15,000 in any year;
- have no employees subject to worker's compensation or other similar disability laws;
- conform to local, state, and federal laws.

"Incidental business at home" is a business activity, other than farming, conducted on your residence premises which must:

- not yield gross revenues in excess of \$15,000, in any year, except for the business activity of managing one's own personal investments;
- have no employees subject to worker's compensation or other similar disability laws;
- conform to local, state, and federal laws.

"Incidental business property" is limited to the rental or holding for rental, to be used as a residence, of a condominium or cooperative unit owned by you or a family member, an apartment unit rented to you or a family member, a one or two family dwelling owned by you or a family member, or a three or four family dwelling owned and occupied by you or a family member. We provide this coverage only for premises covered under the Required Primary Underlying Insurance unless the rental or holding for rental is for:

- a residence of yours or a family member's that is occasionally rented and that is used exclusively as a residence; or
- part of a residence of yours or a family member's by one or two roomers or boarders; or
- part of a residence of yours or a family member's as an office, school, studio, or private garage.

"Incidental farming" is a farming activity which meets all of the following requirements:

- is incidental to your or a family member's use of the premises as a residence;
- does not involve employment of others for more than 1,500 hours of farm work during the policy period;
- does not produce more than \$25,000 in gross annual revenue from agricultural operations;
- and with respect to the raising or care of animals:
- does not produce more than \$50,000 in gross annual revenues;
- does not involve more than 25 sales transactions during the policy period;
- does not involve the sale of more than 50 animals during the policy period.

"Residence premises conditional business liability" is limited to business or professional activities when legally conducted by you or a family member at your residence. We provide coverage only for personal injury or property damage arising out of the physical condition of that residence if:

- you or a family member do not have any employees involved in your business or professional activities who are subject to workers' compensation or other similar disability laws; or, if you or a family member are a doctor or dentist, you do not have more than two employees subject to such laws;
- you or a family member do not earn annual gross revenues in excess of \$5,000, if you or a family member are a home day care provider.

We do not cover damages or consequences resulting from business or professional care or services performed or not performed.

**Exclusions***(continued)*

The following additional exclusion applies only to "incidental farming" as described under the exclusion, **Business pursuits**.

**Contamination.** We do not cover any actual or alleged damages arising out of the discharge, dispersal, seepage, migration or release or escape of pollutants. Nor do we cover any cost or expense arising out of any request, demand or order to:

- extract pollutants from land or water;  
remove, restore or replace polluted or contaminated land or water; or
- test for, monitor, clean up, remove, contain, treat, detoxify or neutralize pollutants, or in any way respond to or assess the effects of pollutants.

However, this exclusion does not apply if the discharge, dispersal, seepage, migration, release or escape is sudden and accidental. A "pollutant" is any solid, liquid, gaseous or thermal irritant or contaminant, including smoke (except smoke from a hostile fire), vapor, soot, fumes, acids, alkalis, chemicals and waste. A "contaminant" is an impurity resulting from the mixture of or contact of a substance with a foreign substance. "Waste" includes materials to be disposed of, recycled, reconditioned or reclaimed.

**Financial guarantees.** We do not cover any damages for any covered person's financial guarantee of the financial performance of any covered person, other individual or organization.

**Professional services.** We do not cover any damages for any covered person's performing or failure to perform professional services, or for professional services for which any covered person is legally responsible or licensed.

**Acts of war.** We do not cover any damages caused directly or indirectly by war, undeclared war, civil war, insurrection, rebellion, revolution, warlike acts by military forces or personnel, the destruction or seizure of property for a military purpose, or the consequences of any of these actions.

**Contractual liability.** We do not cover any assessments charged against a covered person as a member of a homeowners, condominium or cooperative association. We also do not cover any damages arising from contracts or agreements made in connection with any covered person's business. Nor do we cover any liability for unwritten contracts, or contracts in which the liability of others is assumed after a covered loss.

**Covered person's or dependent's personal injury.** We do not cover any damages for personal injury for any covered person or their dependents where the ultimate beneficiary is the offending party or defendant. We also do not cover any damages for personal injury for which you can be held legally liable, in any way, to a family member, your spouse or domestic partner or for which a family member, your spouse or domestic partner can be held legally liable, in any way, to you.

However, we do cover damages for bodily injury arising out of the use of a motorized land vehicle for which you can be held legally liable to a family member, your spouse or domestic partner or for which a family member, your spouse or domestic partner can be held legally liable to you to the extent that coverage is provided under this policy. This coverage applies only to the extent such damages are covered by primary underlying insurance and exceed the limits of insurance required for that motorized land vehicle under the Required Primary Underlying Insurance provisions of this policy.

**Liability for dependent care.** We do not cover any damages for personal injury for which a covered person's only legal liability is by virtue of a contract or other responsibility for a dependent 's care.

**Illness.** We do not cover personal injury or property damage resulting from any illness, sickness or disease transmitted intentionally or unintentionally by a covered person to anyone, or any consequence resulting from that illness, sickness or disease. We also do not cover any damages for personal injury resulting from the fear of contracting any illness, sickness or disease, or any consequence resulting from the fear of contracting any illness, sickness or disease.

**Fungi and mold.** We do not cover any actual or alleged damages or medical expenses arising out of mold, the fear of mold, or any consequences resulting from mold or the fear of mold. "Mold" means fungi, mold, mold spores, mycotoxins, and the scents and other byproducts of any of these.

## **Exclusions**

(continued)

**Nuclear or radiation hazard.** We do not cover any damages caused directly or indirectly by nuclear reaction, radiation, or radioactive contamination, regardless of how it was caused.

## **POLICY TERMS**

This part of your Group Personal Excess Liability Policy explains the conditions that apply to your policy.

### **General Conditions**

These conditions apply to your policy in general, and to each coverage provided in the policy.

#### **Policy period**

The effective dates of your policy are shown in the Coverage Summary. Those dates begin at 12:01 a.m. standard time at the mailing address shown.

All coverages on this policy apply only to occurrences that take place while this policy is in effect.

#### **Transfer of rights**

If we make a payment under this policy, we will assume any recovery rights a covered person has in connection with that loss, to the extent we have paid for the loss.

All of your rights of recovery will become our rights to the extent of any payment we make under this policy. A covered person will do everything necessary to secure such rights; and do nothing after a loss to prejudice such rights. However, you may waive any rights of recovery from another person or organization for a covered loss in writing before the loss occurs.

