
**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, 2026**

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)

26-2634160
(I.R.S. Employer
Identification No.)

8283 Greensboro Drive, McLean, Virginia
(Address of principal executive offices)

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>Trading Symbol</u>	<u>Name of Each Exchange on Which Registered</u>
Class A Common Stock	BAH	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

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 every Interactive Data File required to be submitted 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 such files). Yes No

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

Large Accelerated Filer	<input checked="" type="checkbox"/>	Accelerated filer	<input type="checkbox"/>
Non-accelerated filer	<input type="checkbox"/>	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 has filed a report on and attestation to its management's assessment of the effectiveness of its internal control over financial reporting under Section 404(b) of the Sarbanes-Oxley Act (15 U.S.C. 7262(b)) by the registered public accounting firm that prepared or issued its audit report.

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If securities are registered pursuant to Section 12(b) of the Act, indicate by check mark whether the financial statements of the registrant included in the filing reflect the correction of an error to previously issued financial statements. Yes No

Indicate by check mark whether any of those error corrections are restatements that required a recovery analysis of incentive-based compensation received by any of the registrant's executive officers during the relevant recovery period pursuant to §240.10D-1(b). Yes No

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 30, 2025, the last business day of the registrant's most recently completed second quarter, the aggregate market value of the registrant's voting and non-voting common stock held by non-affiliates was \$11,488,325,864.

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

	Shares Outstanding as of May 18, 2026
Class A Common Stock	119,746,130

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the registrant's Proxy Statement for its Annual Meeting of Stockholders scheduled for July 22, 2026 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, 2026, 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, 2026. 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. A number of important factors could cause actual results to differ materially from those contained in or implied by these forward-looking statements, including the 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

Booz Allen Hamilton Holding Corporation (herein referred to as “Booz Allen,” the “Company,” “we,” “us,” or “our”) is an advanced technology company building products and solutions for government and business. For more than 112 years, Booz Allen has evolved to meet the needs of commercial, international, and government customers. After September 11th, 2001, the Company undertook a fundamental transformation when it expanded into critical and sensitive national security missions. Our teams began delivering mission impact, executing full-spectrum cyber operations, helping the U.S. military counter the threat of improvised explosive devices (“IEDs”), standing up counter-terrorism fusion centers, and supporting intelligence missions. This work helped lay the foundation for the Company’s national security portfolio and strengthened its credibility in highly complex missions. In 2008, a strategic business decision was made to prioritize and protect the Company’s government and national security interests and spin off its global commercial business.

In 2013, Booz Allen began another massive multi-year transformation by making significant investments in the emerging technologies that would help transform government. The Company rebuilt its workforce with technologists that bring deep mission expertise in national security and other core government missions. These investments propelled Booz Allen as a leader in artificial intelligence (“AI”), cyber, quantum, and other advanced technologies.

Today, Booz Allen is a leader at the forefront of the nation’s technology ecosystem. We build tech for a diverse base of federal government and commercial customers, both domestically and in select foreign locations. By investing in emerging technologies, talent, and new business models, including partnerships with leading technology companies, venture investments, and the development of military grade products, we are accelerating the delivery of tech solutions. We believe this will create sustainable high quality growth for the Company.

Our Technology

Booz Allen builds advanced technology products and solutions that drive outcomes across government and business. Our technologies are designed to solve complex, high stakes challenges with the scale and speed to meet today’s missions demand. We build proprietary technologies and co-create with leading commercial partners and start-ups to rapidly build, scale, and deploy proven innovations.

Our advanced technology capabilities are grounded in decades of leadership across AI, cybersecurity, data, and engineering. As the federal government's largest AI provider with approximately 400 active AI projects, we build secure AI solutions and advanced capabilities spanning agentic AI, physical AI, and AI-Radio Access Network (AI-RAN), and other emerging technologies designed for mission critical environments. We also have one of the most impactful cyber businesses globally, protecting U.S. federal, defense, and intelligence agencies, as well as private sector customers, including Fortune 500 and Global 1,000 companies. These capabilities are supported by enterprise-scale digital modernization expertise spanning cloud-enabled infrastructure, data platforms, and software applications.

Our core technologies include:

- **Cyber:** We build cyber tech to close the speed gap between AI-powered adversaries and traditional cyber defenses. From national missions to critical infrastructure, our elite cyber operators anticipate evolving threats and build military-grade defensive solutions for global customers. Vellox, our AI-native cyber product suite, pairs machine-speed automation with models trained on real-world adversary tradecraft to outpace attackers.
- **Defense Tech:** We build secure AI-enabled defense tech products from first prototype to mission deployment in our three flagship engineering facilities, where we build mission-ready technology today, not years from now. Our more than 20 manufacturing centers and advanced R&D labs reinforce this work through rapid, on-site testing and iteration. We unite mission understanding with emerging technologies through autonomous and tactical solutions, command and control systems, and intelligent warfighter systems. Our products, including Sit(x)^R, EdgeExtendTM, and the Modular Detachment Kit, are engineered to be war-fighter ready and provide operational advantage across mission-critical environments.

We build mission-ready solutions that deliver real-world impact faster. We develop, scale and deploy advanced capabilities across established and emerging technology domains, including AI, cyber, edge, autonomy, space, and quantum, for our customers' most critical missions. To accelerate the development and deployment of transformative technologies, our engineers and technologists combine our proprietary tech and deep technical expertise with strategic partnerships, venture investments, and co-creation across the commercial innovation ecosystem from hyperscalers like AWS to leading venture capital firms like Andreessen Horowitz (a16z) and emerging defense technology companies like Shield AI. By connecting commercial innovation with mission engineering and operational deployment, we shape the next generation of technologies advancing America's future.

Our Long-Term Growth Strategy

Through our VoLT strategy, which stands for Velocity, Leadership, and Technology, we are accelerating Booz Allen's transformation and positioning the Company for the next era of growth: one defined by faster and more efficient innovation, higher-value technology outcomes, and greater impact for our customers and the nation.

Velocity: Get There First

Combine our unique position in the tech ecosystem and mission engineering to build specialized products and solutions at speed

- Co-innovate with leading commercial tech partners for rapid development
- Use strategic acquisitions to accelerate market positions

Leadership: Built with Conviction

Build advanced technology businesses that scale to the needs of our nation

- Direct our scale to solve the most critical national priorities with cutting-edge technology
- Adopt an outcomes orientation and prioritize our business

Technology: Differentiate to Win

Put transformative tech at the heart of the customer mission to deliver the next generation of impact

- Scale AI into every customer environment and across all aspects of our business
- Anticipate and invest in the next wave of transformative technologies, including Quantum and 6G

Our Operating Model

We operate as a single profit and loss center. Our operating model encourages collaboration allowing us to bring a mix of the best talent to every customer engagement. It also encourages and enables continuous investment in the right markets, capabilities, and talent to position us for further growth by anticipating what government and commercial customers will need next.

Across all markets, we address our customers' complex and evolving needs by deploying multifaceted teams with a combination of advanced technical expertise, market-leading innovation, and deep mission understanding. These customer-facing teams, which are fundamental to our differentiated value proposition, better position us to identify and deliver against diverse customer needs in a more agile manner. Our significant win rates during fiscal 2026 on new and re-competed contracts of 57% and 89%, respectively, as compared to 56% and 92%, respectively, in fiscal 2025, demonstrate the strength of this approach.

Our Customers

Booz Allen is committed to solving our customers' toughest challenges, and we work with a diverse base of public and private sector customers across a number of industries in the U.S. and select foreign locations. We bring advanced technical capabilities to help our customers win in today's competitive world and prepare for what's next.

National Security Customers

Defense

Booz Allen develops and deploys advanced technologies that are central to the nation's defense mission, accelerating critical outcomes for the warfighter. Our scaled Defense Tech business delivers innovation at the speed of operational need, building products and solutions that strengthen national security and reinforce U.S. technological leadership. We continue to make significant investments in warfighter, mission, and enterprise technologies — including autonomy and applied artificial intelligence — to help deter adversaries and ensure readiness across all domains.

Our core defense customers include all six branches of the U.S. military, the Office of the Secretary of Defense, and the Joint Staff. Our key defense customers include the Army, Navy/Marine Corps, Air Force, Space Force, Coast Guard, and Joint Combatant Commands. Defense customers also include foreign military sales and work performed under Status of Forces Agreements ("SOFA") to U.S. and non-U.S. government customers.

Intelligence

We deliver innovative, highly technical capabilities and solutions that directly impact core national security missions across the Intelligence Community and national cyber mission providers. Our biggest driver is the demand for innovation, requiring us to anticipate and implement advanced technology solutions tailored to our customers' unique mission needs. Technology is at the center of our customers' missions and ours—we are investing in emerging technologies like AI, zero trust cyber solutions, multi-cloud, quantum, and 6G to adapt ahead of adversaries. Our highly technical talent and innovative solutions and products are shaping the future of our national security ecosystem. The national security workforce remains focused on what is next, blending cleared and uncleared talent across dispersed geographies, ensuring mission impact.

Our intelligence customers include organizations of the U.S. Intelligence Community, the National Security Agency, Defense Intelligence Agency, and other departments or agencies.

Civil and Commercial Customers

Our civil work centers on the federal missions that are the highest priority to the domestic agenda, and we excel at helping our customers innovate their most critical missions. From healthcare, homeland security, and financial services to justice, law enforcement, immigration, energy, transportation, and labor, we work at the core of the mission to modernize systems, boost efficiencies, and save money.

Our civil government customers include many of the civil agencies of the U.S. government, of which the Department of Veterans Affairs was the single largest customer in fiscal 2026, from which we derived 10% of our revenue. Modernization and transformation are key needs of our customers, and we offer the technical expertise and mission understanding required to deliver innovative solutions to all our customers' needs across the civil portfolio.

Our global commercial business partners with customers, from sophisticated multinational organizations to small-to-medium sized organizations, to deliver incident response and advanced cyber technology enterprise products and solutions. Our extensive industry expertise is earned through years of working with market leading customers in financial services, health and life sciences, software and technology, manufacturing, logistics, and energy.

Contracts

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

- 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.
- Indefinite contract vehicles provide for the issuance by the government customer 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.

We delivered solutions, outcomes, and services under 5,026 contracts and task orders in fiscal 2026 and approximately 84% of our revenue was derived from 2,426 active task orders under IDIQ contract vehicles. Our top IDIQ contract vehicle represented approximately 17% of our revenue in fiscal 2026. Our largest task order under an IDIQ contract vehicle accounted for approximately 4% of our revenue in fiscal 2026. Our largest definite contract represented approximately 1% of our revenue in fiscal 2026. For risks related to our contracts, see “Item 1A. Risk Factors—Industry and Economic Risks.”

Competition

We operate in highly competitive markets, and we compete with companies of all types and sizes. Our major competitors include large enterprise software companies, large global technology providers, government contractors focused principally on the provision of technology services to the U.S. government, large defense contractors that provide both products and technology services to the U.S. government, diversified service providers, systems integrators, small businesses, and technology startups. Due to the diverse requirements of the U.S. government and our commercial customers, we frequently collaborate with other companies to compete for contracts and bid against these same companies in other situations. In addition, we also collaborate with technology partners, including through strategic partnerships and investments, to develop and scale new capabilities to meet the demands of our customers.

We compete based on various factors, including our ability to deliver innovative technology solutions and cost effective services in a timely manner, technical expertise and capabilities, customer knowledge and past performance, our ability to successfully recruit and retain appropriately skilled and experienced talent, including security-cleared personnel, our reputation and relationship with our customers, pricing, and our ability to successfully adapt to evolving U.S. government procurement processes.

Our People and Culture

As of March 31, 2026, we employed approximately 31,500 people across the U.S. and select global regions, including 28,800 customer staff. We work in 23 countries, with 32 major business centers and more than 20 engineering, manufacturing, and R&D facilities. Our workforce brings deep technical expertise in areas of artificial intelligence, cyber, quantum, and software engineering. Our workforce is highly credentialed, holding certifications in leading edge technologies, and approximately 87% , 46%, and 4% holding bachelors, masters, and doctoral degrees, respectively (based upon voluntary self-reporting). Nearly 30% of our workforce identifies as veterans or individuals with military experience, and approximately 77% of our employees hold security clearances (based on voluntary self-reporting). Our workforce blends advanced technical capabilities with deep mission and domain experience to deliver products and solutions to meet our customers’ most complex problems.

Culture and Values

Our values Ferocious Integrity, Unflinching Courage, Passionate Service, Champion’s Heart, and Collective Ingenuity anchor how we lead and operate. We cultivate a culture that fuels innovation, accelerates performance, and ensures employees can grow and thrive. A flexible environment, purposeful engagement, and comprehensive wellbeing programs support our people throughout their careers.

At Booz Allen, we act ethically, hold ourselves accountable, and lead with integrity. Our people possess strong character, expertise, and exceptional passion. Our Code of Business Ethics and Conduct represents our values in action and sets forth expectations for our employees on how they should operate on behalf of the Company. We reinforce our culture with annual mandatory training for all employees on our values and how to navigate challenging business issues ethically. We inspire curiosity, encourage people to ask questions, raise concerns, explore solutions, and think outside the box to find creative answers.

Talent, Mobility, and Performance

We deploy a modern talent ecosystem designed to identify, advance, and retain highly skilled technologists and mission experts. Our talent mobility tools, robust performance framework, and data-driven insights align employee development with enterprise needs while enabling personalized career growth.

Learning and Capability Development

We invest heavily in upskilling and technical development to stay ahead of rapidly evolving mission demands. Hands on learning, credentials, and our Technical Experience Groups (TXGs) build deep expertise, create mentorship pathways, and strengthen engagement. Leadership development programs reinforce a one-team mindset and prepare employees for the next generation of challenges.

Technology, Experience, and Innovation

Our workforce builds, scales, and deploys advanced capabilities across established and emerging technology domains, including AI, cyber, defense tech, digital transformation, space, and quantum. Strategic partnerships across industry, academia, and government, combined with our position at the center of the national security and technology ecosystem enable us to anticipate and scale emerging technologies at speed.

Patents and Proprietary Information

Our business utilizes a variety of proprietary rights in delivering products and services to our customers. We claim a proprietary interest in certain 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 and pending 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 trademarks registered in the United States and certain foreign countries, including Booz Allen Hamilton® and Booz Allen®.

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

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 following:

- 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 Truthful Cost or Pricing Data Statute (formerly known as the Truth in Negotiations Act), which requires certification and disclosure of cost and pricing data in connection with the negotiation of certain contracts, modifications, or task orders;
- 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, regulating the handling, use, and dissemination of personally identifiable information in the course of performing a U.S. government contract, performing work for our commercial customers or running the business;
- 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 War 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 and allowability 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 War, the Defense Contract Audit Agency (“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 (“DCMA”), as our cognizant government contract management agency, may determine that a portion of our claimed costs are unallowable based on the findings and recommendations in the DCAA’s audits. In addition, the DCMA directly reviews the adequacy of certain of our business systems, such as our purchasing system. See “Item 1A. Risk Factors—Legal and Regulatory Risks—Our work with government customers exposes us to additional risks inherent in the government contracting environment, 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. To help ensure compliance with these laws and regulations, all of our employees are required to attend ethics training at least annually, and to participate in other compliance training relevant to their position. Additionally, with respect to our foreign operations, 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 could 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 to enforce its procurement law and policies. These include proposing a contractor, certain of its operations or individual employees for debarment or suspending or debaring 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—Legal and Regulatory Risks—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 (the “SEC”). The SEC maintains a website (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, Quarterly Reports on Form 10-Q, and Current Reports on Form 8-K, and any amendments to those forms) through the “Investors” portion of our website (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.

This risk factor summary contains a high-level summary of risks associated with our business. It does not contain all of the information that may be important to you, and you should read this risk factor summary together with the more detailed discussion of risks and uncertainties set forth following this summary. A summary of our risks includes, but is not limited to, the following:

Industry and Economic Risks

- risks relating to our relationships and reputation with the U.S. government;
- changes in U.S. government spending and mission priorities, including due to uncertainty relating to the funding of the U.S. government and increasing the debt ceiling;
- our ability to compete effectively in the competitive bidding and re-competing processes, including increasing competition from non-traditional contractors and changes in government procurement practices, and delays or losses of contract awards caused by competitors’ protests of major contract awards received by us;
- the loss of GSA schedules, or our position as prime contractor on GWACs;
- variable purchasing patterns under GSA schedules, blanket purchase agreements, and IDIQ contracts;
- changes in the mix of our contracts and our ability to accurately estimate or otherwise recover expenses, time, and resources for our contracts;
- changes in estimates used in recognizing revenue;
- our ability to realize the full value of and replenish our backlog, generate revenue under certain of our contracts, and the timing of our receipt of revenue under contracts included in backlog;
- risks related to inflation and new or increased tariffs that could impact the cost of doing business and/or reduce customer buying power;
- risks related to the deterioration of economic conditions or weakening in the credit or capital markets, including financial institution instability that could impair access to our funds and adversely affect our liquidity;

- internal system or service failures and security breaches, including, but not limited to, those resulting from external or internal threats, including cyber-attacks on our network and internal systems, or on our customers' network or internal systems, including more frequent and sophisticated threats such as those by bad actors looking to augment traditional cyber tools and tradecraft with artificial intelligence capabilities;
- compliance with evolving data privacy and cybersecurity laws and regulations, including complex, fragmented, and changing foreign, federal, state, and local requirements and the potential for liability arising from noncompliance;
- risks related to the development and use of artificial intelligence, which include potential liability as well as regulatory, competition, reputational and other risks;
- risks related to the operation of financial management systems;
- our ability to attract, train, or retain employees with the requisite skills and experience and ensure that employees obtain and maintain necessary security clearances and effectively manage our cost structure;
- the loss of members of senior management or failure to develop new leaders;
- misconduct or other improper activities from our employees, subcontractors, or suppliers, including the improper access, use, or release of our or our customers' sensitive, classified, or export-controlled information;
- 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 customers;
- risks related to changes to our operating structure, capabilities, or strategy intended to address customer needs, grow our business, or respond to market developments; and
- risks related to completed and future acquisitions, joint ventures or investments, including our ability to realize the expected benefits from such transactions.

Legal and Regulatory Risks

- failure to comply with numerous laws and regulations, including the FAR, False Claims Act, DFARS, and FAR Cost Accounting Standards and Cost Principles;
- risks related to our foreign operations;
- the adoption by the U.S. government of new laws, rules, and regulations, new interpretations or enforcement priorities relating to existing laws, and changes in procurement practices;
- the incurrence of additional tax liabilities, including as a result of changes in tax laws or management judgments involving complex tax matters;
- continued efforts to change how the U.S. government reimburses compensation related costs and other expenses or otherwise limit such reimbursements and an increased risk of compensation being deemed unreasonable and unallowable or payments being withheld as a result of U.S. government audit, review, or investigation;
- inherent uncertainties and potential adverse developments in legal or regulatory proceedings;
- the impact of changes in accounting rules and regulations, or interpretations thereof, that may affect the way we recognize and report our financial results, including changes in accounting rules governing recognition of revenue; and
- the impact of changing weather patterns, natural disasters, and pandemics, epidemics, and similar disease outbreaks on our and our customers' businesses and operations, as well as risks related to increased scrutiny and changing expectations and practices related to climate change and related governance matters generally.

Risks Related to Our Indebtedness

- the impact of our substantial indebtedness and our ability to service and refinance such indebtedness; and
- the restrictions and limitations in the agreements and instruments governing our indebtedness.

Risks Related to Our Common Stock

- the volatility of the market price of our Class A common stock; and
- the timing and amount of our dividends, if any.

Industry and Economic Risks

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

The U.S. government is our primary customer. We expect to continue to derive the vast majority of our revenue from work performed under U.S. government contracts. 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 is 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 customer personnel.

Our relationship with U.S. government agencies could be harmed by 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 customers, including as a result of misconduct or other improper activities by our employees, subcontractors, or suppliers, or a failure to maintain adequate protection against security breaches, including those resulting from cyber-attacks. 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. In addition, to the extent our performance under a contract does not meet a U.S. government agency's expectations, the customer 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.

