Kroll, LLC
Prescription Drug Plan

Plan Document and
Summary Plan Description

Effective May 1, 2018

Kroll, LLC reserves the right to amend the Kroll, LLC Health & Welfare Plan (the "Health & Welfare Plan"), including, without limitation, this Kroll, LLC Prescription Drug Plan (the "Rx Plan") (which is a component plan of the Health & Welfare Plan), at any time or from time-to-time without the consent of or, to the extent permitted by law, prior notice to any employee or participant. Although Kroll, LLC expects to continue the Health & Welfare Plan indefinitely, it is not legally bound to do so, and it reserves the right to terminate the Health & Welfare Plan or any Health & Welfare Plan benefit option, feature or component (including, without limitation, the Rx Plan) at any time without liability.

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Introduction

The Kroll, LLC Prescription Drug Plan (the "Rx Plan") is designed to pay a portion of covered prescription drug expenses for you and your eligible dependents. The Rx Plan is a component plan in the Kroll, LLC Health & Welfare Plan (the "Health & Welfare Plan").

When you enroll in one of the following medical options offered under the Health & Welfare Plan (the "Medical Plan"), you are automatically enrolled in the Rx Plan:

- Aetna 1350 with HSA Medical Plan (Choice POS II network)
- Aetna 2000 with HSA Medical Plan (Choice POS II network)
- Aetna 1350 without HSA Medical Plan (Choice POS II network)
- Aetna 2000 without HSA Medical Plan (Choice POS II network)

Kroll, LLC (the "Company") has designated CVS Caremark as the pharmacy benefit manager for the Rx Plan. Benefits under the Rx Plan are administered by CVS Caremark under a contract between the Company and CVS Caremark.

This summary describes benefits under the Rx Plan, and is intended to supplement the Plan Document and Summary Plan Description for the Health & Welfare Plan (the "Health & Welfare Plan Document"). This summary, together with the Health & Welfare Plan Document, is a summary plan description for the Rx Plan.

This summary describes the major provisions of the Rx Plan, but does not provide complete details. Except where noted, eligibility for coverage, effective dates of coverage, termination of coverage, and continuation of coverage for benefits under the Rx Plan are as determined for coverage under the Medical Plan. Refer to the Health & Welfare Plan Document for more information about these topics as well as others, including information about your rights and obligations under the Rx Plan and the Health & Welfare Plan.

If there is any conflict between the Health & Welfare Plan Document and this summary, this summary will control unless otherwise required by law or specified in this summary or the Health & Welfare Plan Document. You should not rely on any oral description of the Rx Plan, because the written terms of the Rx Plan and the Health & Welfare Plan will govern.

As used in this summary, the terms "you" or "your" mean an employee who has met the eligibility requirements to participate in the Health & Welfare Plan and the Rx Plan; receipt of this summary does not mean that you meet these requirements or that these requirements have been waived.

This summary is effective May 1, 2018.

Enrollment in the Rx Plan and Coverage

When you enroll in the Medical Plan (in one of the medical options listed in the "Introduction" section above), you are automatically enrolled in the Rx Plan as of the same date your Medical Plan coverage is effective. The Rx Plan does not require a separate enrollment. *You cannot enroll in the Rx Plan without enrolling in the Medical Plan*.

Refer to the Health & Welfare Plan Document for information on the eligibility requirements for the Medical Plan and the Rx Plan, including information on employee and dependent eligibility.

Your coverage level under the Rx Plan will be the same as the coverage level you select for the Medical Plan. Coverage for your dependents usually begins when your coverage begins.

You have an opportunity once each year, during open enrollment, to make changes to your Medical Plan coverage level. Under certain circumstances, described in the Health & Welfare Plan Document, you may be able to make mid-year changes to your Medical Plan coverage. Changes to your Medical Plan coverage may impact your Rx Plan coverage.

Who Pays for Rx Plan Coverage

The cost of your Rx Plan coverage is paid by the Company and by you through the premiums you pay to the Medical Plan. The Company sets the amount of your Medical Plan premiums each year and a portion of the premiums you pay will apply toward the cost of your Rx Plan coverage. The remainder of the cost of your Rx Plan coverage that is not paid by you is paid by the Company.