#### **Concealment or fraud**

We do not provide coverage if you or any covered person has intentionally concealed or misrepresented any material fact relating to this policy before or after a loss.

#### **Application of coverage**

Coverage applies separately to each covered person. However, this provision does not increase the amount of coverage for any one occurrence.

#### **Assignment**

You cannot transfer your interest in this policy to anyone else unless we agree in writing to the transfer.

#### **Policy changes**

This policy can be changed only by a written amendment we issue.

#### **Bankruptcy or insolvency**

We will meet all our obligations under this policy regardless of whether you, your estate, or anyone else or their estate becomes bankrupt or insolvent.

#### **In case of death**

In the event of your death, coverage will be provided until the end of the policy period or policy anniversary date, whichever occurs first, for any surviving member of your household who is a covered person at the time of death. We will also cover your legal representative or any person having proper temporary custody of your property.

#### **Liberalization**

We may extend or broaden the coverage provided by this policy. If we do this during the policy period or within 60 days before it begins, without increasing the premium, then the extended or broadened coverage will apply to occurrences after the effective date of the extended or broadened coverage.

#### **Conforming to state law**

If any provision of this policy conflict with any applicable laws of the state you live in, this policy is amended to conform to those laws.

#### **Conforming to trade sanction laws**

This policy does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance.

# GROUP PERSONAL EXCESS LIABILITY POLICY

## ***Liability Conditions***

These conditions apply to all liability coverages in this policy.

### **Other Insurance**

This insurance is excess over any other insurance except for those policies that

- are written specifically to cover excess over the amount of coverage that applies in this policy; and
- schedule this policy as underlying insurance.

### **Your duties after a loss**

In case of an accident or occurrence, the covered person shall perform the following duties that apply:

**Notification.** You must notify us or your agent or broker as soon as possible.

**Assistance.** You must provide us with all available information. This includes any suit papers or other documents which help us in the event that we defend you.

**Cooperation.** You must cooperate with us fully in any legal defense. This may include any association by us with the covered person in defense of a claim reasonably likely to involve us.

**Examination.** A person making a claim under this policy must submit as often as we reasonably require:

- to physical exams by physicians we select, which we will pay for; and
- to examination under oath and subscribe the same; and authorize us to obtain:
  - medical reports; and
  - other pertinent records.

### **Appeals**

If a covered person, or any primary insurer, does not appeal a judgment for covered damages, we may choose to do so. We will then become responsible for all expenses, taxable costs, and interest arising out of the appeal. However, the amount of coverage for damages will not be increased.

## ***Special Conditions***

In the event of conflict with any other conditions of your policy, these conditions supersede.

### **Legal action against us**

You agree not to bring action against us unless you have first complied with all conditions of this policy.

You also agree not to bring any action against us until the amount of damages you are legally obligated to pay has been finally determined after an actual trial or appeal, if any, or by a written agreement between you, us and the claimant. No person or organization has any right under this policy to bring us into any action to determine the liability of a covered person.

### **Notice of cancellation and coverage termination conditions**

The Sponsoring Organization may cancel this policy by returning it to us or notifying us in writing at any time subject to the following:

- the Sponsoring Organization must notify us in advance of the requested cancellation date; and
- the Sponsoring Organization must provide proof of notification to each member of the Defined Group covered under this policy.

We may cancel this policy or any part of it subject to the following conditions. Our right to cancel applies to each coverage or limit in this policy. In the event we cancel this policy, we are under no obligation to provide you with an opportunity to purchase equivalent coverage.

## **Special Conditions**

*(continued)*

**Within 60 days.** When this policy or any part of it has been in effect for less than 60 days, we may cancel with 30 days notice for any reason.

**Nonpayment of premium.** We may cancel this policy or any part of it with 10 days' notice if the Sponsoring Organization or you fail to pay the premium by the due date, regardless of whether the premium is payable to us, to our agent, or under any financial credit.

**Misrepresentation.** We may cancel this policy or any part of it with 30 days notice if the coverage was obtained through misrepresentation, fraudulent statements, or omissions or concealment of a fact that is relevant to the acceptance of the risk or to the hazard we assumed.

**Increase in hazard.** We may cancel this policy or any part of it with 30 days notice if there has been a substantial change in the risk which increases the chance of loss after insurance coverage has been issued or renewed, including but not limited to an increase in exposure due to rules, legislation, or court decision.

**Procedure.** To cancel this policy or any part of it, we must notify you in writing. This notice will be mailed to the Sponsoring Organization at the mailing address shown in the Coverage Summary and we will obtain a certificate of mailing. This notice will include the date the cancellation is to take effect.

**Termination.** Should an individual for any reason no longer qualify as a member of the Defined Group, coverage will cease sixty (60) days from the date that individual no longer qualifies as a member of the Defined Group, or the policy expiration or cancellation date, whichever comes first.

**Refund.** In the event of cancellation by the Sponsoring Organization or us, we will refund any unearned premium on the effective date of cancellation, or as soon as possible afterwards to the Sponsoring Organization. The unearned premium will be computed short rate for the unexpired term of the policy.

**ENDORSEMENT**

Policy Period      JANUARY 01, 2018      to      JANUARY 01, 2019

Effective Date      JANUARY 01, 2018

Policy Number

Insured      BOOZ ALLEN  
HAMILTON INC  
  
Group Personal  
Excess Program

Name of Company      FEDERAL  
INSURANCE  
COMPANY

Date Issued      DECEMBER 29,  
2017

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**ANNUAL PREMIUM ADJUSTMENT CLAUSE**

This policy is written with a deposit premium to be adjusted on either each policy anniversary or at policy expiration. The premium will be adjusted on the basis of the difference between:

- \* the total number of participants at inceptions; and
- \* the actual number of participants at each policy anniversary.

This difference will be multiplied by fifty percent (50%) of the annual rate per participant, resulting in either an additional or return premium.

ALL OTHER TERMS AND CONDITIONS REMAIN UNCHANGED.

Authorized Representative





\$300,000 single limit each occurrence.

FAILURE TO COMPLY WITH THE REQUIRED PRIMARY UNDERLYING INSURANCE WILL RESULT IN A GAP IN COVERAGE.