Further, negative publicity concerning government contractors in general, or us, our business practices, or our products and services, regardless of accuracy or completeness, may harm our reputation among federal agencies and federal government contractors, and the credibility of our brand, and adversely affect our ability to attract or retain customers or talent. Due to the sensitive nature of our work and our confidentiality obligations to our customers, we may be unable or limited in our ability to respond to such negative publicity, which could also harm our reputation and business. 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 levels 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 and in the future may be reduced in certain periods, and have been and in the future may be affected by the U.S. government's efforts to improve efficiency and reduce costs affecting U.S. government programs generally. Our business, prospects, financial condition, or operating results could be materially harmed by, among other causes, the following:

- U.S. government budget deficits and budgetary constraints, including mandated automatic spending cuts, affecting U.S. government spending generally, or specific agencies in particular, and changes in available funding;
- a shift in the permissible federal debt limit;
- 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;
- a shift in expenditures away from U.S. government agencies or programs that we support, including changes or delays in such programs, shifts in the scope of work, or shifts away from the federal government to state and local governments, or away from government contractors, in general, or from us;
- changes in U.S. government customer cybersecurity investments and resourcing that impact the security posture of systems hosted by the Company on behalf of the U.S. government and under a U.S. government authority to operate;
- U.S. government shutdowns due to, among other reasons, a failure to fund the government 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;
- increased U.S. government processing times for security clearances and other governmental consents;
- delays in the U.S. government contract procurement process or in the payment of our invoices by government payment offices; and

- an inability by the U.S. government to fund its operations as a result of a failure to increase the U.S. government's debt ceiling, the exhaustion of "extraordinary measures" to borrow additional funds without breaching the government's debt ceiling, a credit downgrade of U.S. government obligations or for any other reason.

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, foreign conflicts, trade tensions related to international trade policies, under-staffing or layoffs within the government, natural disasters, public health crises, 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 customer locations or facilities as a result of such disruptions.

If government funding relating to our contracts with the U.S. government becomes unavailable, or is reduced or delayed, or planned orders are reduced, our contracts or subcontracts under such programs may be terminated or adjusted by the U.S. government or the prime contractor, if applicable. Our operating results could also be adversely affected by spending caps or changes in the budgetary priorities of the U.S. government or Department of War, as well as delays in program starts or the award of contracts or task orders under contracts.

These or other factors could cause our defense, intelligence, or civil customers 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 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 or re-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 and re-competing 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 and re-competing processes involve 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 addition, changes in U.S. government procurement practices, including the increased use of alternative contracting methods, such as other transaction authority agreements, may reduce barriers to entry for non-traditional contractors, increase competition, and increase pricing pressure, which could adversely affect our ability to win new contracts or task orders and our profitability.

In circumstances where contracts are held by other companies and are scheduled to expire, we still may not be provided the opportunity to bid or otherwise compete 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 and re-competing processes, we may not be able to enter, operate, or expand in the markets for the 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.

In the current environment, we have seen delays in procurements generally as well as an overall decline in the number of bid protests from unsuccessful bidders on our 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. There can be no assurance that these delays will not ultimately have a material adverse impact on our business and financial performance. While the National Defense Authorization Act (NDAA) for fiscal year 2026 contained provisions intended to curb protests by incumbent contractors, it remains too early to predict the impact such provisions will have upon protest rates.

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 subcontractor position.

We believe that one of the key elements of our success is our position as the holder of 2,426 active task orders under IDIQ contract vehicles as of March 31, 2026.

IDIQ contracts provide for the issuance by the customer 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 customer. 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.

In addition, 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. 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.

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. 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 ongoing 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, as amended, 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 or deliver a specific outcome 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, through the recent executive order “Promoting Efficiency, Accountability, and Performance in Federal Contracting,” directs federal agencies, subject to certain exceptions, to increase the use of firm-fixed price contracts for new awards to the maximum extent consistent with law. Additionally, agencies are directed, to the maximum extent practicable and consistent with law, to seek to modify, restructure, or renegotiate, their top ten highest-dollar-value contracts issued on an other-than-fixed price basis. This executive order may result in future contract modifications and conversions of existing contracts to fixed-price contracts. 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 may increase our risk of incurring losses.

Additionally, our profits could be adversely affected if our costs under any contract 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. Additionally, as more contracts with the U.S. government transition to fixed-price, we face greater risk of cost overruns due to ambiguities in the contract itself regarding delineation of responsibilities between us and the U.S. government and uncertainty with how the government may manage the contract in practice. We record provisions in our consolidated financial statements for losses on our contracts when necessary, 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.

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 a 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.

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 current or future total backlog. There is a 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, 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. 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, de-obligated, or terminated early; in the case of funded backlog, the period of performance for the contract has expired or the U.S. government has exercised its unilateral right to cancel multi-year contracts and related orders or terminate existing contracts for convenience or default; in the case of unfunded backlog, funding may not be available; or, in the case of priced options, our customers may not exercise their options.

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. The amount of our funded backlog is also subject to change, due to, among other factors: changes in congressional appropriations; 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 our contracts, or cancellation of contracts, by the U.S. government at any time. As a result of the U.S. government's review of federal spending across U.S. government agencies, we have had certain of our contracts impacted, reduced or canceled as a result of these reviews, which has reduced the amount of our total backlog and could have a material adverse impact on our business and financial performance. Furthermore, even if our backlog results in revenue, the contracts may not be profitable.

Our backlog does not include contracts that have been awarded but are currently under protest and also does not include any task orders under IDIQ contracts, GSA Schedule or other master agreement contract vehicles, except to the extent that task orders have been awarded to us under those contracts. For additional disclosure regarding our backlog, please 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."

Systems that we develop, integrate, maintain, or otherwise support could experience security breaches which may damage our reputation with our customers 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 government functions. Our systems also store, process, and transmit sensitive Company and government and commercial customer information, including personally identifiable, health and financial information. The cybersecurity threats we, our customers, and third parties face have grown more frequent and sophisticated, including but not limited to bad actors looking to augment traditional cyber tools and tradecraft with artificial intelligence capabilities that increase the speed, scale, and intricacy of threats, which may not be recognized until after they have been launched. A security breach, including from insider threats, could result in the exfiltration of our or our customers' data and has the potential to do serious harm to our business, damage our reputation, prevent us from executing further work on sensitive systems for U.S. government or commercial customers, hinder future contract win rates, and/or cause us to incur significant expense to respond to and remediate the breach. 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 prevent, detect and monitor threats to our customers and may expose us or our customers and business partners to financial loss or physical or reputational harm.

We help our customers prevent, detect, monitor and mitigate threats to their people, information, and facilities. These threats may originate from nation states, terrorists or criminal actors, activist hackers, financially or politically motivated actors, or others who seek to harm our customers. Successful attacks on our customers may cause reputational harm to us and our customers and business partners, as well as liability to our customers or third parties. If we are associated with our customers and business partners in this regard, our staff, systems, information, and facilities may be targeted by a similar group of threat actors and may be at risk for financial loss or physical or reputational harm.

We also design and develop technologies that are highly technical and complex and may contain errors, defects, or security vulnerabilities that cannot be discovered before they are released, installed, and used by our customers. The introduction of new and emerging technologies, such as AI, further increases this risk. Errors, defects or vulnerabilities in the technology we develop could disrupt our customers' or their customers' proper functioning of the technology, cause disruptions in our customers' business operations, or allow unauthorized access to proprietary information, which could cause reputational harm to us and our customers, and could have a material adverse effect on our business and results of operations.

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 customers, which could damage our reputation and have a material adverse effect on our business and results of operations.

We create, implement, integrate, and maintain information technology ("IT") systems that (a) are often mission critical, (b) regularly involve sensitive information, (c) may be deployed within war zones or other hazardous environments, and/or (d) can include information whose confidentiality is protected by law or contract. Additionally, we maintain internal systems housing sensitive employee and confidential company data. As a result, our systems and IT work products are susceptible to systems or service failures resulting from technical complexity, failures of third-party service providers, natural disasters, power shortages, insider threats (including improper access to the Company's, customers' or third parties' information or resources, employee error, or malfeasance), terrorist attacks, physical or electronic security breaches, cyber-attacks, computer viruses, or similar events or disruptions. Our systems and IT work product are the target of constantly evolving cyber-attack vectors, including malware, social engineering, denial-of-service attacks, malicious software programs, phishing, smishing, vishing, identity spoofing (including "deep fakes"), account takeovers, and other cyber-attacks fueled by emerging technologies, including cyber-attacks enhanced or facilitated by artificial intelligence. Additionally, future technological advances, including quantum computing, could potentially compromise the cryptographic foundations of our systems, posing additional risk to the security of those systems. We have observed an increase in the frequency and sophistication of the cyber and security threats these systems face, with attacks that are more advanced and persistent, targeting us because 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, persons with access to systems inside our organization, foreign governments, and cyber terrorists. We also may from time to time modernize, upgrade, replace, or consolidate certain of our internal systems and related processes, and delays in implementing such changes or failures of such systems to operate as intended could disrupt our operations, require significant time, effort, and costs to implement changes or corrections, and adversely affect our business and results of operations.

We have put in place policies, controls, and technologies to help detect and protect against such attacks, but we cannot guarantee that future incidents will not occur. If an incident occurs, we may not be able to successfully mitigate the impact. We have been the target of these types of attacks in the past, and attempted attacks are likely to continue. Due to the ongoing geopolitical conflicts in Eastern Europe and the Middle East, and increased tensions in Asia, state-sponsored parties or their supporters may launch retaliatory cyber-attacks and may attempt to conduct other geopolitically motivated retaliatory actions. Those same parties may also attempt to fraudulently induce employees or authorized third parties, including contractors, to disclose sensitive information in order to gain access to our systems or data, or that of our customers, or service providers. 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 customer or proprietary data, interruptions or delays in our customers' businesses, or 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. If our employees, contractors, suppliers or other authorized third parties do not adhere (whether inadvertently or intentionally) to appropriate information security protocols, our protocols are inadequate, or our or our customers' sensitive information is released and/or compromised, we may experience significant negative impacts to our reputation and expose us or our customers to liability. We are not immune from the possibility of a malicious insider compromising our information systems and infrastructure, including but not limited to insiders exfiltrating the personal data of employees and customers, stealing corporate trade secrets and key financial metrics, illegally diverting funds, or intentionally disclosing our secrets (e.g., application credentials) to others in order to bypass our security policies and control mechanisms. No series of measures can fully safeguard against every insider threat. Refer to "Item 1C. Cybersecurity" for additional information about our cybersecurity risk management program.

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

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

In addition, we may have insufficient recourse against our vendors or subcontractors for costs, losses or claims we incur as a result of or reliance on their systems, services or other applications having significant defects, errors, or vulnerabilities, or which are successfully attacked by cyber and other security threats, resulting in our inability to meet our customers' expectations. Further, 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 customers 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, may harm our customer relationships, and may adversely affect our ability to attract or retain talent. 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.

Implementation of and compliance with various data privacy and cybersecurity laws, regulations and standards could require significant investment into ongoing compliance activities, trigger potential liability, and limit our ability to use personal data.

Any failure by us, our vendors or other business partners to comply with foreign, U.S. federal, state or local laws and regulations regarding data privacy, including the protection of personal or confidential information of our customers or employees which we may handle and process, or cybersecurity could result in significant monetary damages, regulatory enforcement actions, fines, penalties, private litigation or claims, and/or criminal prosecution in one or more jurisdictions, including as a result of the perception of our practices, products, and services in relation to violations of individual privacy, data protection rights, or cybersecurity requirements. We may also incur substantial expenses in implementing and maintaining compliance with such laws and regulations, or anticipated laws and regulations, including those that require certain types of data to be retained on servers within these jurisdictions or otherwise impose data sovereignty, localization, and cross-border transfer restrictions on how and where data is stored, processed, accessed, or transferred. These laws and regulations, and anticipated laws and regulations, are increasing in complexity and number, change frequently, sometimes conflict or create different requirements across jurisdictions, and are subject to interpretation by different regulators and courts, creating the possibility of different compliance measures or enforcement risks across jurisdictions, which may cause additional expenses for compliance with such laws and regulations. Our failure to comply with applicable laws and regulations may result in privacy claims or enforcement actions against us, including liabilities, fines and damage to our reputation, any of which may have a material adverse effect on our results of operations.

More than 20 U.S. states have enacted comprehensive privacy laws, and we are also subject to federal, state, local, and foreign privacy and data protection laws and regulations such as the European Union's ("EU") General Data Protection Regulation (the "GDPR"), and the United Kingdom's GDPR, that impose compliance obligations on companies that process personal data. These data privacy laws and regulations govern the collection, use, and processing of personal information, provide rights to residents of those respective states, in some cases including personal information collected from residents in the context of recruitment and employment, as well as business-to-business arrangements. The number and fragmentation of these laws create a complex regulatory landscape. Compliance with these laws, or new and evolving foreign, U.S. federal, state or local privacy laws, requires investments into compliance programs, investments to deploy, operate and maintain technology that enables compliance, potential modifications to business processes, ongoing data protection activities and documentation requirements, and creates the potential for fines, individual claims and other liabilities for noncompliance as well as litigation risks, particularly in the event of a data breach, and could have a material adverse effect on our business, including how we use personal information or our results of operations. Certain foreign, U.S. federal, state laws and regulations also impose obligations to maintain and implement an information security program that includes administrative, technical, physical, or organizational safeguards, and in some cases may require cybersecurity audits, risk assessments, or compliance measures relating to automated decision-making technologies, as well as obligations to give notice to affected individuals and to certain regulators in the event of a data breach. We may be required to spend significant resources to comply with these information security and data breach legal requirements. A significant data breach (including various forms of external attack, such as ransomware, as well as data incidents resulting from internal actions or omissions) could have negative consequences for our business and future prospects, including possible penalties, fines, damages, reduced customer demand, legal claims against and by customers, personnel, business partners or other persons claiming to be affected, harm to our systems and operations and harm to our reputation and brand.

In addition, as a contractor supporting defense and national security customers, we are subject to certain additional regulatory compliance requirements relating to data privacy and cybersecurity. Under the DFARS and other federal regulations, our networks and IT systems are required to comply with the security and privacy controls in certain National Institute of Standards and Technology Special Publications ("NIST SP"). To the extent that we do not comply with the applicable security and control requirements, unauthorized access or disclosure of sensitive information could result in a contract termination, which could have a material adverse effect on our business and financial results and lead to reputational harm. We are also subject to the Department of War Cybersecurity Maturity Model Certification ("CMMC"), requirements, which are being phased into covered solicitations and contracts and require contractors to obtain specified certifications relating to cybersecurity standards in order to be eligible for certain contract awards and, in some cases, contract modifications or option exercises. Although we have obtained CMMC level 2 certification, maintaining that status and satisfying applicable ongoing compliance, assessment, affirmation, monitoring, remediation, and renewal requirements may require significant effort and expense. In addition, certain subcontractors and vendors may also be required to comply with CMMC requirements. If we, or members of our supply chain, fail to maintain required compliance or certification levels, we could be unable to bid on, receive, or continue performing certain contracts or contract options, which could adversely affect our revenue, profitability, and reputation. In addition, any obligations that may be imposed on us under the CMMC may be different from or in addition to those otherwise required by applicable laws and regulations, which may cause additional expense for compliance.

We develop and use artificial intelligence, which could expose us to financial, regulatory, strategic, reputational, and other risks.

We use artificial intelligence, including agentic, physical, and adversarial artificial intelligence, and similar tools and technologies (collectively, “AI”) that collect, aggregate, manipulate, or generate data and systems in connection with our business. The development, deployment and oversight of the use of AI by us, either directly by our staff or indirectly through our suppliers or third-party AI developers, as well as the use of AI by competitors, requires us to invest substantially in AI technology resources and related governance. There is no guarantee that our use of AI will enhance our products or services, produce the intended results, or keep pace with the use of AI by our competitors. For example, AI algorithms may produce incomplete, insufficient, inaccurate, biased or otherwise flawed results or rely upon incomplete, insufficient, inaccurate, biased or otherwise flawed data, and any of these deficiencies may not be easily detectable despite the mitigations in place. Degraded or flawed performance could also result from adversarial attacks that include data poisoning, prompt injection, malware risks, and evasion techniques. If the AI that we use produces deficient, inaccurate, or controversial results, or if public opinion of AI is adversely affected due to actual or perceived risks regarding the usage of AI, we could incur operational inefficiencies, competitive harm, legal liability, brand or reputational harm, or other adverse impacts on our business. Further, ownership and intellectual property rights of content generated by or manipulated with AI is a developing area, presenting unique challenges that could affect our business interests and restrict our delivery of AI-driven solutions. If we, or the third-party AI developers on which we rely, do not have sufficient rights to use the data or other material relied upon by such AI technologies, we also may incur liability through the alleged violation of applicable laws and regulations, third-party intellectual property, data privacy, or other rights or contractual obligations. Although we conduct diligence on third-party AI developers, we will not be able to control the manner in which third-party AI technologies are developed or maintained. Our ability to develop, deploy, maintain, or scale AI technologies may also depend on our ability to obtain or access high-quality datasets, models, computing resources, and other AI system components from third parties on commercially reasonable terms, and any limitation, interruption, pricing change, licensing restriction, or other reduction in such access could impair our ability to deliver AI-enabled solutions competitively or at all. It is not possible to predict all the operational or technological risks that may arise relating to the use of AI, any of which may materially and adversely affect our business and results of operations.

Legal and regulatory frameworks related to the use of AI are evolving, including due to the perceived or actual risks of bias, lack of transparency, and information security. The technologies underlying AI and its uses are subject to a variety of laws and regulations, including intellectual property, data privacy and security, consumer protection, competition, and equal opportunity laws, and may be subject to new laws and regulations or new interpretations of existing laws and regulations. AI is the subject of ongoing review by various U.S. and foreign governmental and regulatory agencies. The U.S. policy environment for AI is rapidly changing through executive orders, other executive actions, agency guidance, procurement directives, and rulemaking, and these developments may impose new or different compliance obligations, alter enforcement priorities, and require us to modify our AI governance, development, deployment, and contracting practices. In addition, the EU AI Act, which applies to certain AI systems and general-purpose AI models and affects data and governance practices used to develop, test, deploy, and use them, is being implemented in phases. The enactment or expansion of laws and regulations related to the use of AI in our operations could result in increased compliance costs related to our use of AI, while the persistence of regulatory ambiguity results in uncertainty regarding potential compliance obligations and presents challenges to longer-term strategic decision-making. Additionally, we may not always be able to anticipate how courts and regulators will apply existing laws to AI how new legal frameworks will develop to address AI, or how we must respond to these frameworks, as they are rapidly evolving. We may also have to expend resources to adjust our offerings in certain jurisdictions if the legal frameworks are not consistent across jurisdictions.

Further, we face competition from other companies that are developing their own AI-enabled technologies, which may be superior to our technologies or more cost-effective to develop and deploy. In addition, as we develop and deploy AI-enabled solutions, our customers may not accept new pricing models designed to reflect the value, efficiency gains, or differentiated capabilities of those solutions, which could limit our ability to realize an adequate return on our AI investments. While AI is currently the focus of significant investment and strategic prioritization, there is a risk that if the expected value of AI does not materialize at scale, or if high-profile AI failures emerge, customers may reassess their AI plans, which could lead to reduced funding and a reduction in certain of our AI initiatives. These factors could materially and adversely affect our business, financial condition and results of operations.

We may fail to attract, train, and retain skilled and qualified employees, which may impair our ability to generate revenue, effectively serve our customers, 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 and/or 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. The government and industry have recognized that the current process for obtaining security clearances is time-consuming, sometimes taking years to complete, and can present a risk to customer mission. See “— We may fail to obtain and maintain necessary security clearances which may adversely affect our ability to perform on certain contracts.” In addition, as technologies and customer demands evolve rapidly, including in AI and other advanced technologies, we may need to make significant investments to train and re-skill our workforce, and we may not be successful in doing so quickly enough or at all.

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. Additionally, our ability to attract, hire, and retain skilled and qualified employees may be impacted by our engagements in, or perceived connections to, politically or socially sensitive activities, adverse labor and economic market conditions, as well as pandemics, epidemics or similar disease outbreaks.