Benefit Summaries

How Your Prescription Benefits Work

You must meet the annual deductible before the Rx Plan starts to pay prescription benefits. Once the deductible is met, you then pay a copay (flat fee) of $5 for generic medications or coinsurance (a percentage of the cost) for select brand name medications. Benefits may be subject to a minimum and/or maximum, as shown in the Prescription Drug Plan Chart below. After each eligible family member meets his or her individual out-of-pocket maximum (combined with the out-of-pocket maximum in the Medical Plan), the Rx Plan will pay 100% of his or her covered expenses. Or, after the family out-of-pocket maximum has been met, the Rx Plan will pay 100% of each eligible family member's covered expenses.

No Cost Sharing for Certain Preventive Care Prescriptions

Certain prescriptions that are considered to be preventive under federal law are mandated to be

covered in full and the cost sharing schedule (as shown in the Prescription Drug Plan Chart below) does not apply. To determine whether a particular prescription is covered under this federal mandate or if a specific medication has a quantity limit, you can search by the name of the drug on CVS Caremark's website, www.caremark.com. Or, call CVS Caremark's Member Services telephone number at 1-877-906-6844.

Prescription Drug Plan Chart

	Aetna 2000 Plan		Aetna 1350 Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
	Amounts listed below are the amounts you pay			
Annual deductible[1] » Employee Only Coverage » Family Coverage	 $2,000 $4,000	 $4,000 $8,000	 $1,350 $2,700	 $2,600 $5,200
Annual out-of-pocket maximum[2] » Per Individual » Per Family	 $6,000 $12,000	 $12,000 $24,000	 $3,000 $6,000	 $6,000 $12,000
Prescriptions drugs filled at participating retail pharmacy[3][4] (30 day supply) » Generic » Select Brand Name	 $5 copay 20% coinsurance with a $25 minimum/$50 maximum	 Not covered Not covered	 $5 copay 20% coinsurance with a $25 minimum/$50 maximum	 Not covered Not covered
Prescription drugs filled by mail-order service[3][4] (90 day supply) » Generic » Select Brand Name	 $10 copay 20% coinsurance with a $50 minimum/$100 maximum	 Not covered Not covered	 $10 copay 20% coinsurance with a $50 minimum/$100 maximum	 Not covered Not covered

(1) The annual deductible is the amount you must pay before the Medical Plan and the Rx Plan will pay towards your eligible medical and prescription drug expenses. Please note: In-network preventive care is not subject to the annual deductible. If you are enrolled in medical coverage and covering one or more family members under the Medical Plan, you will need to meet the Family Coverage deductible. The Employee Only Coverage deductible applies only when the employee and no family members are covered under the Medical Plan.

(2) The maximum out-of-pocket is the maximum amount you will have to pay for eligible expenses each year. For purposes of the out-of-pocket maximum, the out-of-pocket maximum can be met as follows: (1) each individual covered under the Medical Plan can meet the individual out-of-pocket maximum and his/her eligible expenses will be covered at 100%; or (2) one or one or more covered individuals combined can meet the family out-of-pocket maximum and each covered family member's eligible expenses will be covered at 100%.

(3) The annual Medical Plan deductible must first be met before copay or coinsurance apply. Your prescription drug copays and coinsurance count towards the Medical Plan out-of-pocket maximums.

(4) Certain prescriptions that are considered to be preventive under federal law are mandated to be covered in full and the above cost-sharing schedule does not apply. Contact CVS Caremark for more information as to whether a particular prescription drug is covered under this federal mandate.

(5) Medications used for fertility are subject to a lifetime Maximum Allowable Benefit of $7,500.

How to Use the Rx Plan

CVS Caremark is the pharmacy benefit manager and administers the Rx Plan for the Company.

Prescription medications covered under the Rx Plan can be purchased from a participating retail pharmacy or from CVS Caremark's Mail Service, as described in more detail below.