ALL OTHER TERMS AND CONDITIONS REMAIN UNCHANGED.

Authorized Representative

A handwritten signature in black ink, appearing to be "P. M. Q.", is written over a light yellow rectangular background.

# Officer Annual Performance Bonus

**SPONSORING ORGANIZATION:** People Services

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## INTRODUCTION

A primary component of officer compensation at Booz Allen is the annual performance bonus. The purpose of this policy is to establish eligibility and methodology for delivering the officer annual performance bonus payment.

## RELATED POLICIES

- Officer Transition Policy (Details process for officer leaving under the Officer Transition Policy)
- Officer Leave of Absence (Details process for officer leaving under the Officer Leave of Absence Policy)
- Officer Retirement (Details process for officer leaving under the Officer Retirement Policy)
- Officer Termination (Details process for officer leaving under the Officer Termination Policy)

## SCOPE

This policy applies to all officers of the firm.

## POLICY

The officer annual performance bonus is based on annual firm performance and is paid to each officer after the close of a fiscal year, subject to approval by the Compensation Committee of the Board of Directors.

Each officer is designated a number of points for the annual performance bonus which is based on their level. The designation of points does not in any way constitute or imply any guarantee or commitment by the firm to pay a bonus. At the end of the fiscal year, the Compensation Committee of the Board of Directors approves a U.S. dollar value per point which is multiplied by each officer's designated points to determine the annual performance bonus amount.

In certain circumstances, an officer may be reassigned to a lower level which would result in the officer receiving a reduced point value. The Leadership Team may assign a salary that varies from the standard amount designated for that particular level (i.e., allow the officer to continue to receive their prior salary or some amount in excess of the salary for their new level). The Chief People Officer, in consultation with the Leadership Team, will determine and approve the effective date of the salary change and duration of the variance, as applicable. This variance in salary is considered an advance on bonus and thus, in these situations, the officer's annual performance bonus will be adjusted to ensure that their total compensation matches that of the other officers in the same level.

## Termination of Employment

Depending on the reason an officer leaves Booz Allen employment, they may be eligible for, but are not guaranteed, an annual performance bonus. Eligibility for an annual performance bonus to a terminating officer is determined on a case by case basis and is subject to approval by management and the Compensation Committee of the Board of Directors. Management and the Compensation Committee of the Board of Directors will consider the following when determining if an officer whose employment has terminated or is scheduled to terminate will receive an annual performance bonus:

- The reason(s) which led to the termination of the officer's employment.
- Whether responsibilities for existing or prospective client assignments were completed professionally and/or effectively transferred to another officer.
- Whether appropriate follow-up action was taken by the officer to collect any outstanding client receivables.
- Whether the former officer's conduct prior to and following termination avoided disruption with respect to the firm's relationships with its employees and its clients. If the former officer left to join a

competitor, whether there had been any solicitation or encouragement of other employees to leave the firm or any solicitation of clients of the firm with whom the departed officer had established relationships while an employee of the firm.

- Whether information confidential to the firm or any of its clients has been maintained as confidential by the former officer.

***Officers who are terminated For Cause are not eligible for an annual performance bonus.***

The annual performance bonus for officers whose employment has terminated will be paid at the same time as all active officers and will be prorated for the period of the performance for which the officer was employed. Ordinarily, no bonus for a fiscal year will be paid to officers whose employment terminates prior to June 1st of that fiscal year.

For officers placed into a transition period (see Officer Transition Policy), accrual for an annual performance bonus ceases on the day the transition period begins. For example, an officer who starts transition on October 1 will be eligible for bonus consideration during the period from April 1 through September 30.

**Leave of Absence**

For officers on an approved leave of absence, upon recommendation of management and with the approval of the Compensation Committee of the Board of Directors, a prorated bonus payment may be made based on performance during the fiscal year in which leave was taken. Officers on an approved leave of absence who qualify for bonuses during any fiscal year will receive bonus payments when that fiscal year's bonuses are paid to active officers.

**Exceptions to this Policy**

Any request for an exception to this policy must be reviewed and approved by the Chief People Officer.

**VIOLATIONS OF POLICY, REPORTING, AND NO TOLERANCE FOR RETALIATION**

Any employee who violates this policy will be subject to disciplinary action (up to and including termination of employment), in accordance with our Disciplinary Action Policy.

If you observe or have reasonable suspicion of a violation of this policy, you have a duty to report those concerns. To report a possible violation of this policy or the Green Book, please contact your job or career manager, an Ethics Advisor, Ethics & Compliance ([ethics@bah.com](mailto:ethics@bah.com)), the appropriate Business Partner or Enterprise Solutions Group resource, the Legal Department, our Chief Ethics and Compliance Officer or the EthicsFirst Line at 800-501-8755 (US) or international, +1-888-475-0009, or <https://boozallen.alertline.com>.

We take all allegations of misconduct seriously, and as stated in our Non-Retaliation Policy, we will not tolerate retaliation of any sort against any employee because they raise a good faith ethical or legal concern.

**POINTS OF CONTACT AND ADDITIONAL RESOURCES**

General questions regarding this policy can be directed to the Chief People Officer.

## Transition

### SCOPE:

The firm will support the transition efforts of departing Officers when business conditions, changes in the firm's strategy, Officer performance, and other factors (other than misconduct) cause the firm to terminate an Officer's employment.

### GENERAL POLICY STATEMENT:

Transition support may include one or more of the following as appropriate:

- A reasonable period of continued employment with reduced work requirements during which time the Officer can pursue other employment/business opportunities
- Written and personal referrals by other partners when requested
- Continued participation in normal Officer activities during the transition period

### Transition Period Guidelines

Officers with fewer than eight years of tenure as an Officer may receive four months of transition time to seek other employment. One additional month for each year as an Officer may be added to the transition period, not to exceed 11 months of total transition time.

Officers with eight or more years of tenure as an Officer may receive up to 12 months of transition time to seek other employment.

### Payment(s) During Transition

During the transition period, the Officer's compensation will be equal to his/her base salary in effect at the date of notification, unless otherwise determined by the CPO. Compensation will be paid monthly on the regular payroll date of each calendar month, beginning in the first full calendar month of the transition period. Each payment made pursuant to this policy shall be considered a separate payment within the meaning of Treasury Reg. § 1.409A-2(b)(2)(iii).