If we are unable to recruit and retain a sufficient number of qualified employees, or cannot obtain their appropriate security clearances in a timely manner, or fail to deploy such employees, our ability to maintain and grow our business and to effectively serve our customers 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 customers, 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 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 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. Security clearances are issued at the discretion of the U.S. government and there can be no assurance that we will be able to obtain or maintain the security clearances necessary to perform our contracts. Depending on the level of required clearance, security clearances can be difficult and time-consuming to obtain. In the current environment we are seeing delays by the U.S. government in the processing of security clearances and there have been recent examples of large numbers of security clearances being revoked by executive orders. If we or our employees are unable to obtain or retain necessary security clearances in a timely manner, or a significant number of our employees lose security clearances, we may not be able to win new business, and our existing customers 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, effectively rebid on expiring contracts, or retain 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 expenses and achieve efficiencies, our competitiveness and profitability may be adversely affected.

Global inflationary pressures and new or increased tariffs on certain imports have increased the prices of goods and services, which could raise the costs associated with providing our services, diminish our ability to compete for new contracts or task orders, and/or reduce customer buying power.

For a variety of reasons, including geopolitical factors, the global economy in which we operate has faced, and may continue to face, heightened inflationary pressure, impacting the cost of doing business (in both supply and labor markets). These inflationary pressures have been and could continue to be exacerbated by geopolitical turmoil and economic policy actions, including new or increased tariffs on certain imports from other countries, and the duration of such pressures is uncertain. We generate revenue through various fixed price and multi-year government contracts, our primary customer being the U.S. government, which has traditionally been viewed as less affected by inflationary pressures. However, our approach to include modest annual price escalations in our bids for multi-year work may be insufficient to counter inflationary cost pressures, which may result in significant cost overruns on each contract. In addition, new or increased tariffs could result in increased costs for hardware and other goods necessary to support business operations. This could result in reduced profits, or even losses, as inflation increases, particularly for fixed-priced contracts, and our longer-term multi-year contracts as contractual prices become less favorable to us over time. In the competitive environment in which we operate as a government contractor, the lack of pricing leverage and power to renegotiate long-term, multi-year contracts, coupled with reduced customer buying power as a result of inflation, could reduce our profits, disrupt our business, or otherwise materially adversely affect our results of operations.

Deterioration of economic conditions or weakening in credit or capital markets may have a material adverse effect on our business, results of operations and financial condition.

Volatile, negative, or uncertain economic conditions, an increase in the likelihood of a recession, or concerns about these or other similar risks may negatively impact our customers' ability and willingness to fund their projects. Our customers reducing, postponing or cancelling spending on projects in respect of which we provide services may reduce demand for our services quickly and with little warning, which could have a material adverse effect on our business, results of operations and financial condition.

Moreover, instability in the credit or capital markets in the U.S., including as a result of failures of financial institutions and any related market-wide reduction in liquidity, or concerns or rumors about events of these kinds or similar risks, could affect the availability of credit, making it relatively difficult or expensive to obtain additional capital at competitive rates, on commercially reasonable terms or in sufficient amounts, or at all, thus making it more difficult or expensive for us to access funds or refinance our existing indebtedness, or obtain financing for acquisitions. Such instability could also cause counterparties, including vendors, suppliers and subcontractors, to be unable to perform their obligations, or to breach their obligations, to us under our contracts with them. If any such counterparties are unable to perform their obligations to us or our customers, we may be required to provide additional services or make alternate arrangements on less favorable terms. In addition, instability in the credit or capital markets could negatively impact our customers' ability to fund their project and, therefore, utilize our services, which could have a material adverse effect on our business, results of operations and financial condition. Further, if one or more financial institutions with which we maintain our cash, cash equivalents, or other investments were to fail or become subject to receivership or similar proceedings, our access to such funds could be temporarily impaired, which could adversely affect our liquidity, disrupt our business, or otherwise materially adversely affect our results of operations.

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 customers are important to our business and our ability to identify new business opportunities. 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 customer 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 fraud or other misconduct by employees, subcontractors, suppliers or other third parties with which we do business could occur. Misconduct by employees, subcontractors or suppliers could include intentional or unintentional failures to comply with U.S. government procurement regulations, engaging in other unauthorized activities, misusing authorized access, or falsifying time records. Misconduct could also involve the improper use or mishandling of our customers' sensitive, classified, or export-controlled information, or the inadvertent or intentional disclosure of our or our customers' sensitive information in violation of our contractual, statutory, or regulatory obligations, among other things. It is not always possible to deter employee, subcontractor, or supplier misconduct, and the precautions we take to prevent and detect this activity may not always 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 clearances 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 compete with companies of all types and sizes, including large enterprise software companies, large global technology providers, government contractors focused principally on the provision of technology services to the U.S. government, large defense contractors that provide both products and technology services to the U.S. government, diversified service providers, systems integrators, small businesses, and technology startups. We may also face competition from new entrants into our markets, including companies divested by large prime contractors in response to increasing scrutiny of organizational conflicts of interest issues or commercial companies in response to the U.S. government's push for modernization and innovation in procurement. There continues to be an 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:

- make acquisitions of businesses, or establish teaming or other agreements among themselves or third parties, that allow them to offer more competitive and comprehensive solutions;
- 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;
- offer products that may compete with our products that are or will be on the market;
- 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 customers, 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 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 customers, 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, or increased regulatory scrutiny or regulations governing information sharing and related practices, 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, customer 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 customer 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.

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.

A delay in the completion of the U.S. government's budget process, including as a result of a failure to raise the debt ceiling, could result in a reduction in our backlog and have a material adverse effect on our revenue and operating results.

Appropriations for the U.S. government's fiscal year 2026 were delayed, with Congress enacting partial appropriations legislation in multiple tranches, with such appropriations ultimately covering a majority of federal agencies. However, a full-year, comprehensive appropriations agreement has not been reached for all agencies, and certain portions of the government have been funded through continuing resolutions or remain subject to funding uncertainty, including the Department of Homeland Security, for which funding has been provided only on a partial basis, while certain components, including its immigration enforcement operations, remain subject to funding uncertainty. As a result, uncertainty regarding federal funding levels persists. To the extent the U.S. Congress is unable to approve the annual federal budget before the start of the U.S. government's fiscal year 2027, funding for new projects may not be available and funding on contracts we are already performing may be delayed. If Congressional efforts to approve such funding fail, and Congress is unable to craft a long-term agreement on the U.S. government's ability to incur indebtedness in excess of its current limits, the U.S. government may not be able to fulfill its current funding obligations and there could be significant disruption to all discretionary programs, which would have corresponding impacts on us and our industry. 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 U.S. government shutdown, which could result in us incurring substantial costs without reimbursement under our contracts. The delay or cancellation of key programs or the delay of contract payments may 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 the passage of legislation needed to approve any supplemental appropriation bill is delayed, the overall funding environment for our business could be adversely affected.

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 implementing advanced defense and technology systems and products, including cybersecurity products and services. New technologies may be untested or unproven, and insurance may not be available. We maintain insurance policies that mitigate against risk and potential liabilities related to our operations, including data breaches. 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.

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, licenses, and other contractual arrangements, as well as employment, 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 prior to and during employment. Inventions created during employment require inventors 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 trade secrets, trademarks, 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. We will also need to continue to respond to and anticipate changes resulting from disruptive technologies, including from AI. If we are not successful in protecting and preserving our intellectual property rights and licenses, including trade secrets, or in staying ahead of developing AI technologies and strategically incorporating them into our business, our business and financial performance could be materially and adversely affected.

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, copyright, trademark, trade secret, 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, customers, 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 customers, acquiring new customers by leveraging our core competencies, further developing our existing capabilities and service offerings, creating new capabilities and service offerings to address our customers' emerging needs, and undertaking business development efforts focused on identifying near-term developments and long-term trends that may pose significant challenges for our customers. These efforts entail inherent risks associated with innovation and competition from other participants in those areas, potential failure to help our customers respond to the challenges they face, our ability to comply with uncertain evolving legal standards applicable to certain service offerings, including those in the cybersecurity area, and, with respect to potential growth in foreign jurisdictions, 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, including the GDPR and the EU AI Act. See “—Implementation of and compliance with various data privacy and cybersecurity laws, regulations and standards could require significant investment into ongoing compliance activities, trigger potential liability, and limit our ability to use personal data.” As we attempt to develop new relationships, customers, 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.

The needs of our customers change and evolve regularly due to complex and rapidly changing technologies. Our success depends upon our ability to identify emerging technological trends; develop technologically advanced, innovative, and cost-effective products and services; and market these products and services to our customers. Our success also depends on our continued access to suppliers of important technologies and components. 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.

Our ability to grow our business by leveraging our operating model to efficiently and effectively deploy our people across our customer base is also 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 foreign operations, we are providing customer services and undertaking business development efforts in numerous and disparate geographic locations both domestically and in select foreign locations. Our ability to effectively serve our customers 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.

Changes to our operating structure, capabilities, or strategy intended to address our customers' 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 customers, effectively responding to developments in our markets and successfully building platforms intended to provide the foundation to support 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 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 general, access to classified information, technology, facilities, or programs requires appropriate personnel security clearances, is subject to additional contract oversight and potential liability, and may also require appropriate facility clearances and other specialized infrastructure. A significant number of our employees have security clearances which preclude them from providing information regarding certain customers and services provided to such customers to other employees (or members of our board of directors) 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, important information concerning our business may not be available, which may limit insight into a substantial portion of our business and reduce the ability 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 any of our U.S. government or commercial customers, 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. For example, our U.S. government customers may delay or fail to pay invoices for a number of reasons, including lack of appropriated funds, lack of an approved budget, lack of revised or final settled billing rates as a result of open audit years 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. In recent months, we have experienced, and may continue to experience, delays in the payment of invoices by our U.S. government customers. Should such delays become significant, there may be a material and adverse affect on our business.

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

As part of our operating strategy, we continually monitor U.S. government spending and budgetary priorities to align our investments in new capabilities to drive organic growth, and selectively pursue acquisitions, investments, partnerships, and joint ventures that broaden our domain expertise and service offerings, and/or establish relationships with new customers. These transactions pose many risks, including:

- we may not be able to identify suitable acquisition and investment candidates at prices we consider attractive;
- as a result of continued uncertainties in economic conditions and U.S. government spending (generally and/or specific agencies) and mission priorities, acquisition and investment candidates may choose to delay entering into acquisition or investment transactions;
- we may not be able to compete successfully for identified acquisition and investment candidates, complete acquisitions and investments on intended terms and timeline (including, without limitation, by failing to obtain required regulatory or other approvals or the benefit of safe harbors in a timely manner, or required financing on acceptable terms), or accurately estimate the financial effect of acquisitions and investments on our business;
- as a result of increased scrutiny by antitrust authorities and changes to mandatory filing requirements, we may announce acquisition or investment transactions that require significant time and resources to complete, are challenged by such authorities or are ultimately not fully completed due to a failure to obtain antitrust or other regulatory approvals;
- future acquisitions and investments may require us to issue common stock, restricted stock or restricted stock units, incur additional debt, 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 customers;
- we may have difficulty integrating personnel from an acquired company with our people, our culture of integrity, and our core values;
- we may have difficulty integrating acquired businesses, resulting in diminished strategic value of a potential transaction and unforeseen difficulties, such as incompatible accounting, information management, or other control systems, and greater expenses than expected;
- we may assume legal or regulatory risks, particularly with respect to smaller businesses that have immature business processes and compliance programs, which may be required to comply with additional laws and regulations or to engage in remediation efforts to cause an acquired company to comply with applicable laws and regulations, and such risks may result in liabilities resulting from an acquired company's failure to comply with applicable laws or regulations;
- 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 or future impairments of intangible assets, each of which could reduce our future reported earnings;
- we may not be able to effectively influence the operations of our minority investments, joint ventures or partnerships, or we may be exposed to certain liabilities if our partners do not fulfill their obligations; and
- as a result of an acquisition or investment, we may be targeted by additional cybersecurity threat actors or experience a cyber incident due to the security posture of the acquired company or its suppliers.

In addition, 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 comply with applicable laws or regulations, or to have fulfilled its contractual obligations to the U.S. government or other customers. 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, guarantees or other financial arrangements, 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, within expected time frames or due to a failure of a prospective purchaser to obtain financing or a failure to obtain antitrust or other related regulatory approvals.

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, 2026, the value of our goodwill was \$2,399 million. 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.

Legal and Regulatory Risks

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.

We are required to comply with numerous laws and regulations, including those relating to the formation, administration, and performance of U.S. government contracts, which affect how we do business with our customers. Such laws and regulations, including executive orders, administration agency rulemaking and interpretations, and other governmental actions, 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, the 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 Truthful Cost or Pricing Data Statute (formerly known as the Truth in Negotiations Act), which requires certification and disclosure of cost and pricing data in connection with the negotiation of certain contracts, modifications, or task orders;
- 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, contract requirements and executive orders, including those related to cybersecurity, 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 regulating the handling, use, and dissemination of personally identifiable information in the course of performing a U.S. government contract, performing work for our commercial customers or running the business;
- 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 War 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 and allowability requirements that govern our right to reimbursement under certain cost-based U.S. government contracts and require consistency of accounting practices over time.

The U.S. government, U.S. states and other jurisdictions in which we do business may adopt 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 statutes 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, triggering of price reduction clauses, withholding or 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.”

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. 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 (such as matters involving alleged violations of civil rights, wage and hour, and worker’s compensation laws), relationships with customers and contractors, intellectual property disputes, and other business matters. Any such claims, proceedings or investigations may be time-consuming, costly, divert management resources, or otherwise have a material adverse effect on our result of operations.

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 coverage 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 cannot predict the consequences of future geopolitical events, but they may adversely affect the markets in which we operate and our results of operations.

Ongoing instability and current geopolitical conflicts in global markets, including ongoing conflicts in Eastern Europe and the Middle East, increased tensions in Asia, and political and economic instability in Venezuela, the potential for future geopolitical conflicts and terrorist activities, and trade tensions related to recent shifts in international trade policies could have a material adverse effect on our business, operations and profitability. These types of matters cause uncertainty in financial markets and may significantly increase the political, economic and social instability in the geographic areas in which we operate.

In addition, in connection with the current status of foreign relations with Russia, particularly in light of the conflict between Russia and Ukraine, the U.S. government has imposed enhanced export controls on certain products and sanctions on certain industry sectors and parties in Russia. The U.S. government has imposed tariffs, and may impose new or increased tariffs, on certain imports from other countries. The governments of other jurisdictions in which we operate, such as the European Union and Canada, may also implement sanctions or other restrictive measures. These potential sanctions, tariffs, and export controls could adversely affect the Company and/or our supply chain, business partners, or customers.

We are subject to risks associated with operating in foreign jurisdictions.

We have operations in select foreign locations and, therefore, our business operations are subject to a variety of risks associated with conducting business in foreign jurisdictions, including:

- Changes in or interpretations of laws or policies that may adversely affect the performance of our services;
- Political and economic instability in foreign countries and foreign security concerns, such as those relating to geopolitical conflict, as well as trade tensions related to recent shifts in international trade policies, and potential actions or retaliatory measures taken in respect thereof;
- Imposition of inconsistent or conflicting laws or regulations;
- Reliance on the U.S. or other governments to authorize us to export products, technology, and services to customers and other business partners;
- Reliance on foreign countries for critical parts in order to meet our technical delivery requirements;
- Conducting business in places where laws, business practices, and customs are unfamiliar or unknown;
- Failure to comply with U.S. government and foreign laws and regulations applicable to foreign business, sanctions, employment, privacy, data protection, information security, or data transfer could have an adverse impact on our business with the U.S. government and could expose us to risks and costs of non-compliance with such laws and regulations, in addition to administrative, civil, or criminal penalties;
- Failure by third parties that we work with, including suppliers, subcontractors, and vendors, to comply with U.S. government and foreign laws and regulations applicable to foreign business, sanctions, employment, privacy, data protection, information security, or data transfer could expose Booz Allen to risks and costs of non-compliance with such laws and regulations, in addition to administrative, civil, or criminal penalties;
- U.S. and foreign government import and export control requirements and regulations, including International Traffic in Arms Regulations and the anti-boycott provisions of the U.S. Export Administration Act, technology transfer restrictions and other administrative, legislative, or regulatory actions that could materially interfere with our ability to offer our products or services in certain countries;
- Imposition of limitations on or increase of withholding and other taxes on payments by foreign subsidiaries or joint ventures;
- Changes in state and federal regulations in state money transmission regulations, anti-money laundering regulations, economic and trade sanctions administered by the U.S. Treasury Department's Office of Foreign Asset Control;
- Imposition of tariffs or embargoes, export controls, and other trade restrictions; and
- Financial and operational implications associated with potential commercial customer data sovereignty requirements that require hosting data and systems locally.

In addition, we are subject to the U.S. Foreign Corrupt Practices Act (the “FCPA”) and other laws that prohibit improper payments or offers of payments to foreign government officials, political parties and commercial entities for the purpose of obtaining or retaining business. We have operations and deal with governmental customers and regulators in countries known to create heightened corruption risk, including certain developing countries. Our activities in these countries create the risk of unauthorized payments or offers of payments by one of our employees or third parties that we work with that could implicate Booz Allen for violations of various laws including the FCPA and other anti-corruption laws. Our operations in select foreign locations also involve activities involving the transmittal of information, which may include personal data, which 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. We are also subject to applicable sanctions laws, regulations, embargoes, or restrictive measures intended to prevent unauthorized transactions with prohibited persons, entities, and countries, including, those administered and enforced by the U.S. Department of Treasury’s Office of Foreign Assets Control, the Office of Financial Sanctions Implementation in the UK, and the competent authorities responsible for the administration and enforcement of Sanctions in individual EU Member States.

If we were to fail to comply with the FCPA, other applicable anti-corruption laws, import-export control regulations, sanctions, data privacy laws, or other 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.

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.

Efforts by the U.S. government to reform its procurement practices have focused on, among other areas, 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. Recently, U.S. government agencies have issued proposed regulations, which provide for and update definitions of each of the above types of conflicts of interest and provide illustrative examples of various relationships that contractors could have that would give rise to potential conflicts of interest. The resulting rule making process, as well as continuing reform initiatives in procurement practices, may result in future amendments to the FAR, increasing the restrictions in current organizational conflicts of interest regulations and rules, or place heightened scrutiny on the relationships we have with other entities, including partnerships and investments. Similarly, organizational conflicts of interest remain an active area of bid protest litigation, increasing the likelihood that competitors may leverage such arguments in an attempt to overturn agency award decisions. To the extent that proposed and future organizational conflicts of interest laws, regulations, and rules or interpretations thereof 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.

Changes in tax law or judgments by management related to complex tax matters could adversely impact our results of operations.

We are subject to taxation in the U.S. and certain other foreign jurisdictions. Any future changes in applicable federal, state and local, or foreign tax laws and regulations or their interpretation or application, including those that could have a retroactive effect, could result in the Company incurring additional tax liabilities in the future. For example, the “Tax Cuts and Jobs Act,” enacted in 2017, eliminated the option to deduct research and development costs currently and required taxpayers to capitalize and amortize such expenditures over five or fifteen years. Subsequently, on July 4, 2025, the U.S. federal tax legislation commonly referred to as the “One Big Beautiful Bill Act,” was enacted, which makes a number of changes to U.S. federal income tax law, including permanently suspending the requirement to capitalize and amortize domestic research and development costs and permitting such deductions on a current basis. Any further changes in tax laws or regulations that are applied adversely to us could have a material adverse effect on our business, financial condition and results of operations.

Additionally, we recognize liabilities for uncertainty in income taxes when it is more likely than not that a tax position will not be sustained on examination and settlement with various taxing authorities. We regularly assess the adequacy of our uncertain tax positions and other reserves, which requires a significant amount of judgment. Although we accrue for uncertain tax positions and other reserves, the results of regulatory audits and negotiations with taxing and customs authorities may be in excess of our accruals, resulting in the payment of additional taxes, duties, penalties and interest. As a result, any final determination of tax audits or related litigation may be materially different than our current provisional amounts, which could materially affect our tax obligations and effective tax rate.

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 customers with rights, remedies, and obligations not typically found in commercial contracts. These rights and remedies allow government customers, 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 Truthful Cost or Pricing Data Statute, 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 or 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.