ID Cards

When you first enroll in the Rx Plan, you will receive ID cards from CVS Caremark. It is important to remember to *use your Rx Plan (CVS Caremark) ID card at the pharmacy,* rather than your Medical Plan ID card.

Covered Medications

In order for the Rx Plan to cover a prescription, the prescribed item must meet the following requirements:

- It must be prescribed by a licensed physician.
- It must be approved by the Federal Food and Drug Administration (FDA).
- It must be dispensed by a pharmacy.
- It must meet the Rx Plan's special requirements for certain drugs, and it must not be listed under the "Exclusions" section of this summary.

The Rx Plan provides coverage for federal legend drugs, which are drug products bearing the legend "Caution: Federal law prohibits dispensing without a prescription." The Rx Plan also covers certain prescription supplies, oral contraceptives, and some compound medications that contain at least one federal legend drug in a therapeutic amount.

Benefits

A "formulary" is a list of medicines that are included in a prescription benefit plan. The Rx Plan will cover the medicines that are included in the Rx Plan's formulary, provided the drugs are being used appropriately. Drugs determined to be "non-formulary" are not covered by the Rx Plan.

The Rx Plan has adopted CVS Caremark's current formulary, referred to as the "Value Formulary," as the Rx Plan's covered formulary. Prescription drugs are classified as either generic or brand name (as described in more detail below). The Value Formulary covers all generics and some select brands when generics are not available. Formulary exceptions are required for non-formulary brands for medical necessity.

A current list of drugs covered under the Value Formulary is available on CVS Caremark's website, www.caremark.com, or by calling CVS Caremark's Member Services telephone number at 1-877-906-6844. CVS Caremark updates the Value Formulary quarterly. Updates may include adding a new drug or changing the categories of a drug (for example, from brand name to generic).

Generic Drugs

New drugs, like many other new products, are developed under patent protection. The patent protects the investment in the drug's development by giving the manufacturer the exclusive right to sell the drug while the patent is in effect. When patents or other periods of exclusivity on brand name drugs expire, pharmaceutical manufacturers can apply to the FDA to sell generic versions of the same chemical compound.

Generic drugs must meet strict FDA requirements for safety and effectiveness. The proposed generic equivalent must have an FDA-approved brand name drug that is the "same" in terms of:

- Active ingredient(s)
- Labeled strength, and labeling information
- Dosage form, such as tablets, patches and liquids
- Administration - for example, swallowed as a pill or given as an injection
- Bioequivalence - performs in the same manner as the brand name drug
- Quality, purity and stability under extremes of heat and humidity

Generic drugs generally cost less than brand name drugs. They often have a different appearance (e.g., color, shape) and different inactive ingredients from their brand name counterparts for ease in identification, but they are designed to have the same therapeutic performance.

Brand Name Drugs

Brand name drugs are medications and supplies requiring a prescription that are distributed under a trademarked name by the pharmaceutical manufacturer whose new drug application was approved by the FDA.

Exclusions and Benefit Limitations

Exclusions

The following medicines and benefits are not covered by the Rx Plan. Some of these medicines may be covered by the Medical Plan.

- Drugs determined as "non-formulary" based on CVS Caremark's current formulary.
- Non-Federal Legend and Over the Counter Medications (including drugs for which a prescriptions for formerly required).
- Injectables that are not self-administered.
- Biologicals (immunization agents and vaccines).
- Allergy serums.
- Blood or blood plasma products.
- Barrier contraceptives, such as diaphragms and condoms.
- Mifeprex.
- RU-486.

- Ostomy supplies.
- Therapeutic devices or appliances.
- Drugs to promote or stimulate hair growth or for cosmetic purposes.
- Drugs labeled: "Caution: Limited by Federal law to investigational use", or experimental drugs, even though a charge is made to the participant.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any state or governmental agency, or medication furnished by any other drug or medical service for which no charge is made to the participant.
- Medication that is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution that operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Implantable time-released medications.
- Nutritional supplements, except for those included on CVS Caremark's list of approved nutritional products intended for treatment of specific metabolic conditions, and which are purchased through a pharmacy.
- Unit doses of medication.
- Any prescription refilled in excess of the number of refills specified by the prescribing physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.
- Drugs requiring prior authorization for which a prior authorization was not obtained.
- Drugs which are new to market for which a coverage determination has not yet been made.
- Items not specifically described as covered by the Rx Plan.