### Client and Administrative Obligations

During the transition period, the Officer is expected to complete/transfer all current and ongoing client responsibilities and or administrative duties during such time frame as designated by a supervising Officer. The Officer is not required to initiate new client assignments/duties. Officers will be expected to be available to work as directed by a designated supervising Officer but may not be required to perform any services during the transition period. If service level is expected to drop to 20% or less of the Officer's prior service level, separation from service will be deemed to occur for purposes of compliance with IRS Section 409A.

During the transition period, the Officer is expected to actively pursue other employment/business opportunities. However, employment with the firm will cease when the Officer becomes an employee of another organization and/or engages in any business development activities in competition with the firm.

### Bonus Payment

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Bonus eligibility will end on the day the transition period begins. At the sole discretion of the firm, upon recommendation of management, and with the approval of the Compensation Committee of the Board of Directors, a bonus payment for the portion of the fiscal year prior to the beginning of the transition period may be made to a departing Officer based on performance and in consideration of successful discharge/transfer of Officer-related responsibilities. (Refer to the *Bonus Awards for Departing Officers policy*.) Departing Officers who qualify for bonuses during any fiscal year will receive bonus payments when that fiscal year's bonuses are paid to active Officers. Bonus payments may be made entirely in cash and will not include an equity component unless approved by the requisite leadership.

**Outplacement**

Reasonable outplacement assistance may be provided up to a maximum cost of \$30,000 with the approval of the Chief Personnel Officer.

**Officer Perquisites**

Approved Officer perquisites (e.g., financial counseling, will and estate planning, club dues) will be continued for costs incurred up to 60 days prior to departure. Officers who are transitioning from the firm will not be eligible to expense initiation fees or monthly dues that are associated with membership to club that was joined during the transition period.

**Retirement Plans**

In accordance with ECAP terms and provisions, the Officer will remain eligible for normal ECAP contributions and vesting during the transition period. All contributions and vesting will cease upon the Officer's termination date.

**Other Benefits**

Medical insurance, life insurance, and other benefits will continue according to the terms and provisions of the firm's insurance contracts until the date of departure. Upon departure, the Officer may elect conversion or COBRA continuation options, if applicable.

Matters related to equity in Booz Allen Hamilton Holding Corporation from terminated Officers shall be under the authority of the Compensation Committee of the Board of Directors of Booz Allen Hamilton Holding Corporation, and shall be governed generally by the Amended and Restated Stockholders Agreement, applicable Stock Option Agreements and Restricted Stock Agreements, Amended and Restated Equity Incentive Plan (EIP), Rollover Stock Option Agreement, and Officers' Rollover Stock Plan, as applicable.

**Other Payments**

Any payments and/or reimbursements in addition to those established by these guidelines must be approved by the CEO and Chief Personnel Officer.

**Cost Allocation**

Costs associated with the continuation of work, fringe, and transition benefits are paid by the Officer's business unit. With CEO approval, the points of an Officer in transition status will be carried by Corporate.

**Release of Claims**

**OFFICER POLICY**

Transition payments and benefits shall be contingent upon the Officer's execution and non-revocation of a release of claims in the form provided by the firm. Any payment (other than base salary during the Officer's Transition Period) that would otherwise have been made during such execution and revocation period shall be paid in a lump sum on the first payment date to occur after the release becomes irrevocable, provided that, if such execution and revocation period spans more than one calendar year, no such payments shall be made until the first payroll date in the second calendar year. Failure by an Officer to execute an irrevocable release of claims within the time frame established by the firm will result in the Officer's forfeiture of all payments and benefits otherwise due under this Policy.

**POINTS OF CONTACT AND ADDITIONAL RESOURCES:**

Any request for variations from this policy must be reviewed and approved by the Chief Personnel Officer.

**DISCLAIMER**

Please note that this policy and any other firm policies are not a contract and do not create any contractual relationship of any kind between the firm and any of its employees, including without limitation any right to continued employment for any period of time with the firm. Rather, this policy and other firm policies provide general guidance as to the firm's policies and procedures.

All employees are employed at all times "at-will," which means that either the employee or the firm has the right to terminate the employee's employment at any time for any or no reason with or without notice.

The policy applies to all directors, officers, and employees of the firm; the failure of any of these individuals to comply with the policy may result in disciplinary action up to and including termination of employment. In accordance with the Code of Business Ethics and Conduct (Green Book), all such individuals also are obligated to report any observed or reasonably suspected violations of this policy. The firm's non-retaliation policy applies to anyone making a report and is strictly enforced.

This policy is proprietary and confidential. The firm reserves the right to change, amend, or discontinue any or all of its policies and procedures, at any time in its discretion with or without notice. This policy supersedes any and all previous such firm policies that may at any time have been applicable to the employee.

## RESTRICTED STOCK AGREEMENT

This Restricted Stock Agreement (the “Agreement”), dated as of the Grant Date, between Booz Allen Hamilton Holding Corporation, a Delaware corporation (the “Company”), and the participant (the “Participant”), is being entered into pursuant to the Second Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation (the “Plan”). Capitalized terms used herein without definition have the meaning given in the Plan.

Grant of Restricted Shares. Subject to the terms and conditions of this Agreement and the Plan, the Company hereby evidences and confirms its grant to the Participant, effective as of the Grant Date a number of shares of restricted stock (the “Restricted Shares”). Upon grant, the Company shall record the Restricted Shares in the books and records of the Company or a certificate of Shares will be issued, which entry or certificate shall bear the legends set forth in Section 5(b). Any certificate issued in respect of the Restricted Shares will be delivered on behalf of the Participant to the Secretary of the Company, to be held in custody until the later of the date (i) they become vested in accordance with Section 3(a) and (ii) the Participant requests such instrument from the Company.

Forfeiture Risk. The Participant hereby (i) appoints the Company as the limited attorney-in-fact of the Participant to take such actions as may be necessary or appropriate solely to effectuate a transfer of the record ownership of any such shares that are unvested and forfeited hereunder and (ii) agrees to sign such stock powers and take such other actions as the Company may reasonably request to accomplish the transfer of any unvested Restricted Shares that are forfeited hereunder. The Company does hereby indemnify and hold harmless the Participant from any wrongful use of the power of attorney granted above.

Vesting of Restricted Shares.