In connection with the efforts by the U.S. government to reduce federal spending across federal civilian, defense, and intelligence departments and agencies, we have had, and may in the future have, certain of our contracts renegotiated, modified, reduced or canceled and may in the future continue to experience such adjustments. See "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations—Factors and Trends Affecting Our Results of Operations—U.S Political, Budget and Regulatory Environment" for additional disclosure regarding our business environment. Similarly, if a U.S. government customer 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, such actions could cause reputational harm to us, and could have a material adverse effect on our revenue and results of operations.

Our work with government customers exposes us to additional risks inherent in the government contracting environment, which could reduce our revenue, disrupt our business, or otherwise materially adversely affect our results of operations.

U.S. government contractors (including their subcontractors and others with whom they do business) operate in a highly regulated environment and are routinely audited and reviewed by the U.S. government and its agencies, including the DCAA, DCMA, Department of War Inspector General, and others. These agencies review our performance on contracts, pricing practices, cost accounting practices, and compliance with applicable policies, laws, regulations, and standards, including applicable government cost accounting standards, as well as our contract costs, including allocated indirect costs. The DCAA audits and the DCMA reviews, among other areas, the adequacy of our internal control systems and policies, including our DFARS required business systems, which are comprised of our purchasing, property, estimating, earned value, accounting and material management 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 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. 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 the provision for claimed costs, which is based on management's estimates and assumptions that are inherently uncertain and may not cover actual losses. For example, DCAA audits may result in, and have historically resulted in, the Company's inability to retain certain claimed costs, including executive and employee compensation, due to differing views of the allowability and reasonableness of such costs. As of March 31, 2026, years subsequent to the Company's fiscal year 2011 remained subject to audit and/or final resolution. As of March 31, 2026, the Company recognized a liability of \$248 million for estimated adjustments to claimed costs based on its historical DCAA audit results, including the final resolution of such audits with the DCMA. Determining the provision for claimed costs is complex and subject to management's estimate of adjustments to claimed costs based on the number of years that remain open to audit and expected final resolution by U.S. government agencies. As a result, significant changes in estimates could have a material effect on the Company's results of operations. 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.

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, require us to retroactively and prospectively adjust previously agreed to billing or pricing rates for our work, and could harm our reputation and relationships with our customers 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 War's contracting officers to impose contractual withholding at no less than certain minimum levels based on assessments of a contractor's business systems. 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. We could also suffer serious reputational harm if allegations of impropriety were made against us.

In addition, operation of our financial management systems, including changes to modernize and upgrade those systems, and certain changes to our cost accounting practices that we have adopted may negatively impact our profitability. In particular, the changes to our cost accounting practices required us to estimate changes in costs for certain contracts and make payments in connection with such estimates. The changes are subject to audit by the DCAA and negotiation with the DCMA, which could result in additional payments that may be material and not recoverable. To the extent we are unable to fully mitigate the costs associated with changes to our cost accounting practices as we implement the new systems, our business and financial results may be adversely affected.

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 limits such reimbursements; and
- at its option, terminate or decline to renew our contracts.

We continue to see delays in procurements with our U.S. government customers, and these delays are expected to continue in the near term. 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, and changes to the procurement system could cause delays in the procurement decision-making process. Any such delays in procurements generally, 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.

The U.S. government may prefer 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 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 business is subject to a number of risks related to climate and environmental matters, including regulatory, political, reputational, litigation and financial risks, that could adversely affect our results of operations or financial condition.

Our business is subject to a number of risks related to climate and environmental matters, including regulatory, political, reputational, litigation and financial risks. We have operations located in regions that have been, and may in the future be, impacted by physical risks related to climate, including rising sea levels, severe weather events, and natural disasters, as well as disease outbreaks. Such events could disrupt our operations or those of our customers and suppliers, including the inability of employees to work, destruction of facilities, loss of life, and adverse effects on our supply chain and the integrity of information technology systems, all of which could materially increase our costs and expenses, delay or decrease revenue from our customers, and disrupt our ability to maintain business continuity. We could incur significant costs to improve the resiliency of our infrastructure and otherwise prepare for, respond to, and mitigate the effects of climate-related events.

There are numerous foreign, U.S. and state laws and regulations related to climate and environmental management disclosures, including regulations related to greenhouse gas emissions reporting. These regulations often impose different and, occasionally, conflicting or contradictory requirements, which may result in increased compliance and operational costs to comply with such regulatory requirements as well as an increased potential for liability arising from noncompliance with such requirements.

Additionally, the evolving technological, social, legal, and political context of these issues as well as changing expectations from foreign, U.S. and state governments, customers, employees, investors, and other stakeholders may create conflicts, disaffection, and dissatisfaction between regulatory requirements and various stakeholder expectations, which could result in potential damage to our reputation and adversely affect our business.

Risks Related to Our Indebtedness

We have indebtedness and may incur 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.

We have indebtedness, and we are able to, and may, incur additional indebtedness in the future. The material terms of our indebtedness are described in Note 10, “Debt,” to the consolidated financial statements contained within this Annual Report on Form 10-K. The level of our indebtedness could have important consequences to holders of our common stock, including:

- making it more difficult for us to satisfy our existing debt obligations;
- limiting our ability to refinance our existing indebtedness or 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;
- increasing our vulnerability to general adverse economic and industry conditions, including increased interest rates;
- 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 agreements governing our indebtedness 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. 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 existing debt obligations.

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 Indebtedness.”

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. Our cash flows could be reduced for a number of reasons, including as a result of unexpectedly aggressive capital calls from our venture capital investments.

The agreements governing our indebtedness restrict our ability to incur additional indebtedness, which could limit 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. 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 would be in default and the following events could occur: lenders under our Senior Credit Facility and holders of our outstanding senior notes could declare all outstanding principal and interest to be due and payable; and lenders under the Revolving Credit Facility could terminate their commitments to provide loans. All of these events could force us into bankruptcy or liquidation and result in investors' losing some or all of the value of their 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 Senior Credit Facility and the indentures governing our outstanding 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;
- enter into sale-leaseback transactions;
- incur liens;
- consolidate, merge or sell all or substantially all of our and our subsidiaries' assets; 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 Senior Credit Facility require us to maintain a consolidated net total leverage ratio that will be tested at the end of each fiscal quarter. Our ability to satisfy such 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 Senior Credit Facility would also permit the lenders under the Revolving Credit Facility to terminate all other commitments to extend further credit under that facility. 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 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 Senior Credit Facility are at variable rates of interest and expose us to interest rate risk. Following the significant increases in interest rates during 2022 and 2023, rates have gradually declined but, as of March 2026, remain above recent historical lows. Future movements in interest rates remain uncertain. With an increase in interest rates, our debt service obligations on the variable rate indebtedness would increase even though the amount borrowed remains the same, and our net income and cash flows, including cash available for servicing our indebtedness, would correspondingly decrease.

Based on the outstanding \$1.5 billion term loan and any balances drawn under the revolving credit facility as of March 31, 2026, and after considering interest rate swaps that fix the interest rate on \$350 million of principal of our variable-rate debt, each quarter point change in interest rates would result in a \$3 million change in our projected annual interest expense on the outstanding indebtedness under our Senior Credit Facility. We have entered into interest rate swaps and may in the future enter into additional interest rate derivatives that balances our debt portfolio and keeps a neutral stance on interest rates. 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.

We and our indebtedness have 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 Hamilton Holding Corporation 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 Hamilton Holding Corporation 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 receipt of funds from its subsidiaries via dividends or intercompany loans. 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 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 has authorized and declared a regular quarterly dividend for each quarter in the last several years. The Board 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 taking into account future earnings, cash flows, financial requirements and other factors. There can be no assurance that the Board will declare any dividends in the future. Additionally, recent executive orders and proposed legislation limiting the ability of certain defense contractors in some circumstances to pay dividends could limit or prohibit our ability to pay regular or special 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.

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 by-laws 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 Hamilton Holding Corporation that our stockholders might consider in their best interests. These provisions include:

- granting to the Board the sole power to set the number of directors and to fill any vacancy on the Board;
- 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;
- the establishment of advance notice requirements for stockholder proposals and nominations for election to the Board at stockholder meetings; 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 1C. Cybersecurity.

As one of the world's largest cybersecurity solution providers, we routinely defend against advanced persistent threats both internally and for our customers. Our cybersecurity risk management program is an integral part of our overall Enterprise Risk Management ("ERM") program, and is designed to assess, identify, manage and mitigate internal and external cybersecurity risks, threats and incidents.

Risk Management and Strategy

Cybersecurity oversight is embedded in our ERM Steering Committee, chaired by the President and Chief Operating Officer and including senior executives such as the Chief Information Security Officer ("CISO") and Chief Information Officer ("CIO"). This committee:

- Provides oversight of cybersecurity risk within the broader ERM framework and reviews management's approach to cybersecurity risk identification, assessment, and response;
- Reviews management's alignment of cybersecurity risk management priorities and strategies with business objectives; and
- Receives updates from management regarding cybersecurity assessments, exercises, mitigation activities, and significant cybersecurity risks.

See "Item 1C. Cybersecurity—Governance—Management's Responsibilities" below for additional information regarding our cybersecurity risk management program.

Governance

Management's Responsibilities

Our cybersecurity risk management program is led by our CIO and CISO, who are responsible for our information security strategy, policies, compliance, security architecture and engineering, security operations, and cybersecurity threat detection and response. Our CIO has served as chief technology officer for several large-scale enterprises in the healthcare industry and has more than 30 years of enterprise information technology experience, with deep expertise in aligning technology strategy with business goals, advancing cybersecurity capabilities, and leveraging AI and cloud computing to drive performance and efficiency. Our CISO has over 20 years of information security and program management experience and has served as the CISO for other large-scale enterprises. In addition to our CIO and CISO, we leverage our commercial incident response team and government cyber expertise to harden our cybersecurity infrastructure.

As a government contractor, we are required to comply with extensive regulations and standards, including but not limited to, cybersecurity regulations and standards, Cybersecurity Maturity Model Certification (CMMC) requirements, and the requirements of the DFARS. Booz Allen achieved a Final C3PAO (CMMC Third Party Assessment Organization) CMMC Level 2 Certification in October 2025 which is valid for 3 years with a mandated annual attestation of compliance from the CISO. Additionally, our cybersecurity risk management program is guided by the National Institute of Standards and Technology ("NIST") Cybersecurity Framework. Our policies and implemented controls have been assessed and are subject to assessment by external organizations, including industry partners, the federal government, and third party assessors. We work closely with our subcontractors and suppliers to identify and manage cybersecurity risks and, as appropriate, require them to comply with applicable laws and regulations. These contractual requirements include the requirement that our subcontractors implement certain security controls, and that our subcontractors self-report the status of their implementation of these controls to the U.S. government.

To manage cybersecurity risk introduced from our supply chain, depending on the nature of a supplier's work and the sensitivity of our and our customers' information provided to the supplier, we also require suppliers to complete our security questionnaire

and provide evidence of security accreditations, to include as applicable CMMC compliance proof, and we evaluate supplier compliance with security requirements using internal and third-party resources.

Our CISO also leads our Cyber Fusion Center (“CFC”), whose function is, pursuant to our Cyber Incident Response Plan, to stay apprised of existing and emerging cybersecurity threats and monitor our information systems to proactively identify, protect against, and mitigate cybersecurity threats. The CFC uses intelligence collected from various sources, fused with intelligence collected from analysis and response actions, to proactively search for and address adversary activity against our information systems. The CFC possesses in-depth knowledge of network, endpoint, perimeter security systems, identity-based vulnerabilities, data protection, threat intelligence, forensics, penetration testing, and threat detection, monitoring, and response, as well as the functioning of specific applications or underlying information systems infrastructure. Additionally, the CFC regularly conducts table top exercises to test and evaluate our incident response processes in routine and emerging areas of cyber risk. The CFC partners with a third party managed systems security provider (“MSSP”) to augment 24x7 cyber incident monitoring.

The Cyber Incident Response Team (“CIRT”) is responsible for the incident response process and provides direction and guidance to users of our information systems when responding to cybersecurity incidents. The CIRT also provides intrusion monitoring of networks and information systems, and performs triage and analysis of cyber and data loss events to identify and respond to potential incidents, including potential incidents occurring on third-party systems. The CIRT also includes data loss prevention (“DLP”) capabilities, and proactively monitors and protects sensitive data across the organization, identifying and mitigating risks of data exfiltration, misuse, or unauthorized access. The team leverages DLP tools to detect and respond to anomalies in data usage, transmissions, and storage. The CIRT categorizes anomalous cybersecurity and data loss events into discrete levels in which cybersecurity events are escalated to appropriate levels of management, as well as our Crisis Management Team, Cyber Incident Materiality Committee, Audit Committee, and Board, based on the severity of the incident. While typical cybersecurity management and incident response is provided by internal resources, we have arrangements with certain third parties whom we can engage if additional support or resources are required.

Board of Directors’ Roles and Responsibilities

The Board oversees the Company’s risk management processes, including those relevant to cybersecurity risks, and the Audit Committee provides focused governance of cybersecurity, ensuring that cybersecurity threats, vulnerabilities, and incident response measures are continuously assessed and managed. The Audit Committee receives regular briefings from the CISO on risks related to internal systems, third-party relationships, and emerging cybersecurity threats. The Audit Committee provides updates to the Board on significant cybersecurity risks and the Company’s mitigation strategies.

Cybersecurity Threats

Even with our extensive and systematic approach to cybersecurity, we may not be successful in preventing or mitigating a cybersecurity incident that could have a material adverse effect on us. While we maintain cybersecurity insurance, the cost related to cybersecurity threats or disruptions may not be fully insured.

During the period covered by this Annual Report, we have not experienced any cybersecurity incidents that have materially affected or are reasonably likely to materially affect our business strategy, results of operations, or our financial condition. Future cybersecurity incidents could, however, materially affect our business strategy, results of operations, reputation, or financial condition.

See Item 1A., “Risk Factors,” for a discussion on cybersecurity risks and how they could materially affect the Company.

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 plan to relocate our headquarters in the fall of 2027 to Reston, Virginia, dependent upon the timing of the completion of various tenant improvements. 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; Washington, D.C.; Chantilly, Virginia; Laurel, Maryland; Panama City Beach, Florida; Arlington, Virginia; Bethesda, Maryland; Alexandria, Virginia; and Colorado Springs, Colorado. 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. government. 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 million square feet. We believe our facilities meet our current needs.

Item 3. Legal Proceedings.

The Company is involved in legal proceedings and investigations arising in the ordinary course of business, including those relating to employment matters, relationships with customers and contractors, intellectual property disputes, compliance with various laws and regulations, and other business matters. We have provided information about these legal proceedings and investigations in Note 18, “Commitments and Contingencies,” to the consolidated financial statements contained within this Annual Report on Form 10-K. 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 both March 31, 2026 and March 31, 2025, there were no material amounts accrued in the consolidated financial statements related to these proceedings.

Item 4. Mine Safety Disclosures.

None.

Information about our Executive Officers.

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

Name	Age	Position
Horacio D. Rozanski	58	Chairman and Chief Executive Officer
Kristine Martin Anderson	57	President and Chief Operating Officer
Troy Lahr	52	Executive Vice President and Chief Financial Officer
Shannon Fitzgerald	53	Executive Vice President and Civil Sector President
Andrea Inserra	56	Executive Vice President and Defense Sector President
Thomas Pfeifer	66	Executive Vice President and National Security Sector President
Joshua Petty	52	Executive Vice President and General Counsel
Dennis Metzfield	46	Vice President, Controller and Chief Accounting Officer

Horacio D. Rozanski is our Chairman and Chief Executive Officer. A respected business leader, Mr. Rozanski led our transformation into an advanced technology company. He joined Booz Allen in 1992 as a consultant to commercial customers, was elected Vice President in 1999, and served as our Chief Personnel Officer, Chief Strategy and Talent Officer, Chief Operating Officer, and President before becoming Chief Executive Officer in 2015. Mr. Rozanski became Chairman of our Board of Directors in July 2024. Mr. Rozanski currently serves as Chairman of the board of directors for Children’s National Hospital and is a member of the board of directors at Marriott International, Inc. (NASDAQ: MAR). He is also a member of the Business Roundtable, the Economic Club of Washington, D.C., and the United States Holocaust Memorial Museum’s Committee on Conscience, and Vice Chair of the Trump Kennedy Center Corporate Fund Board.

Kristine Martin Anderson is our President and Chief Operating Officer. Ms. Anderson joined Booz Allen in 2006, and has held a variety of leadership roles. In addition to serving as Chief Operating Officer since May 2022, she was appointed President in May 2026. Ms. Anderson served as President for the Company’s Civil sector from April 2018 to May 2022, and led the Company’s civil health business from 2015 to 2018. Prior to joining Booz Allen, Ms. Anderson was Vice President for Operations and Strategy at CareScience, a health care software solutions company.

Troy Lahr is an Executive Vice President at Booz Allen and our Chief Financial Officer. Prior to joining Booz Allen in May 2026, Mr. Lahr served as Senior Vice President and Chief Financial Officer at Sierra Space. Prior to joining Sierra Space, Mr. Lahr spent approximately ten years at Boeing (NYSE: BA) serving in roles of increasing responsibility, most recently serving as Chief Financial Officer for Boeing’s Defense, Space & Security business. Prior to joining Boeing, Mr. Lahr spent twelve years at Stifel Financial Corporation as an equity analyst researching the aerospace & defense industry.

Shannon Fitzgerald is an Executive Vice President at Booz Allen and President for the Company’s Civil sector. Prior to becoming President for the Company’s Civil sector in May 2026, Ms. Fitzgerald served as the Company’s Chief Strategy officer, leading the company’s growth strategy and positioning Booz Allen to deliver advanced technologies across critical government and commercial missions. Ms. Fitzgerald has over 25 years of experience at Booz Allen and previously led Booz Allen’s civil focused domestic resilience and citizen services businesses. She has worked with a broad set of civil customers including homeland security, law enforcement, finance, energy, transportation, and health agencies. Ms. Fitzgerald also serves as an instructor for the Change Management Advanced Practitioner course at Georgetown University’s McDonough School of Business.

Andrea Inserra is an Executive Vice President at Booz Allen and President for the Company's Global Defense sector. Prior to becoming President for the Company's Global Defense sector in April 2025, Ms. Inserra served as an Executive Vice President and market leader for Booz Allen's aerospace business, serving customers in the U.S. Air Force, Space Force, and NASA. Ms. Inserra has over 25 years of experience at Booz Allen, and previously led the operations and strategy team for Booz Allen's defense and commercial businesses and was a leader in our military and civil health businesses. Ms. Inserra serves on the board of directors for the Armed Services YMCA and Haskell. Previously, Ms. Inserra served on the boards of the Association of Military Surgeons of the United States and the Catholic University of America School of Engineering.

Thomas Pfeifer is an Executive Vice President at Booz Allen and President for the Company's National Security sector. Mr. Pfeifer joined Booz Allen in 1989 and has over 40 years of industry experience. Prior to becoming President for the Company's National Security sector in August 2022, Mr. Pfeifer led several business units focused on defense military intelligence, space, national agencies, the Air Force, and NASA, where he focused on evolving the businesses closer to the mission. He is a member of the Institute of Navigation (ION), the Institute of Electrical and Electronic Engineering (IEEE) Computer Society, the American Society for Quality (ASQ), and the Armed Forces Communications and Electronics Association (AFCEA).

Joshua Petty is an Executive Vice President at Booz Allen and our General Counsel. Mr. Petty joined Booz Allen in 2014 and leads the Company's Legal, Ethics & Compliance department. Prior to joining Booz Allen, Mr. Petty spent approximately 13 years at Accenture plc (NYSE: ACN) serving in roles of increasing responsibility, most recently serving as global government compliance officer and a managing director.

Dennis Metzfield is a Vice President at Booz Allen and our Controller and Chief Accounting Officer since February 2025. Mr. Metzfield joined the Company in November 2024 as Vice President and Controller. Prior to joining the Company, he spent 7 years at Huntington Ingalls Industries (NYSE: HII), where he most recently served as the Corporate Assistant Controller. Prior to joining Huntington Ingalls Industries, Mr. Metzfield served as a Senior Manager in Deloitte's accounting advisory practice.