Use of a Brand Name Drug

The Value Formulary covers all generics and some select brands when generics are not available. If a generic drug is available, but you prefer to use the brand name drug, you may use the brand name drug. However, you will pay the full cost for the brand name drug unless CVS Caremark receives and approves a CVS Caremark Tier Exception Form from your physician stating the brand name drug is medically necessary. Brand name drugs that are deemed medically necessary will be covered at the Select Brand Name benefit rate listed in the table Prescription Drug Plan Chart on page 3.

Prior Authorization

For certain medications, the Rx Plan requires prior authorization by CVS Caremark before benefits will be paid. The list of medications that require prior authorization will change from time to time, and drugs that do not currently require prior authorization may require prior authorization in the future. In order to determine whether a specific medication has a prior authorization requirement, you can search by the name of the drug on CVS Caremark's website, www.caremark.com, or call CVS Caremark's Member Services telephone number at 1-877-906-6844.

To obtain a prior authorization, your physician must complete a CVS Caremark Prior Authorization Form, which is available by calling CVS Caremark's Member Services. Prior authorizations are typically approved for a one-year period, unless otherwise noted.

Quantity Limits

For certain medications, the Rx Plan has limits on the quantity that will be covered. The list of medications that have quantity limits will change from time to time and drugs that do not currently have quantity limits may have quantity limits in the future. In order to determine whether a specific medication has a quantity limit, you can search by the name of the drug on CVS Caremark's website, www.caremark.com, or call CVS Caremark's Member Services telephone number at 1-877-906-6844.

Refill Limits

For refills from a retail pharmacy, 70% of the prior order of the medication must have been used, and for refills through CVS Caremark by Mail, 60% of the prior order must have been used before the prescription can be refilled. If you will be traveling and need to refill your prescription early, let the pharmacist know and request that he or she call CVS Caremark's Member Services for a "vacation override."

Specialty Medications Supply Limitation

Specialty medications require a 30 day supply limitation. However, in certain instances, a 90 day supply will be allowed. For example, a 90 day supply may be allowed if you are travelling or if a doctor if a doctor feels that it is medically necessary to prescribe a 90 day supply. For more information as to whether a particular specialty medication is subject to this limitation, you can search by the name of the drug on CVS Caremark's website, www.caremark.com, or call CVS Caremark's Member Services telephone number at 1-877-906-6844.

Drug Utilization Review

CVS Caremark gives participating network pharmacies information that helps protect patients from interactions between current medications and a new drug being prescribed, or other adverse reactions, such as previously identified allergies. The pharmacist at the CVS pharmacy or participating network pharmacy is alerted to a potential reaction at the time the new drug is entered into CVS Caremark's system at the time of purchase. The pharmacist can then discuss the situation with the patient, and/or the patient's physician. This safety feature, which is also available to CVS Caremark Mail Service pharmacists, is especially important if more than one physician is prescribing medications for an individual, or if prescriptions are filled at different pharmacies.

Filling Your Prescriptions

Retail Pharmacies

CVS Caremark gives you access to a network of approximately 68,000 pharmacies, including pharmacies located in some Target®, Walmart®, and Costco® stores and more than 9,660 CVS pharmacy stores.

Present your Rx Plan (CVS Caremark) ID card when you purchase your medication at a retail pharmacy that is part of CVS Caremark's retail pharmacy network. You will be charged the applicable cost, copay, coinsurance and any other applicable charges per the Medical Plan option you've chosen. You do not need to file any claims for these prescriptions.