(a) Restricted Period. Subject to the continued service of the Participant as a Director of the Company through the applicable vesting date, the Restricted Shares granted pursuant to this Agreement shall vest as provided on the Fidelity NetBenefits website at [www.netbenefits.com](http://www.netbenefits.com).

(b) Termination of Employment. Notwithstanding anything contained in this Agreement to the contrary, if the Participant’s service as a director of the Company terminates for any reason prior to the applicable vesting date, any unvested Restricted Shares shall be forfeited.

Restrictions on Transfer. Unvested Restricted Shares may not be transferred, other than by will or by the laws of descent and distribution and provided that the deceased Participant’s beneficiary or the representative of his or her estate acknowledges

and agrees in writing, in a form reasonably acceptable to the Company, to be bound by the provisions of the Plan and this Agreement as if such beneficiary or estate were the Participant.

Participant's Representations, Warranties and Covenants.

(a) No Conflicts; No Consents. The execution and delivery by Participant of this Agreement, the consummation of the transactions contemplated hereby and the performance of Participant's obligations hereunder do not and will not (a) materially conflict with or result in a material violation or breach of any term or provision of any Law applicable to either Participant or the Restricted Shares or, (b) violate in any material respect, conflict with in any material respect or result in any material breach of, or constitute (with or without notice or lapse of time or both) a material default under, or require either Participant to obtain any consent, approval or action of, make any filing with or give any notice to any Person as a result or under the terms of, any contract, agreement, instrument, commitment, arrangement, or understanding to which Participant is a party.

(b) Legends. The Participant acknowledges and agrees that the Restricted Shares received hereby and represented by physical certificate(s) will bear the following legend (or one to substantially similar effect):

“THE SECURITIES REPRESENTED HEREBY ARE SUBJECT TO ADDITIONAL RESTRICTIONS ON TRANSFER AND CERTAIN OTHER AGREEMENTS SET FORTH IN THE SECOND AMENDED AND RESTATED EQUITY INCENTIVE PLAN OF BOOZ ALLEN HAMILTON HOLDING CORPORATION AND A RESTRICTED STOCK AGREEMENT BETWEEN THE ISSUER AND THE HOLDER OF THIS CERTIFICATE DATED AS OF \_\_\_\_\_. A COPY OF SUCH PLAN AND AGREEMENT SHALL BE FURNISHED WITHOUT CHARGE BY THE ISSUER TO THE HOLDER HEREOF UPON WRITTEN REQUEST.”

(c) Compliance with Rule 144. If any of the Restricted Shares are to be disposed of in accordance with Rule 144, the Participant shall transmit to the Company an executed copy of Form 144 (if required by Rule 144) no later than

(d) the time such form is required to be transmitted to the Commission for filing and such other documentation as the Company may reasonably require to assure compliance with Rule 144 in connection with such disposition.

(e) Participant Status. The Participant represents and warrants that, as of the date hereof, the Participant is an officer, employee or director of the Company or a Subsidiary.

(f) Section 83(b) Election. The Participant agrees that, within 20 days of the date of this Agreement, the Participant shall give notice to the Company as to whether or not the Participant has made an election pursuant to Section 83(b) of the Internal Revenue Code of 1986, as amended, with respect to the Restricted Shares acquired hereunder (an “83(b) election”). Any such 83(b) election shall use as the value of the Restricted Shares the Fair Market Value of the Restricted Shares on the Grant Date determined as provided in the Plan, and the Participant shall take a consistent position on the Participant’s tax returns.

Dividends, etc. The Participant shall be entitled to (i) receive all dividends or other distributions at the time (and in the same calendar year as) such dividends or distributions are paid with respect to those vested and unvested Restricted Shares of which the Participant is the record owner on the record date for such dividend or other distribution and (ii) vote any Restricted Shares of which the Participant is the record owner on the record date for such vote; provided, however, that any property (other than cash) distributed with respect to a Restricted Share (the “Associated Share”) acquired hereunder, including without limitation a distribution of Restricted Shares by reason of a stock dividend, stock split or otherwise, or a distribution of other securities with respect to an Associated Share, shall be subject to the restrictions of this Agreement in the same manner and for so long as the Associated Share remains subject to such restrictions, and shall be promptly forfeited if and when the Associated Share is so forfeited.

Miscellaneous.

(a) Tax Withholding. Whenever any cash or other payment is to be made hereunder or with respect to the Restricted Shares, the Company or any Subsidiary shall have the power to withhold an amount (in cash or in Common Stock granted hereunder upon vesting) sufficient to satisfy federal, state, and local withholding tax requirements relating to such transaction and the Company or such Subsidiary may defer the payment of cash or other payment until such requirements are satisfied; provided, however, that in the event that the Company withholds shares issuable to the Participant (or any portion thereof) to satisfy any applicable withholding taxes, the Company shall only withhold a number of whole shares having a Fair Market Value, determined as of the date of vesting, not in excess of the minimum of tax required to be withheld by law (or such lower amount as may be necessary to avoid liability award accounting). The Participant shall be responsible for all withholding taxes and other tax consequences of this award of Restricted Shares.

(b) No Right to Continued Service. Nothing in the Plan or this Agreement shall interfere with or limit in any way the right of the Company or any of its Subsidiaries

to terminate the Participant's service as a member of the Board at any time, or confer upon the Participant any right to continue as a member of the Board.

(c) Binding Effect; Benefits. This Agreement shall be binding upon and inure to the benefit of the parties to this Agreement and their respective successors and assigns. Nothing in this Agreement, express or implied, is intended or shall be construed to give any person other than the parties to this Agreement or their respective successors or assigns any legal or equitable right, remedy or claim under or in respect of any agreement or any provision contained herein.

(d) Amendment. This Agreement may not be amended, modified or supplemented orally, but only by a written instrument executed by the Participant and the Company.

(e) Assignability. Neither this Agreement nor any right, remedy, obligation or liability arising hereunder or by reason hereof shall be assignable by the Company or the Participant without the prior written consent of the other party, provided that the Company may assign all or any portion of its rights or obligations under this Agreement to one or more persons or other entities designated by it.

(f) Applicable Law. This Agreement shall be construed in accordance with and governed by the laws of the State of Delaware, without reference to principles of conflict of laws which would give rise to the applicable of the substantive law of another jurisdiction.