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. On May 1, 2026, there were 206,857 beneficial holders of our Class A Common Stock. Our Class A Common Stock is listed on the New York Stock Exchange under the ticker symbol "BAH."

Dividends

The Company plans to continue paying recurring dividends in the future to the extent legally permissible 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 Board of Directors and will depend, among other factors, upon our earnings, liquidity, financial condition, alternate capital allocation opportunities, or any other factors the Board of Directors deems relevant. On May 22, 2026, the Company announced that the Board of Directors had declared a quarterly cash dividend of \$0.59 per share. Payment of the dividend will be made on June 26, 2026 to stockholders of record at the close of business on June 10, 2026.

Recent Sales of Unregistered Securities

None.

Issuer Purchases of Equity Securities

The following table presents the share repurchase activity for each of the three months in the quarter ended March 31, 2026:

Period	Total Number of Shares Purchased⁽¹⁾	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⁽²⁾ (in millions)
January 2026	269,482	\$93	269,482	\$ 734
February 2026	321,937	\$79	316,060	\$ 709
March 2026	461,940	\$78	317,746	\$ 684
Total	<u>1,053,359</u>		<u>903,288</u>	

- (1) The total number of shares purchased includes shares surrendered to satisfy minimum statutory tax withholding obligations related to the vesting of stock awards.
- (2) On December 12, 2011, the Board of Directors initially approved a share repurchase program, which was subsequently increased from time to time, and most recently increased by \$500 million to \$4,085 million on October 22, 2025. As of March 31, 2026, the Company had approximately \$684 million remaining under the 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 stockholder return on our Class A Common Stock between March 31, 2021 and March 31, 2026, 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, 2021 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 RETURN



**ASSUMES \$100 INVESTED ON MARCH 31, 2021
ASSUMES DIVIDEND REINVESTED**

Company/Market/Peer Group	3/31/2021	3/31/2022	3/31/2023	3/31/2024	3/31/2025	3/31/2026
Booz Allen Hamilton Holding Corp.	\$ 100.00	\$ 111.11	\$ 119.45	\$ 194.23	\$ 138.88	\$ 106.18
Russell 1000 Index	\$ 100.00	\$ 113.27	\$ 103.76	\$ 134.75	\$ 145.29	\$ 171.07
S&P Software & Services Select Industry Index	\$ 100.00	\$ 93.96	\$ 78.85	\$ 99.93	\$ 102.84	\$ 91.69

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. Reserved.

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 our consolidated financial statements and the related notes contained elsewhere in this Annual Report, and Part II, Item 7 “Management’s Discussion and Analysis of Financial Condition and Results of Operations” of our Form 10-K for the fiscal year ended March 31, 2025, which provides additional information on comparisons of fiscal 2025 and 2024.

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

Booz Allen is an advanced technology company, building products and solutions for government and business. We are a leader at the forefront of the nation’s technology ecosystem. Our approximately 31,500 employees build tech for a diverse base of federal government and commercial customers, both domestically and in select foreign locations. By investing in emerging technologies, talent, and new business models, including partnerships with leading technology companies, venture investments, and the development of military grade products, we are accelerating the delivery of tech solutions.

Non-GAAP Measures

We publicly disclose certain non-GAAP financial measurements, including *Revenue, Excluding Billable Expenses, EBITDA* and *Adjusted EBITDA*, 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 EBITDA* as a measure of our core operating business, which excludes 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 such as subcontractor expenses, travel expenses, and other non-labor expenses incurred to perform on contracts. Billable expenses generally have lower margin and thus are less indicative of our profit generation capacity. Management believes this metric provides useful information about our business. 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, EBITDA* and *Adjusted EBITDA* are not recognized measurements under accounting principles generally accepted in the United States (“GAAP”) and when analyzing our performance, investors should (i) evaluate each adjustment in our reconciliation of revenue to *Revenue, Excluding Billable Expenses*, net income to *EBITDA* and *Adjusted EBITDA*, and (ii) use *Revenue, Excluding Billable Expenses, EBITDA* and *Adjusted EBITDA* in addition to, and not as an alternative to, revenue and net income, as measures of operating results, each as defined under GAAP. We have defined the aforementioned non-GAAP measures as follows:

- *Revenue, Excluding Billable Expenses* represents revenue less billable expenses.
- *EBITDA* represents net income before income taxes, interest expense, net and other income (expense), and depreciation and amortization.
- *Adjusted EBITDA* represents net income before income tax expense, interest expense, net and other income (expense), and depreciation and amortization and before certain other items, including the change in provision for claimed costs for historical rate years, financing transaction costs, DC tax assessment adjustment, the reserve associated with the U.S. Department of Justice (the “DOJ”) investigation disclosed in Note 20, “Commitments and Contingencies,” to the consolidated financial statements contained within our Annual Report on Form 10-K for the fiscal year ended March 31, 2024, the insurance recoveries related to the settlement of that matter, and other corporate expenses. The Company prepares *Adjusted EBITDA* 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.

Below is a reconciliation of our most directly comparable GAAP measures to our non-GAAP measures, Revenue to *Revenue, Excluding Billable Expenses* and Net income to *EBITDA* and *Adjusted EBITDA*, calculated and presented in accordance with GAAP:

(Amounts in millions)	Fiscal Year Ended March 31,		
	2026	2025	2024
	(Unaudited)		
Revenue, Excluding Billable Expenses			
Revenue	\$ 11,217	\$ 11,980	\$ 10,662
Less: Billable expenses	3,450	3,780	3,282
<i>Revenue, Excluding Billable Expenses*</i>	<u>\$ 7,767</u>	<u>\$ 8,200</u>	<u>\$ 7,380</u>
EBITDA and Adjusted EBITDA			
Net income	\$ 851	\$ 935	\$ 606
Income tax expense	11	284	248
Interest expense, net and other income (expense)	171	151	160
Depreciation and amortization	163	165	164
EBITDA	1,196	1,535	1,178
Change in provision for claimed costs (a)	—	(113)	(18)
Financing transaction costs (b)	—	—	1
DC tax assessment adjustment (c)	—	—	(20)
Legal matter reserve (d)	—	—	27
Other corporate expenses (e)	33	8	7
Insurance recoveries (f)	—	(115)	—
Adjusted EBITDA	<u>\$ 1,229</u>	<u>\$ 1,315</u>	<u>\$ 1,175</u>

* Revenue, Excluding Billable Expenses includes \$113 million of revenue and \$18 million revenue for fiscal 2025 and 2024 respectively, resulting from the reduction to our provision for claimed costs (see note (a) below).

- (a) Represents the reduction to our provision for claimed costs for years prior to fiscal 2025 recorded during the second quarters of fiscal 2025 and 2024, which resulted in a corresponding increase to revenue, as a result of the Defense Contract Audit Agency's findings related to its audits of our claimed costs for multiple fiscal years. See Note 19, "Commitments and Contingencies," to the consolidated financial statements in the Company's Form 10-K for the fiscal year ended March 31, 2025 for further information.
- (b) Reflects expenses associated with debt financing activities incurred during the second quarter of fiscal 2024.
- (c) Reflects the impact (specifically the revenue from recoverable expenses) of the Company's unfavorable ruling from the District of Columbia Court of Appeals related to contested tax assessments from the District of Columbia Office of Tax and Revenue ("DC OTR"). See Note 13, "Income Taxes," to the consolidated financial statements contained within the Annual Report on Form 10-K for the fiscal year ended March 31, 2024 for further information.
- (d) Reserve associated with the U.S. Department of Justice's investigation of the Company. See Note 20, "Commitments and Contingencies," to the consolidated financial statements contained within the Annual Report on Form 10-K for the fiscal year ended March 31, 2024 for further information.
- (e) In fiscal 2026, other corporate expenses consist primarily of nonrecoverable costs associated with employee severance from cost management and restructuring initiatives, transaction costs associated with a divestiture, and acquisition related costs associated with the acquisition of Defy Security, which closed in the first quarter of fiscal 2027. See Note 20, "Supplemental Consolidated Financial Information," to the consolidated financial statements for further information. In fiscal 2025 and fiscal 2024, other corporate expenses consist primarily of acquisition related costs from the acquisitions of PAR Government Systems Corporation ("PGSC") and EverWatch Corp. ("EverWatch").
- (f) Reflects insurance recoveries from claims related to the Company's fiscal 2024 settlement as described in Note 20, "Commitments and Contingencies," to the consolidated financial statements contained within the Annual Report on Form 10-K for the fiscal year ended March 31, 2024.

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."

U.S. Political, Budget and Regulatory Environment

The U.S. continues to face an uncertain and evolving budgetary and regulatory environment, and we expect this uncertainty will continue. Our business performance is affected by the overall level of U.S. government spending and the alignment of our offerings and capabilities with the spending priorities of the U.S. government.

The U.S. government continues to drive changes in the structure and priorities of U.S. government agencies and continues to review spending across U.S. government agencies to ensure it aligns with the administration's priorities of maximizing governmental efficiency and productivity. We have been, and will continue to be, subject to these reviews, and we have had, and may in the future have, certain of our contracts impacted, reduced or canceled as a result of these reviews. We have also experienced price adjustments and renegotiations prior to option exercise of certain of our contracts as a result of these reviews and may in the future continue to experience such adjustments. Further, we are, and may in the future be, subject to customer mandates to formulate additional methods by which to achieve efficiencies in providing our services, and we remain in ongoing discussions with various U.S. government departments and agencies in relation to cost reductions and other potential contract modifications. There can be no assurance that these reviews will not ultimately have a material adverse impact on our business and financial performance.

The administration has put in place a number of executive orders and actions that have and could continue to affect our business. U.S. government agencies are also undertaking their own independent reviews of their contract portfolios and reviewing future procurements in response to recent executive orders focused on efficiency in government procurement. At the same time that the scrutiny is increasing, there have been reductions in personnel at U.S. government agencies with which we do business. These reductions in personnel, along with the changing regulatory environment, have led to a slowed procurement environment, with delays in the granting of new contract awards, increased willingness by agencies to not spend government money, delays in the processing of payments by government payment offices, as well as increased processing times for security clearances and other governmental consents. This slowed procurement environment has resulted in a substantial reduction in the ordinary end of government fiscal year funding surge when compared to prior fiscal years and, in the aggregate, has resulted in negative impacts to our business and financial performance.

We have observed preparatory steps by the U.S. government to implement two specific executive orders that are intended to (i) simplify and accelerate the procurement process through a review and restructuring of the Federal Acquisition Regulation ("FAR"), and its supplements and (ii) modernize defense acquisitions by promoting commercial solutions, innovative acquisition authorities, and other existing streamlined processes. The FAR Council, the body responsible for issuing and maintaining the FAR, substantially completed Phase 1 of FAR reform efforts at the end of September 2025. The Office of Federal Procurement Policy and FAR Council have solicited feedback on these efforts and will turn next to the formal rulemaking process. Likewise, in early November 2025, the Secretary of War announced and released an associated memorandum regarding a new acquisition strategy and directing certain reforms addressing Department of War purchases of military weapons. The Secretary's accompanying memorandum and strategy outline a number of actions focused on rebuilding the Defense Industrial Base, elevating and empowering the acquisition workforce, maximizing acquisition flexibility, developing high performance systems, and improving effective lifecycle risk management. While the impact of the aforementioned changes remains uncertain, the new acquisition strategy and streamlined procurement processes have the potential to have positive impacts on our business.

On November 12, 2025, the President signed into law the Continuing Appropriations, Agriculture, Legislative Branch, Military Construction and Veterans Affairs, and Extensions Act, 2026, which funded the U.S. government under a short-term continuing resolution through January 30, 2026. Appropriations for the U.S. government's fiscal year 2026 were delayed, with Congress enacting partial appropriations legislation in multiple tranches, such appropriations ultimately covering a majority of federal agencies. However, a comprehensive appropriations agreement for the full year has not been reached for all agencies, and certain portions of the government have been funded through continuing resolutions or remain subject to funding uncertainty, including the Department of Homeland Security, for which funding has been provided only on a partial basis, while certain components, including its immigration enforcement operations, remain subject to funding uncertainty. As a result, uncertainty regarding federal funding levels persists. A prolonged government shutdown could have a negative impact on our business, financial condition and operating results.

On December 18, 2025, the National Defense Authorization Act was signed into law, which included a number of reforms that may also impact our business. Although the final bill did not adopt more narrow commercial preferences or expand the statutory definition of contractors who qualify as nontraditional contractors, it did exempt contractors who meet that definition from certain burdensome compliance requirements. The continued focus on removing barriers to new entrants and any related future legislation could reduce the likelihood of direct awards to companies like Booz Allen and effect our competitive position.

On January 7, 2026, the President signed an executive order, “Prioritizing the Warfighter in Defense Contracting”, that, among other things, limits stock buybacks and the payment of dividends by certain defense contractors. This executive order directs the Secretary of War to identify defense contractors that are underperforming on their contracts, not investing their own capital into necessary production capacity, not sufficiently prioritizing United States Government contracts, or whose production speed is insufficient as determined by the Secretary, and that have, during the period of underperformance or insufficient prioritization, investment, or production speed, engaged in any stock buy-back or corporate distribution. If the Company is identified pursuant to this executive order, it may have a negative impact on our dividends, stock buyback programs, and our ability to attract and retain talented executives. Compliance with the requirements of this executive order may be complex, costly and time-consuming, and our subcontractors may not have the necessary resources to ensure compliance. In addition, certain Senators have introduced legislation that would go beyond this executive order by instituting, absent a waiver, a blanket prohibition on such dividends, buybacks, and executive compensation above certain levels. This proposed legislation far exceeds the framework contemplated by the executive order and would introduce significant administrative burdens for us and other companies that could be subject to such legislation.

On April 30, 2026, the President signed an executive order, “Promoting Efficiency, Accountability, and Performance in Federal Contracting,” which directs federal agencies, subject to certain exceptions, to increase the use of firm-fixed price contracts for new awards to the maximum extent consistent with law. Additionally, agencies are directed, to the maximum extent practicable and consistent with law, to seek to modify, restructure, or renegotiate, their top ten highest-dollar-value contracts issued on an other-than-fixed price basis. The Company is supportive of the recent focus by the administration on the increased usage of fixed-price and outcomes-based contracting (we refer to firm fixed price contracts where we deliver a specific outcome for a predetermined price as “outcomes-based contracting”). Compared to time-and-materials and cost-reimbursable contracts, outcomes-based contracting generally offers higher margin opportunities because we receive the benefits of any cost savings, but can involve greater financial risk because we bear the impact of any cost overruns. Additionally, we believe outcomes-based contracting results in more efficient contracting outcomes and potential savings for the U.S. government.

See “Item 1A. Risk Factors—Industry and Economic Risks and —Legal and Regulatory Risks” for additional discussion of risks to the company related to our industry and the political, budget and regulatory environment.

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 customer 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 customer base, and we believe that our diversified contract and customer 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 non-U.S. government customers could have a material adverse effect on our business and results of operations.

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 fixed fee or award 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 customer’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 contracts in this category, 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. We assume the financial risk on time-and-materials contracts because our costs of performance may exceed negotiated hourly rates. 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. In the aggregate, the contract type mix in our revenue for any given period will affect that period's profitability. As described above in "U.S. Political, Budget and Regulatory Environment," we expect the recent executive order directing agencies, subject to certain exceptions, to increase usage of fixed-price contract will result in an overall change in our contract type mix over time. Changes in contract type as a result of re-competes and new business could influence the percentage/mix in unanticipated ways. See "Item 1A. Risk Factors—Industry and Economic Risks."

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

	Fiscal Year Ended March 31,		
	2026	2025	2024
Cost-reimbursable	59%	57%	55%
Time-and-materials	22%	23%	24%
Fixed-price	19%	20%	21%

Contract Portfolio and Revenue Mix

We provide services to our customers 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 ("IDIQ") contract vehicles, which include multiple award government wide acquisition contract vehicles ("GWACs") and General Services Administration ("GSA") Multiple Award Schedule Contracts ("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 4% of our revenue in fiscal 2026. No single definite contract accounted for more than 1% of our revenue in fiscal 2026.

We generate revenue under our contracts and task orders through our provision of services as both a prime contractor and a subcontractor, as well as from the provision of services by subcontractors under contracts and task orders for which we act as the prime contractor. As shown in the table below, the majority of our revenue was generated by contracts and task orders for which we served as the prime contractor; and roughly 25% of revenue was generated by services provided by our subcontractors.

% Revenue As:	Fiscal Year Ended March 31,		
	2026	2025	2024
Prime Contractor	94%	95%	95%
Subcontractor	6%	5%	5%
Total Revenue	100%	100%	100%
Revenue generated by services provided by our subcontractors:	26%	25%	25%

The mix of these types of revenue affects our operating margin. Substantially all of our operating margin is derived from direct customer staff labor as the portion of our operating margin derived from fees we earn on services provided by our subcontractors is not significant.

Contract Backlog

We define backlog to include the following three components:

- *Funded Backlog.* Funded backlog represents the value of orders for services under existing contracts for which funding is appropriated or otherwise authorized less revenue previously recognized on these contracts.

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- *Unfunded Backlog.* Unfunded backlog represents the value of orders (including exercised 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 value of all future contract option periods under existing contracts that may be exercised at our customers' option and for which funding has not been appropriated or otherwise authorized.

Our backlog does not include contracts that have been awarded but are currently under protest and also does not include any task orders under indefinite delivery/indefinite quantity (“IDIQ”) contracts, General Services Administration (“GSA”) Multiple Award schedule contracts (“GSA schedules”) or other master agreement contract vehicles, 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 periods shown:

	Fiscal Year Ended March 31,	
	2026	2025
Backlog:	(In millions)	
Funded	\$ 4,319	\$ 4,421
Unfunded	10,183	8,804
Priced options	23,685	23,802
Total backlog	<u>\$ 38,187</u>	<u>\$ 37,027</u>

Our total backlog consists of contractual values which is inclusive of remaining performance obligations, and potential contract value from unexercised option periods and other unexercised optional orders. As of March 31, 2026 and March 31, 2025, the Company had \$10.7 billion and \$9.5 billion of remaining performance obligations, respectively, and we expect to recognize approximately 65% of the remaining performance obligations as of March 31, 2026 as revenue over the next 12 months, and approximately 75% over the next 24 months. The remainder is expected to be recognized thereafter. We also expect to recognize revenue from a substantial portion of funded backlog as of March 31, 2026, within the next twelve months. However, given the uncertainties discussed below, 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. Our backlog includes orders under contracts that in some cases extend for several years. The U.S. Congress generally appropriates funds for our customers 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 as a key measure of our potential business growth. Total backlog increased by 3% from March 31, 2025 to March 31, 2026. Additions to funded backlog during fiscal 2026 and 2025 totaled \$11.1 billion and \$12.2 billion respectively, as a result of the conversion of unfunded backlog to funded backlog, the award of new contracts and task orders under which funding was appropriated, and the exercise and 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 customer 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. In addition, the amount of our funded backlog is also subject to change due to these factors. In our recent experience, the slowed procurement environment and reductions in contract value have had a negative effect on our ability to convert backlog to revenue as of March 31, 2026, and could have additional impacts in the future to our business and financial performance.

Seasonality

The U.S. government's fiscal year ends on September 30 of each year. We 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

We perform under various types of contracts, which include cost-reimbursable-plus-fee contracts, time-and-materials contracts, and fixed-price contracts. We recognize revenue for each performance obligation identified within our customer contracts when, or as, the performance obligation is satisfied by transferring the promised goods or services. On certain contracts, principally time-and-materials and cost-reimbursable-plus-fee contracts, revenue is recognized using the right-to-invoice practical expedient as we are contractually able to invoice the customer based on the control transferred.

Certain of our contracts contain award fees, incentive fees or other provisions that may increase or decrease the transaction price. These variable amounts generally are awarded upon achievement of certain performance metrics, program milestones or cost targets and may be based upon customer discretion. Management estimates variable consideration as the most likely amount that we expect to achieve based on our assessment of the variable fee provisions within the contract. We evaluate unfunded amounts as variable consideration in estimating the transaction price. We include the estimated variable consideration in our transaction price to the extent that it is probable that a significant reversal of revenue will not occur upon the ultimate settlement of the variable fee provision.