Long-Term Prescriptions

After your third refill of a 30 day supply of a long-term prescription at a CVS pharmacy or any pharmacy in CVS Caremark's network of pharmacies, you will be charged the mail-order copay or coinsurance amount applicable to 90 day mail-order supplies (see chart on page 3) for your 30 day supply (i.e., you will be charged the mail-order copay starting on your fourth refill). You'll receive a reminder from CVS Caremark about the Maintenance Choice Program after your third refill of a 30 day supply of your medication at a retail pharmacy. To avoid this potential increase in your out-of-pocket cost, use the Maintenance Choice Program for your long-term prescriptions.

Maintenance Choice Program for Long-Term Prescriptions

If you use a medication that requires more than a 30 day supply, you have two choices for savings on your out-of-pocket cost to fill your prescription:

1. By using the CVS Caremark Mail Service for home delivery. To use CVS Caremark Mail Service, visit CVS Caremark's website, www.caremark.com, and register (if you're visiting for the first time) or log in. Under "Order Prescriptions" and "Delivery Options" select "Start Mail Service". When you need refills, you can request them online at CVS Caremark's website, by calling CVS Caremark's Member Services telephone number at 1-877-906-6844, or using the Mail Order Service Form that comes with your order. If you have questions about your medication, you can call CVS Caremark to talk with a pharmacist. For more information, see the "CVS Caremark Mail Service" section below.

2. By visiting a CVS pharmacy to fill your prescription and pick up your medication at a time that is convenient for you. To use this option, let your prescriber know that you would like to update your prescription to a 90 day supply. Or, let CVS Caremark know that you would like to begin filling 90 day supplies and they will work with your prescriber to update your prescription. Get started by by registering and logging into CVS Caremark's website, www.caremark.com, using the information above, and selecting a CVS pharmacy location for pickup. Or, you can call CVS Caremark's Member Services telephone number at 1-877-906-6844. If you have questions about your medication, you can talk with a

pharmacist face to face at the CVS pharmacy. You must register your prescription with the CVS Caremark website or you will receive the 30 day supply and be charged the mail-order copay or coinsurance amount applicable to 90 day mail-order supplies described above.

With both options, you can receive up to a 90 day supply of your prescribed medication.

CVS Caremark Mail Service

To get started using CVS Caremark Mail Service, let your physician know that you have a mail-order prescription drug benefit and that you would like to have the maximum supply of medication (usually 90 days) plus refills for up to one year. You may then mail your new prescription(s) with a completed copy of the CVS Caremark Mail Service Order Form to the address listed on the form. You can find the form online at CVS Caremark's website, www.caremark.com.

When your physician prescribes a new medication, it is recommended that you have your physician write two prescriptions: one for a 30 day supply and one for a 90 day supply with refills. You should first fill the 30 day supply prescription at a retail pharmacy and try the new drug to ensure you will not experience any adverse reaction and that the drug will be effective for you. Once you determine that the new drug will work for you, you can fill the 90 day prescription through CVS Caremark Mail Service.

If you submit 30 day prescriptions to CVS Caremark Mail Service, you will be automatically charged the copay or coinsurance applicable to a 90 day supply. To keep your costs down, fill your 30 day prescriptions at a CVS Caremark network pharmacy.

To check on the status of your mail order, you may call CVS Caremark's Member Services telephone number at 1-877-906-6844, or visit CVS Caremark's website, www.caremark.com. You can find out the date your prescription was received, the status of your order, the date your prescription was mailed to you, and other billing and timing information.

Recovery of Overpayments

If the Rx Plan pays benefits to you or to a pharmacy in error, the Rx Plan reserves the right to recover the amount overpaid through whatever means are necessary, including, without limitation, by deducting the excess amounts from your future claims and/or by legal action.

If You Participate in a Health Savings Account

If you participate in a Medical Plan option with a Health Savings Account (HSA) component, you may be able to use your HSA benefits to pay for or reimburse out-of-pocket expenses for prescription drugs. Review your Medical Plan coverage and Health & Welfare Plan Document for more information.

When Coverage Ends

Your Rx Plan coverage ends when your Medical Plan coverage ends.

COBRA Continuation Coverage

For information regarding COBRA continuation coverage for your RX Plan coverage, including an explanation of when COBRA continuation coverage may become available to you and your dependents and what you need to do to protect your right to receive COBRA continuation coverage, refer to the Health & Welfare Plan Document.