(g) Severability; Blue Pencil. In the event that any one or more of the provisions of this Agreement shall be or become invalid, illegal or unenforceable in any respect, the validity, legality and enforceability of the remaining provisions contained herein shall not be affected thereby.

(h) Consent to Electronic Delivery. By executing this Agreement, the Participant hereby consents to the delivery of information (including, without limitation, information required to be delivered to the Participant pursuant to applicable securities laws) regarding the Company and the Subsidiaries, the Plan, and the Restricted Shares via the Company web site or other electronic delivery.

(i) Section and Other Headings, etc. The section and other headings contained in this Agreement are for reference purposes only and shall not affect the meaning or interpretation of this Agreement.

(j) Notices. All notices, requests, claims, demands and other communications hereunder shall be in writing and shall be given or made (and shall be deemed to have been duly given or made upon receipt) by delivery in person, by courier service, by cable, by facsimile, by telegram, by telex or by registered or certified mail

(postage prepaid, return receipt requested) to the respective parties at the following addresses (or at such other address for a party as shall be specified in a notice given in accordance with this Section 7(j)):

(i) if to the Company:

Booz Allen Hamilton Holding Corporation  
8283 Greensboro Drive  
McLean, Virginia 22102  
Attention: Law Department  
Facsimile No.: (703) 902-3580

(ii) if to the Participant, to the address set forth in the Company's records.

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# Officer Perquisites

**SPONSORING ORGANIZATION:** People Services

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## INTRODUCTION

The purpose of this policy is to define the Officer Perquisites.

## RELATED POLICIES

N/A

## SCOPE

Booz Allen provides an extensive perquisite package to Officers, to include reimbursement of club memberships, financial counseling and estate planning, support for home office IT equipment, annual physical examinations, and Officer development.

## POLICY

### Club Memberships

Club memberships are an effective vehicle for promotion of physical health and developing and maintaining close relationships with executives in current and potential client organizations. Officers of the firm are therefore encouraged to join a luncheon/health/sport club and a country/special interest club that will provide them with opportunities to expand their business and professional relationships. (A special interest club is defined as any club used to promote client and market development.)

The firm will support membership in one country/special interest club and one luncheon/sport/health club for each Officer as follows:

- The firm will pay the reasonable annual dues and reasonable initiation fees for one country/special interest club. The Group Leader and the Chief Personnel Officer (CPO) will review club membership requests. Approval decisions will be based on the merits of each case.
- The firm will pay the reasonable annual dues and the reasonable initiation fee for one luncheon/sport/health club. The initiation fee is limited to a maximum of \$2,500. The Group Leader and the Chief Personnel Officer (CPO) will review club membership requests. Approval decisions will be based on the merits of each case.

Reimbursed costs for club dues and initiation fees will be considered imputed income to the individual and is, therefore, subject to income tax withholding. Individuals will be taxed on all reimbursements related to club dues on a monthly basis. Club initiation fees will be taxed, but which can be done over the course of up to three pay periods.

The firm will not reimburse any fees to a club that discriminates in its membership or guest policies; for more complete information regarding the firm's policy against discrimination, refer to the Equal Employment Opportunity Policy located on [people.bah.com](http://people.bah.com). Officers seeking club membership approvals will be required to complete the Club Membership Approval form and sign a certification that they have no reason to believe that the club discriminates in its membership or guest policies. With respect to countries outside the United States, exceptions to this policy may be granted on a case-by-case basis only by the Chief Executive Officer.

Please note that Senior Partners and above are not eligible for reimbursement of club dues or initiation fees.

**Repayment Obligation**

Officers who voluntarily resign from the firm within three years of receiving a club initiation payment in excess of \$50,000 will be responsible for refunding a pro-rata portion to the firm unless waived in writing by the Chief Personnel Officer.

**Transitioning Officers**

Officers who are transitioning from the firm will not be eligible to expense initiation fees or monthly dues that are associated with membership to club that was joined during the transition period.

**Financial Counseling & Estate Planning**

Booz Allen assists Officers with their financial and estate planning by offering a flexible financial counseling and estate planning program. The intention of the program is to enable Officers to focus more effectively on their personal financial circumstances and objectives and to provide them with direct control over the responsiveness and quality of the professional services received.

Each Officer may select his/her own financial counselor, including a personal accountant or attorney, to provide:

- Personal financial counseling
- Personal tax preparation
- Other tax or financial counseling
- Estate planning services (i.e., preparation and updating of wills, trust agreements and other related documents)

The firm will reimburse each Officer up to \$15,000 annually (determined by the date the services were rendered) for approved financial counseling and/or estate planning services.

The firm will also reimburse the following periodic costs:

- Up to \$10,000 in first-year service fees to establish a personal long-term financial strategy and estate plan. (Officers who elect to change financial counseling service firms will not be eligible for this additional reimbursement if it has been previously used.)
- Up to \$7,500 every three years to review and update the Officer's estate plan
- Up to \$3,000 for fees associated with preparing estate plans and related documents following relocation of an Officer by the firm to a new tax jurisdiction (i.e., different state or country)

Reimbursed costs for financial planning and estate planning will be considered imputed income to the individual and is, therefore, subject to income tax withholding.

**Pre-Retirement Financial Counseling**

As part of its financial counseling benefits program, the firm will provide a one-time reimbursement of up to \$5,000 for retirement financial counseling and planning for those close to retirement. The primary purpose of this provision is to provide Officers with an opportunity to determine their annual financial needs in retirement and how best to fund their retirement income through individual and firm-sponsored retirement income and wealth-accumulation programs. This counseling should occur close to the planned date of retirement.

**Reimbursement Procedures**

Requests for reimbursement should be directed to the Total Rewards team. All requests must be accompanied by the service provider's original invoice, which should clearly state what service was performed. Reimbursement can be made directly to the Officer or service provider.

**Cost Allocation**

Costs associated with financial counseling and estate planning will be charged to the Officer's business unit.

**Home Office IT Equipment**

To provide Officers the flexibility to conduct business remotely when necessary, the firm may provide hardware, software and broadband services to Officers who wish to equip a home office. This policy identifies the purchasing protocols established to protect the security and integrity of the firm's information systems and to provide a cost-effective customer support model.