We recognize revenue for fixed-price contracts using a contract cost-based input method and require an Estimate-at-Completion ("EAC"), which management uses to review and monitor the progress towards the completion of our performance obligations. Under this process, management considers various inputs and assumptions related to the EAC, including, but not limited to, progress towards completion, labor costs and productivity, material and subcontractor costs, and identified risks. Estimating the total cost at completion of performance obligations is subjective and requires management to make assumptions about future activity and cost drivers under the contract. Changes in these estimates can occur for a variety of reasons and, if significant, may impact the profitability of our contracts. If the estimate of contract profitability indicates an anticipated loss on a contract, we recognize the total loss at the time it is identified.

For further detail on our contract types and processes, including when a contract is deemed to exist, contract modifications, as well as other specifics, see Note 2, "Summary of Significant Accounting Policies," to the consolidated financial statements contained within this Annual Report on Form 10-K.

Provision for Claimed Costs

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, including the DCAA, audit the Company's claimed 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.

The Company recognizes a reserve for estimated adjustments to historical claimed costs in respect of the years subsequent to fiscal 2011, based primarily on historical audit results. As audits of the periods subsequent to 2011 are completed, our estimates of adjustment to claimed costs for these periods could change. Any such change could materially impact our reported revenue, operating income, net income and basic and diluted earnings per common share.

Recent Accounting Pronouncements

See Note 2, “Summary of Significant Accounting Policies,” to the consolidated financial statements contained within this Annual Report on Form 10-K 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 customer 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. See Note 19, “Business Segment Information,” to the consolidated financial statements contained within this Annual Report on Form 10-K for further information.

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 (the “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, 2026 and 2025 and the Company’s results of operations for fiscal 2026, fiscal 2025, and fiscal 2024.

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 presents items from our consolidated statements of operations for the respective periods shown:

	Fiscal Year Ended March 31,			Fiscal 2026 Versus Fiscal 2025	Fiscal 2025 Versus Fiscal 2024
	2026	2025	2024		
	(In millions)				
Revenue	\$ 11,217	\$ 11,980	\$ 10,662	(6)%	12 %
Operating costs and expenses:					
Cost of revenue	5,305	5,419	4,921	(2)%	10 %
Billable expenses	3,450	3,780	3,282	(9)%	15 %
General and administrative expenses	1,266	1,246	1,281	2 %	(3)%
Depreciation and amortization	163	165	164	(1)%	1 %
Total operating costs and expenses	10,184	10,610	9,648	(4)%	10 %
Operating income	1,033	1,370	1,014	(25)%	35 %
Interest expense, net	(184)	(168)	(147)	10 %	14 %
Other income (expense)	13	17	(13)	(24)%	(231)%
Income before income taxes	862	1,219	854	(29)%	43 %
Income tax (benefit) expense	11	284	248	(96)%	15 %
Net income	\$ 851	\$ 935	\$ 606	(9)%	54 %

Fiscal 2026 Compared to Fiscal 2025

Revenue

Revenue decreased 6% to \$11,217 million, primarily driven by the impact of a slowed procurement and funding environment, including the government shutdown that occurred in the third quarter of fiscal 2026. These factors drove a decrease in headcount, as well as a decline in billable expenses. In addition, the change in revenue was positively impacted by a \$122 million reduction to our provision for claimed costs recorded during fiscal 2025.

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. Cost of revenue as a percentage of revenue was 47% and 45%. Cost of revenue decreased 2% to \$5,305 million, primarily due to decreases in salaries and related benefits due to overall headcount reductions. The principal factors that affect our costs are the increases or decreases in labor and employee related costs as we are awarded contracts, task orders, and additional work under our existing contracts, and the hiring of people with specific skill sets and security clearances.

Billable Expenses

Billable expenses include direct subcontractor expenses, travel expenses, and other expenses incurred to perform on contracts. Billable expenses as a percentage of revenue were 31% and 32%. Billable expenses decreased 9% to \$3,450 million, primarily attributable to decreases in the use of subcontractors driven by customer demand and timing of customer needs, partially offset by increases in other direct expenses as compared to the prior year.

General and Administrative Expenses

General and administrative expenses include indirect labor of executive management and corporate administrative functions, marketing and bid and proposal costs, legal costs, and other discretionary spending. General and administrative expenses as a percentage of revenue was 11% and 10%. General and administrative expenses increased 2% to \$1,266 million. The year over year change, which was relatively flat, was primarily related to an insurance recovery of \$115 million recognized in general and administrative expenses in fiscal 2025 as described in Note 20, "Commitments and Contingencies," to the consolidated financial statements contained within the Annual Report on Form 10-K for the fiscal year ended March 31, 2024, partially offset by decreases in salaries and related benefits, primarily due to overall headcount reductions.

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. Depreciation and amortization expense decreased 1% to \$163 million.

Operating Income

Operating income decreased 25% to \$1,033 million, reflecting decreases in operating margin from 11% to 9%. Operating income was driven by the same factors noted above.

Interest Expense, net

Interest expense, net increased 10% to \$184 million, primarily due to an increase of \$37 million in bond interest expense related to the \$650 million Senior Notes due 2035 (issued in March of fiscal 2025), partially offset by a decrease in interest expense on the Company's term loan due to lower rates year over year. In addition, higher cash balances following the bond issuance noted above drove an increase in interest income year over year.

Other Income (expense)

Other income (expense) decreased 24% to \$13 million, primarily due to higher realized gains in fiscal 2025, partially offset by higher unrealized gains in fiscal 2026.

Income Tax Expense

Income tax expense decreased 96% to \$11 million. The effective tax rate decreased to 1.3% in fiscal 2026 from 23% in fiscal 2025. The decrease in tax expense was primarily driven by a reduction in the income tax reserve related to the completion of the IRS examination procedures and the tax benefit recognized in the third quarter as a result of a higher-than-estimated research and development tax credit and additional foreign derived intangible income deductions.

Liquidity and Capital Resources

As of March 31, 2026, our total liquidity was \$2.2 billion, consisting of \$728 million of cash and cash equivalents and \$1.5 billion 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 respective periods shown:

	Fiscal Year Ended March 31,		
	2026	2025	2024
	(In millions)		
Cash and cash equivalents	\$ 728	\$ 885	\$ 554
Total debt	\$ 3,940	\$ 3,998	\$ 3,412
Net cash provided by operating activities	\$ 1,041	\$ 1,009	\$ 259
Net cash used in investing activities	(300)	(218)	(91)
Net cash used in financing activities	(898)	(460)	(19)
Total (decrease) increase in cash and cash equivalents	\$ (157)	\$ 331	\$ 149

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 the trends and developments described above under “—Factors and Trends Affecting Our Results of Operations”, it may be necessary to borrow under our Credit Agreement to meet cash demands in the future. 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 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 both organic and inorganic growth of our business;
- capital expenditures which primarily relate to the purchase of computers, business systems, furniture and leasehold improvements to support our operations;
- the ongoing maintenance around all financial management systems;
- commitments and other discretionary investments, including potential capital calls for venture capital investments;
- debt service requirements for borrowings under our Credit Agreement and interest payments for the Senior Notes due 2028, Senior Notes due 2029, Senior Notes due 2033, and Senior Notes due 2035; and
- cash taxes to be paid.

From time to time, we evaluate conditions to opportunistically access the financing markets to secure additional debt capital resources and improve the terms of our indebtedness. Some of the possible uses of our remaining excess cash at any point in time may include funding strategic acquisitions and investments, debt repayment, further investment in our business and returning value to stockholders through share repurchases, quarterly dividends and special dividends.

Cash Flows

Operating Cash Flow

Net cash provided by operations was \$1.0 billion in both fiscal 2026 and fiscal 2025. Operating cash flow was consistent with the prior year as lower tax payments were partially offset by the \$115 million in insurance recoveries received in fiscal 2025.

Investing Cash Flow

Net cash used in investing activities was \$300 million in fiscal 2026 compared to \$218 million in the prior year. The increase in net cash used for investing was primarily due to investments in venture and other investment funds, partially offset by acquisition related payments from the Company’s acquisition of PAR Government Systems Corporation in the prior year.

Financing Cash Flow

Net cash used in financing activities was \$898 million in fiscal 2026 compared to \$460 million in the prior year. The increase in net cash used over the prior year was primarily due to no new debt being issued in fiscal 2026, while fiscal 2025 included net proceeds of \$644 million associated with the Company’s issuance of its 5.95% Senior Notes due 2035, an increase in dividends paid of \$8 million, partially offset by a decrease in share repurchases of \$214 million.

Capital Structure and Resources

Our stockholders’ equity totaled \$1,105 million as of March 31, 2026, an increase of \$102 million compared to stockholders’ equity of \$1,003 million as of March 31, 2025. The increase was primarily due to net income of \$851 million and stock-based compensation expense of \$69 million, partially offset by \$591 million in treasury stock resulting from the repurchase of shares of our Class A Common Stock and \$277 million in aggregate quarterly dividend payments.

The Company paid \$2.24 in dividends per share to stockholders of record in fiscal 2026. On May 22, 2026, the Company announced a regular quarterly cash dividend in the amount of \$0.59 per share. The quarterly dividend is payable on June 26, 2026 to stockholders of record on June 10, 2026.

The following table summarizes the cash distributions recognized in the consolidated statement of cash flows for the respective periods shown:

	Fiscal Year Ended March 31,		
	2026	2025	2024
	(In millions)		
Recurring dividends ⁽¹⁾	\$ 276	\$ 268	\$ 254

⁽¹⁾ Amounts represent recurring dividends that were declared and paid for during each quarter of fiscal 2026, 2025, and 2024, respectively.

On December 12, 2011, the Board of Directors initially approved a share repurchase program, which was subsequently increased from time to time, and most recently increased by \$500 million to \$4,085 million on October 22, 2025. The Company may repurchase shares pursuant to the program by means of open market repurchases, directly negotiated repurchases or through agents acting pursuant to negotiated repurchase agreements. During both fiscal 2026 and 2025, the Company purchased 5.6 million shares of the Company’s Class A Common Stock for an aggregate of \$561 million and \$764 million, respectively. As of March 31, 2026, the Company had approximately \$684 million remaining under the 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 \$3.9 billion and \$4.0 billion as of March 31, 2026 and 2025, respectively. The total outstanding debt balance is recorded in the accompanying consolidated balance sheets net of unamortized discount and debt issuance costs of \$24 million and \$28 million, respectively, as of March 31, 2026 and 2025. Our debt is comprised of our Credit Agreement and four separate and distinct tranches of our Senior Notes, which all bear interest at specified rates. See Note 10, “Debt,” to the consolidated financial statements contained within this Annual Report on Form 10-K for further information and specifics on the material terms of our debt.

As of March 31, 2026 and 2025, Booz Allen Hamilton was contingently liable under open standby letters of credit and bank guarantees issued by its banks in favor of third parties that totaled \$3 million and \$4 million, respectively. These letters of credit and bank guarantees primarily support insurance and bid and performance obligations. As of both March 31, 2026 and 2025, approximately \$1 million of these instruments reduced our available borrowings under the Credit Agreement. The remainder is guaranteed under a separate \$3 million facility, of which \$1 million and less than a million were available to the Company at March 31, 2026 and 2025, respectively. See Note 18, “Commitments and Contingencies,” to our consolidated financial statements contained within this Annual Report on Form 10-K for further information.

The Company occasionally borrows under the Credit Agreement’s revolving credit facility for our working capital needs. There were no borrowings during the fiscal year ended March 31, 2026, and during the fourth quarter of fiscal 2025, we borrowed \$200 million on this revolving credit facility, which was subsequently repaid with the proceeds from our latest offering of Senior Notes in the same quarter. As of March 31, 2026 and March 31, 2025, respectively, there was no outstanding balance on the Revolving Credit Facility. See Note 10, “Debt,” to the consolidated financial statements contained within our Annual Report on Form 10-K for the fiscal year ended March 31, 2025 for further information about our latest offering of Senior Notes that was completed in fiscal 2025.

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 18, “Commitments and Contingencies,” to our consolidated financial statements.

Summarized Financial Information

The Senior Notes due 2033 and Senior Notes due 2035 were issued by Booz Allen Hamilton pursuant to the respective Indenture, among Booz Allen Hamilton, the Company and U.S. Bank Trust Company, National Association, as trustee, as supplemented by the respective Supplemental Indenture and are fully and unconditionally guaranteed on an unsecured and unsubordinated basis by the Company pursuant to the respective Indenture.

The tables below present the summarized financial information as combined for the Company and Booz Allen Hamilton as of March 31, 2026, after the elimination of intercompany transactions and balances between the Company and Booz Allen Hamilton and excluding the subsidiaries of both entities that are not issuers or guarantors of the Senior Notes due 2033 and Senior Notes due 2035, including earnings from and investments in these entities. The summarized financial information is provided in accordance with the reporting requirements of Rule 13-01 under Regulation S-X and is not intended to present our financial position or results of operations in accordance with GAAP.

Summarized Statements of Financial Condition

<i>(in millions)</i>	March 31, 2026
Intercompany receivables from non-guarantor subsidiaries	\$ 32
Total other current assets	\$ 2,921
Goodwill and intangible assets, net of accumulated amortization	\$ 1,501
Total other non-current assets	\$ 1,134
Intercompany payables to non-guarantor subsidiaries	\$ 102
Total other current liabilities	\$ 1,645
Long-term debt, net of current portion	\$ 3,921
Total other non-current liabilities	\$ 423

Summarized Statement of Operations

<i>(in millions)</i>	Fiscal Year Ended March 31, 2026
Revenue	\$ 11,115
Revenue from non-guarantor subsidiaries	\$ 18
Operating income	\$ 1,090
Operating loss from non-guarantor subsidiaries	\$ (106)
Net income	\$ 782
Net income attributable to the Obligor Group	\$ 782

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. Due to the wide-ranging adverse impacts on global financial markets, we may be exposed to greater interest rate volatility and market risk in the near future. We actively monitor these exposures and manage such risks through our regular financing activities and through the use of derivative financial instruments.

Our exposure to market risk for changes in interest rates relates primarily to our outstanding debt, cash equivalents, which consist primarily of funds invested in U.S. government money-market funds, our cash flow hedges and our Rabbi trust.

Our exposure to market risk for changes in interest rates related to our outstanding debt will impact our Senior Credit Facility. The interest expense associated with our term loans and any loans outstanding under our Revolving Credit Facility will vary with market rates. A hypothetical interest rate increase of 25 basis points would have increased interest expense related to the outstanding term facilities under our Senior Credit Facility by approximately \$3 million in fiscal 2026 and \$2 million in fiscal 2025, and likewise decreased our income and cash flows.

As of March 31, 2026 and 2025, we had \$728 million and \$885 million, respectively, in cash and cash equivalents. As of March 31, 2026 and 2025 the interest income as a percentage of average monthly balance sheet cash was approximately 4% and 3%, respectively. A hypothetical decrease in market interest rates of 25 basis points would have decreased interest income on our cash and cash equivalents by approximately \$2 million in fiscal 2026 and \$1 million fiscal 2025, and likewise decreased our income and cash flows.

Pursuant to our interest rate risk management strategies, we use interest rate cash flow hedges to add stability to our incurrence of interest rate expense and to manage our exposure to related interest rate movement. As of March 31, 2026, we had effective interest rate swaps with an aggregate notional amount of \$350 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. See Note 11, “Derivatives,” to the consolidated financial statements contained within this Annual Report on Form 10-K for further discussion. As of March 31, 2026, a 25 basis point increase in interest rates would increase the fair value of our interest rate swaps by approximately \$1 million and a 25 basis point decrease in interest rates would decrease the fair value of our interest rate swaps by approximately \$1 million.

We maintain a Rabbi trust to provide for the payment of benefits under our non-qualified deferred compensation plan. As of March 31, 2026, fund assets totaled \$40 million which include mutual fund investments that are subject to fluctuations in market prices and interest rates. Cash distributions made to plan participants are recognized as operating cash flows in the consolidated statement of cash flows and have the effect of lowering both fund assets and the corresponding fund liabilities on a one-for-one basis. Changes in fair value on fund liabilities offset the changes in fair value of fund assets, and changes in fair value on both fund assets and fund liabilities are recognized in earnings on our consolidated statements of operations. See Note 17, “Investments and Fair Value Measurements,” to the consolidated financial statements contained within this Annual Report on Form 10-K for further discussion.

Item 8. Financial Statements and Supplementary Data.

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Report of Independent Registered Public Accounting Firm

To the Stockholders and the 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, 2026 and 2025, 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, 2026, 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 financial position of the Company at March 31, 2026 and 2025, and the results of its operations and its cash flows for each of the three years in the period ended March 31, 2026, 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, 2026, 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 22, 2026 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 the Company's 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.

Critical Audit Matters

The critical audit matters communicated below are matters arising from the current period audit of the financial statements that were communicated or required to be communicated to the audit committee and that: (1) relate to accounts or disclosures that are material to the financial statements and (2) involved our especially challenging, subjective or complex judgments. The communication of critical audit matters does not alter in any way our opinion on the consolidated financial statements, taken as a whole, and we are not, by communicating the critical audit matters below, providing separate opinions on the critical audit matters or on the accounts or disclosures to which they relate.

Revenue recognition for select contracts under the cost-based input method

Description of the Matter

As described in Note 2 to the consolidated financial statements, the Company generally recognizes revenue over time, as its contracts typically involve a continuous transfer of control to the customer. Many of its contracts recognize revenue under a cost-based input method and management estimates the total costs at completion of the performance obligations (EAC). Estimates of costs at completion can change over the contract performance period for a variety of reasons and, if significant, may impact the profitability of the Company's contracts.

Auditing revenue recognition based on the cost-based input method for select contracts was complex due to the judgment involved in evaluating management's estimates of the costs at completion, which include labor, material, and subcontractor costs. The estimates of costs at completion are based on management's assessment of the progress towards completion of the performance obligations and other factors.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design, and tested the operating effectiveness of the controls related to the Company's revenue recognition process, including controls over management's review of the estimated costs at completion for the select contracts and management's review that the data underlying the estimated costs at completion was complete and accurate.

To test the recognition of revenue under the cost-based input method for select contracts, our audit procedures included among others, agreeing key terms to contract documentation, comparing estimated costs to actual costs incurred to date, and obtaining an understanding of the Company's progress on the contract.

Government Contracting Matters – Provision for Claimed Costs

Description of the Matter

As discussed in Note 18 to the consolidated financial statements, in the ordinary course of business, agencies of the U.S. government, including the Defense Contract Audit Agency (DCAA), audit the Company's claimed costs and conduct inquiries and investigations of its business practices with respect to government contracts to determine whether the Company's operations are conducted in accordance with relevant requirements. As of March 31, 2026, the Company had recorded liabilities for estimated adjustments to claimed costs based on its historical DCAA audit results (the provision for claimed costs) and the final resolution of audits with the Defense Contract Management Agency (DCMA).

Auditing the liabilities recorded for certain matters included in the provision for claimed costs was complex due to the inherently judgmental nature of management's estimates, which consider the number of years that remain open to audit and the status of audit results from the DCAA and negotiations with the DCMA. Significant changes in management's estimates could have a material effect on the Company's results of operations.

How We Addressed the Matter in Our Audit

We obtained an understanding, evaluated the design, and tested the operating effectiveness of controls over the Company's determination of the liabilities recorded for certain matters included in the provision for claimed costs. For example, we tested controls over the application of the available historical information from the resolution of audits and communications from the DCAA and DCMA relevant to the estimates.

We also performed audit procedures that included, among others, testing the clerical accuracy of the estimates and testing the application of the available historical information from the resolution of audits and communications from the DCAA and DCMA that were relevant to the estimates.