Please note that Rx Plan coverage can be continued under COBRA only if you elect to continue coverage in a participating Medical Plan under COBRA. COBRA continuation coverage under the Rx Plan cannot be elected separately.

Claims and Appeals Process

Your claims under the Rx Plan will be reviewed under the claims procedures described in the Health & Welfare Plan Document, as modified by the procedures described in this summary for claims under the Rx Plan. To the extent the claims procedures described in this summary are inconsistent with the Health & Welfare Plan Document, this summary will control to the extent consistent with the Patient Protection and Affordable Care Act of 2010 and guidance issued thereunder and DOL Regulation 29 C.F.R. § 2560.503-1.

Refer to the Health & Welfare Plan Document for additional information on the claims and appeals process for the Rx Plan and the Health & Welfare Plan.

How to File a Claim

Your prescription drug claim will be submitted when you present your prescription to the pharmacist. The pharmacist will notify you if the claim has been approved or denied. You may also file a paper claim. Paper claims must be filed within one year of the date the prescription is filled. A paper claim form and filing instructions is available on www.caremark.com. You may also contact CVS Caremark's Member Services at 1-877-906-6844 to request a paper claim form. In the event your paper claim is denied, you will be notified by CVS Caremark in writing.

Appeals Process

If you claim is denied, you may file a written appeal of the adverse benefit determination. All written appeals and supporting information and documentation of a claim under the Rx Plan should be sent to:

Caremark Appeals Department
MC109
P.O. Box 52084 Phoenix, AZ 85072

Fax Number: 866-443-1172 ATTN: APPEALS DEPARTMENT

First Level Appeals (Initial Benefit Reconsiderations): All appeals must be submitted within 180 days of the initial claim denial. The review process includes the consideration of relevant and supporting documentation submitted by you and on your behalf. Supporting documentation may include: a letter written by the physician in support of the appeal, a copy of the claim denial letter sent by CVS Caremark, a copy of your payment receipt or medical records, etc.

Upon receipt of your appeal, an appeals analyst reviews and determines appeals relating to non-clinical benefits claims (e.g., eligibility determinations, copay issues, explicit exclusions under the Rx Plan). Appeals determinations requiring clinical knowledge are reviewed by an appeals pharmacist. All appeals determinations shall be final subject to any provisions for additional review (as described in the Health & Welfare Plan Document and this summary). First level appeals will be reviewed and responded to within 30 days of receipt.

Second Level Appeals (Medical Necessity Appeals / Independent Physician Specialist Review): CVS Caremark has contracted with external, independent review organizations (IROs) to conduct specialist physician reviews of benefits claim denials when you are entitled to obtain such a review. For the Rx Plan, these IRO reviews will only be performed for denials of prior authorization requests where the first level appeal was denied. You (or your personal representative) must make an additional request for an IRO review to occur.

Upon receipt of a second level appeal, the following will occur:

- CVS Caremark will forward, or have forwarded, to the IRO applicable medical records documentation. The independent specialist physician selected by the IRO to conduct the review (the "Independent Reviewer") will review the documentation received with respect to the appeal. If the Independent Reviewer considers additional information necessary or potentially useful in the review, the Independent Reviewer will contact your medical provider to request such information.
- The Independent Reviewer will review available medical records, any additional information obtained from the medical provider, and current medical literature, to make a determination as to the benefits claim. The Independent Reviewer will write a letter describing the rationale in support of his or her final decision. The letter will be forwarded to CVS Caremark for communication to you or your representative.

Appeals Determination

Reviews of claims on appeal are conducted within the applicable time frames for the appeal type. Once the determination on appeal is rendered, the determination is communicated in writing to you or your representative.

Communication is written in a manner to be understood by you or your representative. When the claim on appeal is granted, the communication will explain the steps or process that CVS Caremark or you will need to follow with respect to the claim. When the claim on appeal is denied, the communication provides the specific reason for the denial, and references the

section of the Rx Plan and Health & Welfare Plan on which the denial was based.