The firm will provide up to \$3,000 every three years for the purchase of firm standard business-related software and hardware, including computers, printers, network routers, modems to provide broadband network access, etc. Equipment must be purchased through Information Services from the firm's standard product list. The monthly usage fee for broadband service and an additional phone line to support fax capabilities will also be reimbursed, and their cost will not count towards the \$3,000 stipend. Communication devices (e.g., pagers, cell phones) are not covered under this policy.

Costs associated with the purchase of home equipment will be charged to the Officer's business unit. Since the equipment purchased is for business purposes, costs are not considered taxable income to the Officer.

The firm will only provide support for products purchased from Information Services using the standard products list. Support can include in-home visits during normal business hours to install equipment at the Officer's primary residence if the primary residence is within 50 miles of a supported Booz Allen office. Four hours of in-home support services is available each year thereafter. Telephonic and remote support is available for Officers living beyond this distance.

For broadband service, Information Services will pre-qualify and assist in the procurement of the best service available based on home location for homes located within 50 miles of a supported Booz Allen office. Only broadband service or a substitute of equivalent cost will be reimbursed. Officers are responsible for securing the additional phone line to support fax capabilities, to include installation and maintenance.

Upon termination (voluntary or involuntary) from the firm, ownership of all software/hardware (except system access hardware) may, at the sole discretion of the firm, be transferred to the Officer after all proprietary information is removed and/or returned to the firm. Unless a request for transfer of ownership is approved by the Chief Personnel Officer, all software and hardware must be returned by the Officer to the firm. In addition, no further PHO funding will be available for hardware/software purchases. PHO is authorized, however, to provide "best effort" remote and onsite home office support (not to exceed four hours a year of in-home visits during normal business hours) to executives who have retired in "good standing" or retired officers who are actively serving in a Senior Executive Advisor (SEA) role to the firm. Support is based on the PHO team's availability with active partners taking precedence. Booz Allen email accounts will be disabled on the last day of work with the option to enable an automated Out of Office message for ninety days that will provide redirection information and/or personal contact information. The Chief Personnel Officer must approve any change and or extension to one's Booz Allen email account.

Information Services is responsible for monitoring expenses subject to the three-year allowance and for establishing a process for ordering equipment as well as terminating service once an Officer leaves the firm. Information Services is also responsible for maintaining the list of firm-approved standard products; for assisting Officers with product purchases; and for determining the times, type and scheduling of firm-provided equipment service.

Finance is responsible for establishing appropriate charge numbers and account codes to record expenses.

Officers are responsible for the installation and maintenance of an extra phone line for fax capabilities, requesting reimbursement of monthly usage fees for fax use and broadband services through the expense report process if central billing services are not available, and for returning any firm-provided software or hardware upon request at the time of termination.

**Physical Examinations**

All full-time and part-time Officers are eligible to participate in an annual executive physical. The results of the exam are strictly confidential and will only be shared between the Officer and his/her physician.

Officers may use a physician of his/her choice or use one of the firm-identified medical administrators. The cost of the physical examination (excluding transportation to the physician's office and related expenses) is reimbursed to the Officer through his/her firm-sponsored medical plan. If annual physicals are not covered, the firm will reimburse the cost. The costs will be charged to the Officer's administrative charge number. Invoices not covered by the Officer's firm-sponsored medical plan should be sent to the Total Rewards team for payment.

**Officer Development Fund**

The Officer Development Fund (ODF) program is designed to provide Officers with opportunities to broaden their knowledge and skills in areas of value to them and to our clients. It provides Officers with a vehicle for initiating self-improvement activities tailored to meet their individual professional and personal needs.

In general, the program provides Officers with opportunities to:

- Maintain/improve their functional skills and/or develop increased knowledge of specific topics (e.g., industry trends)
- Become familiar with new ideas from research and academia and participate in the exchange of professional views on these ideas
- Learn from distinguished academics and leading business professionals
- Address specific personal development needs in areas of importance to professional consultants

Development activities can include both formal and informal programs. Formal programs may be offered by leading universities, professional associations, and/or training organizations and would also include developmental coaching. Informal programs could include activities such as original research or working on a book. The prime consideration in determining what is an appropriate activity is that it serve to develop, maintain, or enhance the skills and knowledge of the Officer in areas of potential success of the firm. Moreover, such activities should have a logical place in the overall development of the individual Officer and of the entire Officer corps.

During an Officer's participation in development activities covered by this program, his or her regular compensation, fringe benefits, and Officer perquisites will remain in force. The firm will reimburse up to \$15,000 in expenses over a three-year period, provided expenses are directly related to an approved activity such as:

- Tuition and/or fees
- Travel
- Living expenses
- Study/course materials
- Miscellaneous out-of-pocket costs

Officers have no vested interest in the development fund and are not entitled to any portion of any unexpended amount. If at the end of a three-year period the total accrual for an individual Officer has not been expended, the amount will not be carried forward.

Program costs will be budgeted at the corporate level, carried in a Corporate account for each fiscal year, and will be available for development activity purposes as of April 1 of each year. An Officer elected subsequent to the beginning of any fiscal year will not be eligible to participate in the program until the start of the fiscal year following his or her election.

Proposed development activities must be approved in advance by the appropriate Group Leader and Chief Personnel Officer. (Note: Costs should not be incurred by an Officer until all necessary approvals have been

received by the Talent Development Team). A written description of the proposed activity, with supporting rationale, must be submitted for any development program activity in order for the expenditure to be considered eligible for reimbursement. The form for this purpose is available from the [people.bah.com](http://people.bah.com) website.

All reimbursements for approved ODF program activities should be charged to the corporate account. Invoices and all supporting documents should be sent to the Learning and Development Team.

**VIOLATIONS OF POLICY, REPORTING, AND ZERO TOLERANCE FOR RETALIATION**

Any Booz Allen person who violates this policy will be subject to disciplinary action (up to and including termination of employment), in accordance with our Disciplinary Action Policy.

If you observe or have reasonable suspicion of a violation of this policy you have a duty to report those concerns. To report a possible violation of this policy or the Green Book, please contact your job or career manager, an Ethics Advisor, Ethics & Compliance ([ethics@bah.com](mailto:ethics@bah.com)), the appropriate Business Partner or Enterprise Solutions Group resource, the Legal Department, our Chief Ethics and Compliance Officer or the Ethics Helpline at 800-501-8755 (US) or +1-888-475-0009 (international), or <https://boozallen.alertline.com>.