/s/ Ernst & Young LLP

We have served as the Company's auditor since 2006
Tysons, Virginia
May 22, 2026

BOOZ ALLEN HAMILTON HOLDING CORPORATION
CONSOLIDATED BALANCE SHEETS

	March 31, 2026	March 31, 2025
(Amounts in millions, except share and per share data)		
ASSETS		
Current assets:		
Cash and cash equivalents	\$ 728	\$ 885
Accounts receivable, net	2,063	2,271
Prepaid expenses and other current assets	170	157
Total current assets	2,961	3,313
Property and equipment, net of accumulated depreciation	171	177
Operating lease right-of-use assets	147	178
Intangible assets, net of accumulated amortization	509	563
Goodwill	2,399	2,405
Deferred tax assets	294	332
Other long-term assets	637	344
Total assets	\$ 7,118	\$ 7,312
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Current portion of long-term debt	\$ 19	\$ 83
Accounts payable and other accrued expenses	909	987
Accrued compensation and benefits	641	702
Operating lease liabilities	43	41
Other current liabilities	51	33
Total current liabilities	1,663	1,846
Long-term debt, net of current portion	3,921	3,915
Operating lease liabilities, net of current portion	139	180
Other long-term liabilities	290	368
Total liabilities	6,013	6,309
Commitments and contingencies (Note 18)		
Stockholders' equity:		
Common stock, Class A - \$0.01 par value - 600,000,000 shares authorized; 169,805,201 shares and 168,522,544 shares issued at March 31, 2026 and March 31, 2025, respectively; 120,341,320 shares and 124,879,004 shares outstanding at March 31, 2026 and March 31, 2025, respectively	2	2
Treasury stock, at cost - 49,463,881 and 43,643,540 shares at March 31, 2026 and March 31, 2025, respectively	(3,673)	(3,082)
Additional paid-in capital	1,155	1,042
Retained earnings	3,644	3,070
Accumulated other comprehensive loss	(23)	(29)
Total stockholders' equity	1,105	1,003
Total liabilities and stockholders' equity	\$ 7,118	\$ 7,312

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,		
	2026	2025	2024
	(Amounts in millions, except per share data)		
Revenue	\$ 11,217	\$ 11,980	\$ 10,662
Operating costs and expenses:			
Cost of revenue	5,305	5,419	4,921
Billable expenses	3,450	3,780	3,282
General and administrative expenses	1,266	1,246	1,281
Depreciation and amortization	163	165	164
Total operating costs and expenses	<u>10,184</u>	<u>10,610</u>	<u>9,648</u>
Operating income	1,033	1,370	1,014
Interest expense, net	(184)	(168)	(147)
Other income (expense)	13	17	(13)
Income before income taxes	862	1,219	854
Income tax expense	11	284	248
Net income	<u>\$ 851</u>	<u>\$ 935</u>	<u>\$ 606</u>
Earnings per share of common stock (Note 4):			
Basic	<u>\$ 6.92</u>	<u>\$ 7.28</u>	<u>\$ 4.61</u>
Diluted	<u>\$ 6.90</u>	<u>\$ 7.25</u>	<u>\$ 4.59</u>

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,		
	2026	2025	2024
	(Amounts in millions)		
Net income	\$ 851	\$ 935	\$ 606
Other comprehensive income, net of tax:			
Change in unrealized loss on derivatives designated as cash flow hedges	—	(9)	(2)
Change in postretirement plan costs	6	(30)	(18)
Total other comprehensive income (loss), net of tax	6	(39)	(20)
Comprehensive income	857	896	586

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,		
	2026	2025	2024
	(Amounts in millions)		
Cash flows from operating activities			
Net income	\$ 851	\$ 935	\$ 606
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	163	165	164
Noncash lease expense	51	50	54
Stock-based compensation expense	69	94	95
Deferred income taxes	35	(91)	(101)
Net (gain) loss on investments, dispositions, and other	(16)	(16)	15
Changes in assets and liabilities:			
Accounts receivable, net	207	(206)	(270)
Income taxes receivable / payable	(11)	(31)	(11)
Prepaid expenses and other current and long-term assets	(43)	1	(10)
Accrued compensation and benefits	(60)	207	48
Accounts payable and other accrued expenses	(86)	(66)	(282)
Other current and long-term liabilities	(119)	(33)	(49)
Net cash provided by operating activities	1,041	1,009	259
Cash flows from investing activities			
Purchases of property, equipment, and software	(90)	(98)	(67)
Proceeds from (payments for) business dispositions and acquisitions, net of cash acquired	22	(97)	—
Net payments for investments	(232)	(23)	(24)
Net cash used in investing activities	(300)	(218)	(91)
Cash flows from financing activities			
Proceeds from issuance of common stock	45	38	44
Repurchases of common stock	(598)	(812)	(404)
Cash dividends paid	(276)	(268)	(254)
Proceeds from revolving credit facility	—	200	500
Repayments on revolving credit facility, term loans, and Senior Notes	(62)	(262)	(541)
(Payments for)/net proceeds from debt refinancing and issuance	(7)	644	636
Net cash used in financing activities	(898)	(460)	(19)
Net (decrease) increase in cash and cash equivalents	(157)	331	149
Cash and cash equivalents—beginning of year	885	554	405
Cash and cash equivalents—end of year	\$ 728	\$ 885	\$ 554
Supplemental disclosures of cash flow information			
Net cash paid during the period for:			
Interest	\$ 191	\$ 186	\$ 156
Supplemental disclosures of non-cash investing and financing activities			
Share repurchases transacted but not settled and paid	\$ 16	\$ 22	\$ 29
Unpaid property, equipment and software purchases	\$ 8	\$ 9	\$ 16

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

BOOZ ALLEN HAMILTON HOLDING CORPORATION
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

(Amounts in millions, except share data)	Class A Common Stock		Treasury Stock		Additional Paid-In Capital	Retained Earnings	Accumulated Other Comprehensive Income (Loss)	Total Stockholders' Equity
	Shares	Amount	Shares	Amount				
Balance at March 31, 2023	165,872,332	\$ 2	(34,234,744)	\$ (1,860)	\$ 769	\$ 2,051	\$ 30	\$ 992
Issuance of common stock	1,194,324	—	—	—	29	—	—	29
Stock options exercised	335,612	—	—	—	16	—	—	16
Repurchase of common stock ⁽¹⁾	—	—	(3,524,401)	(418)	—	—	—	(418)
Net income	—	—	—	—	—	606	—	606
Other comprehensive income, net of tax	—	—	—	—	—	—	(20)	(20)
Dividends paid of \$1.92 per share of common stock	—	—	—	—	—	(253)	—	(253)
Stock-based compensation expense	—	—	—	—	95	—	—	95
Balance at March 31, 2024	167,402,268	\$ 2	(37,759,145)	\$ (2,278)	\$ 909	\$ 2,404	\$ 10	\$ 1,047
Issuance of common stock	1,022,351	—	—	—	34	—	—	34
Stock options exercised	97,925	—	—	—	5	—	—	5
Repurchase of common stock ⁽¹⁾	—	—	(5,884,395)	(804)	—	—	—	(804)
Net income	—	—	—	—	—	935	—	935
Other comprehensive income, net of tax	—	—	—	—	—	—	(39)	(39)
Dividends paid of \$2.08 per share of common stock	—	—	—	—	—	(269)	—	(269)
Stock-based compensation expense	—	—	—	—	94	—	—	94
Balance at March 31, 2025	168,522,544	\$ 2	(43,643,540)	\$ (3,082)	\$ 1,042	\$ 3,070	\$ (29)	\$ 1,003
Issuance of common stock	1,123,700	—	—	—	34	—	—	34
Stock options exercised	158,957	—	—	—	10	—	—	10
Repurchase of common stock ⁽¹⁾	—	—	(5,820,341)	(591)	—	—	—	(591)
Net income	—	—	—	—	—	851	—	851
Other comprehensive income, net of tax	—	—	—	—	—	—	6	6
Dividends paid of \$2.24 per share of common stock	—	—	—	—	—	(277)	—	(277)
Stock-based compensation expense	—	—	—	—	69	—	—	69
Balance at March 31, 2026	169,805,201	\$ 2	(49,463,881)	\$ (3,673)	\$ 1,155	\$ 3,644	\$ (23)	\$ 1,105

⁽¹⁾ During fiscal 2026, 2025, and 2024, the Company purchased 5.6 million, 5.6 million and 3.2 million shares, respectively, of the Company's Class A Common Stock for \$561 million, \$764 million, and \$373 million, respectively. Additionally, during fiscal 2026, 2025, and 2024, the Company repurchased shares for \$30 million, \$40 million and \$45 million, respectively, to cover the minimum statutory taxes on repurchases and restricted stock units that vested on various dates during those years.

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 millions, except share and per share data or unless otherwise noted)

1. Business Overview

Our Business

Booz Allen Hamilton Holding Corporation, including its wholly owned subsidiaries, or the Company, we, us, and our, was incorporated in Delaware in May 2008. We are an advanced technology company, building products and solutions for government and business. The Company is a leader at the forefront of the nation's technology ecosystem, and invests in emerging technologies, talent, and new business models, including partnerships with leading technology companies, venture investments, and the development of military grade products. The Company is headquartered in McLean, Virginia, with approximately 31,500 employees as of March 31, 2026, and reports operating results and financial data in one reportable segment.

2. Summary of Significant Accounting Policies

Basis of Presentation

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

The Company uses the equity method to account for investments in limited partnerships with greater than minor influence or in entities that it does not control if it is otherwise able to exert significant influence over the entities' operating and financial policies. Equity investments in entities over which the Company does not have the ability to exercise significant influence and whose securities do not have a readily determinable fair value are carried at cost and are subject to fair value adjustments in certain circumstances (e.g., observable price changes or impairment).

The Company's fiscal year ends on March 31 and unless otherwise noted, references to fiscal year or fiscal relate to fiscal years ended March 31. The accompanying consolidated financial statements present the financial position of the Company as of March 31, 2026 and 2025 and the Company's results of operations for fiscal 2026, 2025, and 2024.

Certain amounts reported in the Company's prior year consolidated financial statements have been reclassified to conform to the current year presentation, including the reclassification of \$26 million of interest income for fiscal 2024 from "Other income (loss), net" into "Interest expense, net" on the consolidated statement of operations. There are no changes to the Company's financial position or results of operations as a result of this reclassification.

Accounting Estimates

The preparation of consolidated financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the reported amounts of assets, liabilities, revenue and expenses, as well as the disclosure of contingent assets and liabilities at the date of the financial statements or during the relevant reporting periods (as applicable). The Company bases its estimates on assumptions that it believes are reasonable and appropriate. Actual results may differ materially from those estimates. Estimates are used for, but not limited to, revenue recognition including the profitability of long-term contracts and cost accruals, the provision for claimed costs, fair value measurements, the valuation and expected lives of acquired intangible assets, incentive compensation, income taxes including reserves for uncertain tax positions, postretirement obligations and contingencies.

Revenue Recognition

The Company performs and generates revenue under three basic types of contracts, as described below:

- **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 fixed fee or award fee.
- **Time-and-Materials Contracts:** Under contracts in this category, 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. We assume the financial risk on time-and-materials contracts because the Company's costs of performance may exceed negotiated hourly rates.
- **Fixed-Price Contracts:** Under a fixed-price contract, we agree to perform the specified work for a predetermined price. To the extent the Company's 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.

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The Company considers a contract with a customer to exist under Accounting Standards Codification (“ASC”) No. 606 - Revenue from Contracts with Customers (“Topic 606”), when there is approval and commitment from both the Company and the customer, the rights of the parties and payment terms are identified, the contract has commercial substance, and collectability of consideration is probable. The Company also will consider whether two or more contracts entered into with the same customer should be combined and accounted for as a single contract. Furthermore, in certain transactions, the Company may commence providing services prior to receiving a formal approval from the customer. In these situations, the Company will consider the factors noted above, the risks associated with commencing the work and legal enforceability in determining whether a contract with the customer exists under Topic 606.

Customer contracts are often modified to change the scope, price, specifications or other terms within the existing arrangement. Contract modifications are evaluated by management to determine whether the modification should be accounted for as part of the original performance obligation(s) or as a separate contract. If the modification adds distinct goods or services and increases the contract value proportionate to the stand-alone selling price of the additional goods or services, it will be accounted for as a separate contract. Generally, the Company’s contract modifications do not include goods or services which are distinct, and therefore are accounted for as part of the original performance obligation(s) with any impact on transaction price or estimated costs at completion being recorded as through a cumulative catch-up adjustment to revenue.

The Company evaluates each service deliverable contracted with the customer to determine whether it represents promises to transfer distinct goods or services. Under Topic 606, these are referred to as performance obligations. One or more service deliverables often represent a single performance obligation. The Company’s contracts generally provide a set of integrated or highly interrelated tasks or services and are therefore accounted for as a single performance obligation. In the limited number of situations where our contracts with customers contain more than one performance obligation, we allocate the transaction price of a contract between the performance obligations in the proportion to their respective stand-alone selling prices. We generally estimate the stand-alone selling price of performance obligations based on an expected cost-plus margin approach as allowed under Topic 606. However, in cases where we provide more than one distinct good or service within a customer contract, the contract is separated into individual performance obligations which are accounted for discretely.

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. Fixed-price contracts are typically billed to the customer using milestone or fixed monthly payments, while cost-reimbursable-plus-fee and time-and-materials contracts are typically billed to the customer at periodic intervals (e.g. monthly or weekly) as indicated by the terms of the contract. Disparities between the timing of revenue recognition and customer billings and cash collections result in changes to net contract assets or liabilities being recognized at the end of each reporting period.

Contract assets primarily consist of unbilled receivables typically resulting from revenue recognized exceeding the amount billed to the customer and right to payment is not just subject to the passage of time. Unbilled amounts represent revenues for which billings have not yet been presented to customers. These amounts are generally billed and collected within one year subject to various conditions including, without limitation, appropriated and available funding. Our customers generally pay our invoices within 30 days of the invoice date, although we experience a longer billing and collection cycle with our global commercial customers. Long-term unbilled receivables not anticipated to be billed and collected within one year, which are primarily related to retainage, holdbacks, and certain years’ long-term rate settlements to be billed at contract close-out, are included in other long-term assets in the accompanying consolidated balance sheets. Contract liabilities primarily consist of billings in excess of costs incurred and deferred revenue. Contract assets and liabilities are reported on a net contract basis at the end of each reporting period. The Company maintains an allowance for credit losses to provide for an estimate of uncollectible receivables.

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Contracts with the U.S. government are generally subject to the Federal Acquisition Regulation (the “FAR”) and are priced based on estimated or actual costs of providing the goods or services. The Company derives a majority of its revenue from contracts awarded through a competitive bidding process. Pricing for non-U.S. government agencies and commercial customers is based on discrete negotiations with each customer. Certain of the Company’s contracts contain award fees, incentive fees or other provisions that may increase or decrease the transaction price. These variable amounts generally are awarded upon achievement of certain performance metrics, program milestones or cost targets and may be based upon customer discretion. Management estimates variable consideration as the most likely amount that we expect to achieve based on the Company’s assessment of the variable fee provisions within the contract, prior experience with similar contracts or customers, and management’s evaluation of the performance on such contracts. The Company may perform work under a contract that has not been fully funded if the work has been authorized by management and the customer to proceed. The Company evaluates unfunded amounts as variable consideration in estimating the transaction price. The Company includes the estimated variable consideration in its transaction price to the extent that it is probable that a significant reversal of revenue will not occur upon the ultimate settlement of the variable fee provision. The Company’s U.S. government contracts generally contain FAR provisions that enable the customer to terminate a contract for default or for the convenience of the U.S. government.

The Company recognizes revenue for each performance obligation identified within its customer contracts when, or as, the performance obligation is satisfied by transferring the promised goods or services. Revenue may either be recognized over time or at a point in time. The Company generally recognizes revenue over time as its contracts typically involve a continuous transfer of control to the customer. A continuous transfer of control under contracts with the U.S. government and its agencies is evidenced by clauses which require the Company to be paid for costs incurred plus a reasonable margin in the event that the customer unilaterally terminates the contract for convenience. For fixed-price contracts where the Company recognizes revenue over time, a contract cost-based input method is generally used to measure progress towards satisfaction of the underlying performance obligation(s). Contract costs include direct costs such as materials, labor and subcontract costs, as well as indirect costs identifiable with, or allocable to, a specific contract that are expensed as incurred. The Company does not incur material incremental costs to acquire or fulfill contracts. Under a contract cost-based input method, revenue is recognized based on the proportion of contract costs incurred to the total estimated costs expected to be incurred upon completion of the underlying performance obligation. The Company generally includes both funded and unfunded portions of customer contracts in this estimation process.

For interim financial reporting periods, contract revenue attributable to indirect costs is recognized based upon agreed-upon annual rates established with the U.S. government at the start of each fiscal year. These 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 overall changes or changes in the rates are recorded in the interim financial reporting period when such changes are identified. At the end of each fiscal year, estimated annual rates are adjusted to reported actual rates, with contract revenue attributable to indirect costs adjusted accordingly. These preliminary actual rates and their impact on contract revenue are subject to final audit and negotiation with the U.S. government, which may take place several years in the future.

On certain contracts, principally time-and-materials and cost-reimbursable-plus-fee contracts, revenue is recognized using the right-to-invoice practical expedient as the Company is contractually able to invoice the customer based on the control transferred. However, we did not elect to use the practical expedient for remaining performance obligations, discussed below, which would allow the Company to exclude contracts using the right-to-invoice from remaining performance obligations. For stand-ready performance obligations under fixed-price contracts, revenue is recognized over time using a straight-line measure of progress as the control of the services is provided to the customer ratably over the term of the contract. If a contract does not meet the criteria for recognition of revenue over time, we recognize revenue at the point in time when control of the good or service is transferred to the customer. Determining a measure of progress towards the satisfaction of performance obligations requires management to make judgments that may affect the timing of revenue recognition.

Many of the Company’s fixed price contracts recognize revenue under a contract cost-based input method and require an Estimate-at-Completion (“EAC”), which management uses to review and monitor the progress towards the completion of its performance obligations. Management considers various inputs and assumptions related to the EAC, including, but not limited to, progress towards completion, labor costs and productivity, material and subcontractor costs, and identified risks. Estimating the total cost at completion of performance obligations is subjective and requires management to make assumptions about future activity and cost drivers under the contract. Changes in these estimates can occur for a variety of reasons and, if significant, may impact the profitability of the Company’s contracts. Changes in estimates related to contracts accounted for under EACs are recognized in the period when such changes are made on a cumulative catch-up basis. If the estimate of contract profitability indicates an anticipated loss on a contract, the Company recognizes the total loss at the time it is identified. For fiscal 2026, 2025 and 2024, the aggregate impact of adjustments in contract estimates was not material.

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Remaining performance obligations represent the transaction price of exercised contracts for which work has not yet been performed, irrespective of whether funding has or has not been authorized and appropriated as of the date of exercise. Remaining performance obligations exclude negotiated but unexercised options, the unfunded value of expired contracts, and certain variable consideration that was determined to be constrained.

Provision for Claimed Costs

U.S. government contracts and subcontracts are subject to extensive legal and regulatory requirements. In the ordinary course of business, agencies of the U.S. government, including the Defense Contract Audit Agency (“DCAA”), audit the Company’s claimed 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.

The Company recognizes a reserve for estimated adjustments to historical claimed costs in respect of the years subsequent to fiscal 2011, based primarily on historical audit results. As audits of the periods subsequent to 2011 are completed, our estimates of adjustment to claimed costs for these periods could change.

Cash and Cash Equivalents

Cash and cash equivalents include unrestricted cash accounts and highly liquid investments that have a maturity of three months or less at the date of purchase. The Company’s cash equivalents consist primarily of 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.

Accounts Receivable

Accounts receivable includes amounts billed and currently due from customers, and amounts billable where the right to consideration is unconditional. We also 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. Amounts billable and unbilled receivables are recognized at estimated realizable value and consist of costs and fees, most of which are expected to be billed and collected generally within one year. When events or conditions indicate that amounts outstanding from customers may become uncollectible, an allowance for expected credit losses is estimated and recorded. This estimate is based on the age of outstanding receivables and/or specific identification of the balances at risk of becoming uncollectible. Upon final determination that a receivable is uncollectible, the receivable is written off against the allowance for expected credit losses.

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. 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, and computer equipment, including laptops and tablets, is depreciated over two to four years. Leasehold improvements are amortized over the shorter of the useful life of the asset or lease term. Maintenance and repairs are charged to expense as incurred.

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. Certain fair value measurements may 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. 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.