We take all allegations of misconduct seriously, and as stated in our Non-Retaliation Policy, we will not tolerate retaliation of any sort against any person because they raise a good faith ethical or legal concern.

**POINTS OF CONTACT AND ADDITIONAL RESOURCES**

General questions regarding this policy can be directed to the Chief People Officer.

**List of Subsidiaries of Booz Allen Hamilton Holding Corporation**

<b>Name</b>	<b>Jurisdiction of Organization</b>
Booz Allen Cyber Solutions, LLC	Delaware
Booz Allen Hamilton Consulting Pte. Ltd.	Singapore
Booz Allen Hamilton (Dubai) Limited	Dubai, UAE
Booz Allen Hamilton Egypt, LLC	Egypt
Booz Allen Hamilton Engineering Holding Co., LLC	Delaware
Booz Allen Hamilton Engineering Services, LLC	Delaware
Booz Allen Hamilton Lebanon S.a.r.l.	Lebanon
Booz Allen Hamilton Inc.	Delaware
Booz Allen Hamilton Intellectual Property Holding, LLC	Delaware
Booz Allen Hamilton International, Inc.	Delaware
Booz Allen Hamilton International Pte. Ltd.	Singapore
Booz Allen Hamilton International (U.K.) Ltd.	United Kingdom
Booz Allen Hamilton Investor Corporation	Delaware
Booz Allen Hamilton Philippines Inc.	Philippines
Booz Allen Hamilton Saudi Arabia, LLC	Saudi Arabia
Booz Allen Hamilton Singapore Holding Company Pte. Ltd.	Singapore
Booz Allen Hamilton Singapore LLP	Singapore
Booz Allen Hamilton Tanzania Limited	Tanzania
Epidemico, Inc.	Delaware
Epidemico Limited	Ireland
PT Booz Allen Hamilton Indonesia	Indonesia
SDI Technology Corporation	Virginia
Morphick, Inc.	Delaware
eGov Holdings, Inc.	Delaware
Aquilent, Inc.	Delaware
Cloud Solutions Group, Inc.	Delaware
Epic Acquisition Software, Inc.	Delaware
Harborview Technologies, LLC	Delaware
Middle Bay Solutions, LLC	Delaware
Middle Bay Solutions II, LLC	Delaware
Riverside Engineering, LLC	Delaware

**Consent of Ernst & Young LLP,  
Independent Registered Public Accounting Firm**

We consent to the incorporation by reference in the following Registration Statements:

- Form S-8 (No 333-205956) pertaining to the Second Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation
- Form S-8 (No 333-171288) pertaining to the Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation, Booz Allen Hamilton Holding Corporation Officers' Rollover Stock Plan, and Booz Allen Hamilton Holding Corporation Employee Stock Purchase Plan
- Form S-3 (No 333-214855) pertaining to the registration of shares of Class A Common Stock of Booz Allen Hamilton Holding Corporation

of our reports dated May 29, 2018, with respect to the consolidated financial statements of Booz Allen Hamilton Holding Corporation and the effectiveness of internal control over financial reporting of Booz Allen Hamilton Holding Corporation, included in this Annual Report (Form 10-K) of Booz Allen Hamilton Holding Corporation for the year ended March 31, 2018.

/s/ Ernst & Young LLP

Tysons, Virginia  
May 29, 2018

**CERTIFICATION OF THE CHIEF EXECUTIVE OFFICER PURSUANT TO RULE 13A-14(A) OF THE  
SECURITIES EXCHANGE ACT OF 1934, AS AMENDED**

I, Horacio Rozanski, certify that:

1. I have reviewed this Annual Report on Form 10-K of Booz Allen Hamilton Holding Corporation.
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report.
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report.
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
  - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
  - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting.
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's Board of Directors (or persons performing the equivalent function):
  - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 29, 2018

By: /s/ Horacio Rozanski

Horacio Rozanski  
President and Chief Executive Officer  
(Principal Executive Officer)

**CERTIFICATION OF THE CHIEF FINANCIAL OFFICER PURSUANT TO RULE 13A-14(A) OF THE  
SECURITIES EXCHANGE ACT OF 1934, AS AMENDED**

I, Lloyd W. Howell, Jr., certify that:

1. I have reviewed this Annual Report on Form 10-K of Booz Allen Hamilton Holding Corporation.
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report.
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report.
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
  - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
  - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
  - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
  - (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting.
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's Board of Directors (or persons performing the equivalent function):
  - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
  - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 29, 2018

By: /s/ Lloyd W. Howell, Jr.

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Lloyd W. Howell, Jr.  
Executive Vice President, Chief Financial Officer and Treasurer  
(Principal Financial Officer)

**CERTIFICATIONS PURSUANT TO  
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002  
(18 U.S.C. SECTION 1350)**

In connection with the report on Form 10-K of Booz Allen Hamilton Holding Corporation (the "Company") for the fiscal year ended March 31, 2018, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), the undersigned President and Chief Executive Officer of the Company certifies, to the best of his knowledge and belief pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

- (1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934.
- (2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: May 29, 2018

By: /s/ Horacio Rozanski

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Horacio Rozanski  
President and Chief Executive Officer  
(Principal Executive Officer)

A signed original of this written statement required by Section 906 has been provided to Booz Allen Hamilton Holding Corporation and will be retained by Booz Allen Hamilton Holding Corporation and furnished to the Securities and Exchange Commission or its staff upon request.

**CERTIFICATIONS PURSUANT TO  
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002  
(18 U.S.C. SECTION 1350)**

In connection with the report on Form 10-K of Booz Allen Hamilton Holding Corporation (the "Company") for the fiscal year ended March 31, 2018, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), the undersigned Executive Vice President, Chief Financial Officer and Treasurer of the Company certifies, to the best of his knowledge and belief pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

- (1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934.
- (2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: May 29, 2018

By: /s/ Lloyd W. Howell, Jr.

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Lloyd W. Howell, Jr.  
Executive Vice President, Chief Financial Officer and Treasurer (Principal  
Financial Officer)

A signed original of this written statement required by Section 906 has been provided to Booz Allen Hamilton Holding Corporation and will be retained by Booz Allen Hamilton Holding Corporation and furnished to the Securities and Exchange Commission or its staff upon request.