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Intangible Assets

Intangible assets primarily consist of programs and contracts assets, channel relationships, the Company's trade name, customer relationships, software and other amortizable intangible assets. The Company capitalizes costs associated with developing internal-use computer software pertaining to upgrades in its business and financial systems. Programs and contract assets, channel relationships, and other amortizable intangible assets are generally amortized on an accelerated basis over the expected life based on projected future cash flows of approximately ten to fourteen years. Software purchased or developed for internal use is amortized over one to ten years. Intangible assets with finite lives are assessed for impairment whenever events or changes in circumstances indicate that the carrying value may not be recoverable. The Company's trade name intangible asset 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 uses 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 years ended March 31, 2026, 2025, and 2024, 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, 2026, 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, 2026, 2025, and 2024, the Company did not record any impairment of goodwill.

Long-Lived Assets

The Company reviews its long-lived assets, including property and equipment, amortizable intangible assets, and right-of-use ("ROU") 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, 2026, 2025, and 2024, the Company did not record any material impairment charges.

Leases

At contract inception, the Company determines whether the contract is, or contains, a lease, which exists when the contract conveys the right to control the use of identified property or equipment for a period of time in exchange for consideration. Operating lease balances are included in operating lease ROU assets, operating lease liabilities, and operating lease liabilities, net of current portion in the Company's consolidated balance sheet. Cash payments arising from operating leases are classified within operating activities in the consolidated statement of cash flows. As of March 31, 2026, the Company had no finance leases.

The Company's leases are generally for facilities and office space and the Company recognizes ROU assets and lease liabilities at the lease commencement date for those arrangements. The initial lease liability is equal to the present value of the future lease payments over the lease term. The initial measurement of the ROU asset is equal to the initial lease liability plus any initial direct costs and prepaid lease payments, less any lease incentives. At the lease commencement date, the Company estimates its collateralized incremental borrowing rate based on publicly available yields adjusted for Company-specific considerations and the Company's varying lease terms in determining the present value of future payments. Certain of the Company's leases contain options to renew or to terminate the lease which are included in the determination of the ROU assets and lease liabilities when it is reasonably certain that the Company will exercise the option. The Company's leases may also include variable lease payments, such as an escalation clause based on consumer price index rates, maintenance costs, and utilities. Variable lease payments that depend on an index or a rate are included in the determination of ROU assets and lease liabilities using the index or rate at the lease commencement date, whereas variable lease-related payments that do not depend on an index or rate are recorded as lease expense in the period incurred. ROU assets are evaluated for impairment in a manner consistent with the treatment of other long-lived assets.

The Company elected the short-term lease policy election not to recognize ROU assets and lease liabilities for leases with an initial term of 12 months or less; lease expense from these leases is recognized on a straight-line basis over the lease term. For all material classes of leased assets, the Company elected to apply the practical expedient to not separate lease components from non-lease components, and instead account for both components as a single lease component. As of March 31, 2026, the Company did not have any lease agreements with residual value guarantees or material restrictions or covenants.

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Income Taxes

Income taxes are accounted for under the asset and liability method in accordance with ASC 740 - Accounting for Income Taxes. 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. If it were to be determined that the Company would be able to realize its deferred income tax assets in the future in excess of its net recorded amount, or that the Company would no longer be able to realize its deferred income tax assets in the future as is currently recorded, the Company would make an adjustment to the valuation allowance which would decrease or increase the provision for income taxes.

The Company periodically assesses its tax positions for all periods open to examination by tax authorities based on the latest available information. Those positions are evaluated to determine whether they will more likely than not be sustained upon examination by the Internal Revenue Service (“IRS”) or other taxing authorities. The Company reserves for these uncertain tax positions related to unrecognized income tax benefits where it is not more likely than not that the Company’s tax position will be sustained on examination and settlement with the various taxing authorities. Liabilities for unrecognized tax benefits are measured based on the largest amount of benefit that is greater than 50% likely of being realized upon ultimate settlement. These unrecognized tax benefits 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.

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 income as of March 31, 2026 and 2025 consisted of net unrealized gains or losses on the Company’s defined and postretirement benefit plans and unrealized gains or losses on interest rate swaps designated as cash flow hedges.

Stock-Based Compensation

The Company’s stock-based compensation to employees are classified as equity plans. Compensation expense for all stock-based awards is measured at the grant date fair value and is recognized ratably over the vesting period, net of estimated forfeitures. The Company estimates forfeitures anticipated to occur during the vesting period, and the number of performance awards expected to vest based on service and performance conditions is adjusted at each reporting date.

Defined Contribution Plan

The Company sponsors the Employees’ Capital Accumulation Plan (the “ECAP”), which is a qualified defined contribution plan that covers eligible U.S. and certain employees in foreign jurisdictions. ECAP provides for distributions to participants by reason of retirement, death, disability, or termination of employment. The Company provides an annual matching contribution of up to 6% of eligible annual compensation.

Defined Benefit Plans for Post Retirement Benefits

The Company provides postretirement healthcare benefits to former officers under a medical indemnity insurance plan, with premiums paid by the Company (the “Officer Medical Plan”), as well as two pension plans for retired officers.

The Company recognizes a liability on the consolidated balance sheets within other long-term liabilities 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 the gains and losses and prior service costs and credits as a component of accumulated other comprehensive income for the changes in the defined benefit plans' funded status that are not recognized as components of net periodic benefit cost. The service cost component of net periodic benefit cost is included in cost of revenue and general and administrative expenses, and the non-service cost components of net periodic benefit cost (interest cost and net actuarial loss) are included as part of other income (expense), in the accompanying consolidated statements of operations.

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Self-Funded Medical Plans

The Company maintains self-funded medical insurance. Self-funded plans include a Preferred Provider Organization (PPO) and Consumer Driven Health Plans (CDHPs) 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, the Company considers the principal or most advantageous market in which the asset or liability would transact, and if necessary, considers assumptions that market participants would use when pricing the asset or liability.

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.

Investments in Variable Interest Entities and Other Investments

The Company invests in companies both directly and indirectly through venture capital funds that advance or develop new technologies applicable to its business. Each investment is evaluated for consolidation under the variable interest entities model and/or the voting interest model. The Company uses the equity method to account for investments in limited partnerships with greater than minor influence or in entities that it does not control if it is otherwise able to exert significant influence over the entities’ operating and financial policies. Equity investments in entities over which the Company does not have the ability to exercise significant influence and whose securities do not have a readily determinable fair value are accounted for under the measurement alternative, where they are subject to fair value adjustments in certain circumstances (e.g. observable price changes or impairment). Realized and unrealized gains or losses on investments are reflected in other income/(expense), on our consolidated statements of operations and investment balances are recorded in other long-term assets on our consolidated balance sheets.

Recently Issued Accounting Pronouncements Adopted

In December 2023, the FASB issued ASU 2023-09, Income Taxes (Topic 740): *Improvements to Income Tax Disclosures*, which requires disclosure of disaggregated information about an entity’s effective tax rate reconciliation as well as information on income taxes paid by jurisdiction. The Company adopted this standard prospectively effective March 31, 2026. The adoption of this ASU affects only the Company’s disclosures, with no impacts to its financial condition or results of operations.

Recently Issued Accounting Pronouncements Not Yet Adopted

In November 2024, the FASB issued ASU 2024-03, *Disaggregation of Income Statement Expenses*, which is intended to enhance transparency into the nature and function of certain expenses as specified by the ASU. The guidance does not change the expense captions an entity presents on the face of the income statement; rather, it requires public business entities to provide disaggregated disclosures of certain expense captions in the notes to the financial statements. The ASU is effective for annual periods beginning after December 15, 2026 and interim periods within fiscal years beginning after December 15, 2027, and can be applied retrospectively or prospectively. The Company is currently assessing the impact of this update, however, its adoption will affect only the Company’s disclosures, with no impacts to its financial condition or results of operations.

In September 2025, the FASB issued ASU 2025-06, *Targeted Improvements to the Accounting for Internal-Use Software*, to modernize the accounting for and disclosure of internal-use software costs. The guidance removes all references to project stages, defines the threshold to begin capitalizing costs, and clarifies the disclosure requirements of capitalized software costs. The ASU is effective for annual periods beginning after December 15, 2027, and interim periods within those fiscal years, and can be applied retrospectively, prospectively, or on a modified transition approach. Early adoption is permitted. The Company is currently assessing the impact of this update.

Other recent accounting pronouncements issued during fiscal 2026 and through the filing date that have not yet been adopted are not expected to have a material impact on the Company’s present or historical consolidated financial statements.

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3. Revenue

For each of the fiscal years 2026, 2025, and 2024, approximately 98% of the Company's revenue was generated from contracts with an agency or department of the U.S. government, including contracts where the Company performed either as a prime contractor or subcontractor, and regardless of the geographic location in which the work was performed.

Disaggregation of Revenue

We disaggregate our revenue from contracts with customers by contract type and by customer type, as well as by whether the Company acts as prime contractor or subcontractor, as we believe these categories best depict how the nature, amount, timing and uncertainty of our revenue and cash flows are affected by economic factors. The following series of tables presents our revenue disaggregated by these categories.

Revenue by Contract Type:

	Fiscal Year Ended March 31,					
	2026		2025		2024	
Cost-reimbursable	\$ 6,587	59%	\$ 6,865	57%	\$ 5,874	55%
Time-and-materials	2,492	22%	2,707	23%	2,530	24%
Fixed-price	2,138	19%	2,408	20%	2,258	21%
Total Revenue	<u>\$ 11,217</u>	<u>100%</u>	<u>\$ 11,980</u>	<u>100%</u>	<u>\$ 10,662</u>	<u>100%</u>

Revenue by Customer Type ⁽¹⁾:

	Fiscal Year Ended March 31,					
	2026		2025		2024	
Defense Customers	\$ 6,069	54%	\$ 5,943	49%	\$ 5,061	47%
Intelligence Customers	1,900	17%	1,867	16%	1,763	17%
National Security Customers	\$ 7,969	71%	\$ 7,810	65%	\$ 6,824	64%
Civil and Commercial Customers	3,248	29%	4,170	35%	3,838	36%
Total Revenue	<u>\$ 11,217</u>	<u>100%</u>	<u>\$ 11,980</u>	<u>100%</u>	<u>\$ 10,662</u>	<u>100%</u>

⁽¹⁾ Customer type is based on public market as determined by government agency mapping.

Revenue by Whether the Company Acts as Prime Contractor or a Subcontractor:

	Fiscal Year Ended March 31,					
	2026		2025		2024	
Prime Contractor	\$ 10,513	94%	\$ 11,397	95%	\$ 10,143	95%
Subcontractor	704	6%	583	5%	519	5%
Total Revenue	<u>\$ 11,217</u>	<u>100%</u>	<u>\$ 11,980</u>	<u>100%</u>	<u>\$ 10,662</u>	<u>100%</u>

Performance Obligations

As of March 31, 2026 and 2025, the Company had \$10.7 billion and \$9.5 billion of remaining performance obligations, respectively. We expect to recognize approximately 65% of the remaining performance obligations as of March 31, 2026 as revenue over the next 12 months, and approximately 75% over the next 24 months. The remainder is expected to be recognized thereafter.

Contract Balances

The following table summarizes the contract assets and liabilities, and accounts receivable, net of allowance recognized on the Company's consolidated balance sheets:

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	March 31,	
	2026	2025
Current assets:		
Accounts receivable–billed	\$ 555	\$ 781
Accounts receivable–unbilled (contract assets)	1,509	1,491
Allowance for credit losses	(1)	(1)
Accounts receivable, net	2,063	2,271
Other long-term assets:		
Accounts receivable–unbilled (contract assets)	58	58
Total accounts receivable, net	\$ 2,121	\$ 2,329
Other current liabilities		
Advance payments, billings in excess of costs incurred and deferred revenue (contract liabilities)	\$ 28	\$ 18

To determine revenue recognized from contract liabilities during the reporting periods, the Company allocates revenue recognized during the period to the beginning balances of individual contract liabilities first, until the revenue exceeds the liability balances. For fiscal 2026, 2025 and 2024, we recognized revenue of \$14 million, \$12 million and \$17 million, respectively, related to our contract liabilities on April 1, 2025, 2024 and 2023, respectively.

4. Earnings Per Share

The Company computes basic and diluted earnings per share amounts based on net income attributable to common stockholders for the periods presented. The Company uses the weighted average number of shares of common stock outstanding during the period to calculate basic earnings per share (“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. Holders of unvested Class A Restricted Common Stock are entitled to participate in non-forfeitable dividends or other distributions (“participating securities”). These unvested restricted shares participated in the Company's dividends declared and paid in each quarter of fiscal 2026, 2025, and 2024. 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 these 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,		
	2026	2025	2024
Numerator: ⁽¹⁾			
Earnings for basic computations	\$ 845	\$ 930	\$ 601
Earnings for diluted computations	\$ 845	\$ 930	\$ 601
Denominator:			
Weighted-average common stock shares outstanding, basic	122,071,669	127,763,166	130,366,501
Dilutive stock options and restricted stock	303,482	527,251	449,402
Weighted-average common stock shares outstanding, diluted ⁽²⁾	122,375,151	128,290,417	130,815,903
Earnings per share of common share:			
Basic	\$ 6.92	\$ 7.28	\$ 4.61
Diluted ⁽²⁾	\$ 6.90	\$ 7.25	\$ 4.59

⁽¹⁾ The difference between earnings for basic and diluted computations and net income presented on the consolidated statements of operations is due to undistributed earnings and dividends allocated to the participating securities. During fiscal 2026, 2025, and 2024, respectively, approximately 0.9 million, 0.7 million, and 1.1 million shares of participating securities were paid dividends totaling \$2 million, \$1 million, and \$2 million, respectively. There were undistributed earnings of \$4 million in both fiscal 2026 and 2025, and \$3 million in fiscal 2024, allocated to the participating class of securities in both basic and diluted earnings per share of common stock.

⁽²⁾ The impact of anti-dilutive options excluded from the calculation of diluted EPS was not material during the periods presented.

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5. Acquisitions and Divestitures

Acquisitions

PAR Government Systems Corporation

On June 7, 2024, the Company completed the acquisition of PAR Government Systems Corporation (“PGSC”), previously a wholly owned subsidiary of PAR Technology Corporation, for approximately \$99 million, net of post-closing adjustments and incurred transaction costs as part of the acquisition. PGSC was founded in 1985 and headquartered in Rome, New York, and delivers differentiated services and solutions in strategic mission areas, including the provision of real-time communications and mobile situational awareness to maintain battlespace dominance for a range of government customers. The acquisition was funded with cash on hand. As a result of the transaction, PGSC became a wholly owned subsidiary of Booz Allen Hamilton Inc.

The acquisition was accounted for under the acquisition method of accounting. The Company completed the determination of fair values of the acquired assets and liabilities assumed during the fourth quarter of fiscal 2025.

The goodwill recognized of \$61 million is primarily attributable to PGSC’s specialized workforce and the expected synergies between the Company and PGSC, and is deductible for tax purposes. The intangible assets recognized of \$27 million consist primarily of contract assets and are being amortized over the estimated useful life of twelve years.

Divestitures

Sale of Contracts

On November 30, 2025, the Company completed a transaction for the sale of a group of contracts, as well as the assets and liabilities associated with those contracts and the workforce that provides services under those contracts. As a result of this transaction, during fiscal 2026 the Company recognized a pre-tax net gain of \$6 million, inclusive of working capital adjustments, which is reflected in other income (expense) on the consolidated statements of operations. The consideration for the sale is subject to customary working capital adjustments and contingent consideration, which may impact the amount of the gain ultimately recognized.

6. Goodwill and Intangible Assets

Goodwill

Goodwill was \$2,399 million and \$2,405 million as of March 31, 2026 and March 31, 2025, respectively. The \$6 million decrease in the carrying amount of goodwill was attributable to the Company's sale of contracts in the third quarter of fiscal 2026.

Intangible Assets

Intangible assets consisted of the following:

	March 31, 2026			March 31, 2025		
	Gross Carrying Value	Accumulated Amortization	Net Carrying Value	Gross Carrying Value	Accumulated Amortization	Net Carrying Value
Amortizable intangible assets:						
Customer contracts and related customer relationships	\$ 619	\$ 365	\$ 254	\$ 619	\$ 305	\$ 314
Software	202	137	65	168	109	59
Total amortizable intangible assets	\$ 821	\$ 502	\$ 319	\$ 787	\$ 414	\$ 373
Unamortizable intangible assets:						
Trade name	\$ 190	\$ —	\$ 190	\$ 190	\$ —	\$ 190
Total	\$ 1,011	\$ 502	\$ 509	\$ 977	\$ 414	\$ 563

Amortization expense for fiscal 2026, 2025, and 2024 was \$95 million, \$95 million, and \$93 million, respectively.

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The following table summarizes the estimated annual amortization expense for future periods:

For the Fiscal Year Ended March 31,	
2027	\$ 81
2028	65
2029	53
2030	42
2031	35
Thereafter	43
Total estimated amortization expense	\$ 319

7. Property and Equipment, Net

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

	March 31,	
	2026	2025
Furniture and equipment	\$ 124	\$ 113
Computer equipment	102	109
Leasehold improvements	263	236
Total	489	458
Less: Accumulated depreciation and amortization	(318)	(281)
Property and equipment, net	<u>\$ 171</u>	<u>\$ 177</u>

Depreciation expense relating to property and equipment was \$38 million for fiscal 2026 and \$41 million for both fiscal 2025 and 2024. Amortization expense related to leasehold improvements was \$30 million for both fiscal 2026 and 2024, and \$29 million for fiscal 2025. During fiscal 2026 and 2025, the Company reduced the gross cost and accumulated depreciation and amortization by \$32 million and \$90 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,	
	2026	2025
Vendor payables	\$ 594	\$ 693
Provision for claimed costs	248	245
Accrued interest	32	16
Accrued expenses	35	33
Total accounts payable and other accrued expenses	<u>\$ 909</u>	<u>\$ 987</u>

See Note 18, "Commitments and Contingencies," to the consolidated financial statements for information on the Company's provision for claimed costs.

9. Accrued Compensation and Benefits

Accrued compensation and benefits consisted of the following:

	March 31,	
	2026	2025
Accrued payroll	\$ 289	\$ 328
Accrued retirement	77	85
Accrued paid time off	222	242
Other	53	47
Total accrued compensation and benefits	<u>\$ 641</u>	<u>\$ 702</u>

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10. Debt

Debt consisted of the following on the dates below:

	Maturity	March 31, 2026		March 31, 2025	
		Interest Rate	Outstanding Balance	Interest Rate	Outstanding Balance
Term Loan A-1	9/7/2027	5.018 %	\$ 714	5.675 %	\$ 1,526
Term Loan A-2	2/27/2031	4.923 %	750	— %	—
Senior Notes due 2028	9/1/2028	3.875 %	700	3.875 %	700
Senior Notes due 2029	7/1/2029	4.000 %	500	4.000 %	500
Senior Notes due 2033	8/4/2033	5.950 %	650	5.950 %	650
Senior Notes due 2035	4/15/2035	5.950 %	650	5.950 %	650
Less: Unamortized debt issuance costs and discount on debt			(24)		(28)
Total			3,940		3,998
Less: Current portion of long-term debt			(19)		(83)
Long-term debt, net of current portion			<u>\$ 3,921</u>		<u>\$ 3,915</u>

Credit Agreement

Booz Allen Hamilton Inc., a wholly owned subsidiary of Booz Allen Hamilton Holding Corporation, as borrower, and Booz Allen Hamilton Holding Corporation, as guarantor, are parties to a Credit Agreement dated as of July 31, 2012, as amended, which as of March 31, 2026, provides the Company with facility term loans of \$1,464 million and a \$1,500 million revolving credit facility, with a sub-limit for letters of credit of \$200 million.

On February 27, 2026 (the “Eleventh Amendment Effective Date”), the eleventh amendment to the Credit Agreement (the “Eleventh Amendment”), dated as of July 31, 2012 (as amended prior to the Eleventh Amendment Effective Date, the “Existing Credit Agreement” and, as amended by the Eleventh Amendment, the “Credit Agreement”) among Booz Allen Hamilton Inc., as borrower, and Booz Allen Hamilton Holding Corporation as guarantor, with Bank of America, N.A., as administrative agent and the lenders from time to time party thereto, provided for a refinancing and modification of the credit facilities, including the amendments set forth in the sections below.

In addition, pursuant to the Eleventh Amendment, certain other amendments to the Existing Credit Agreement were made, including amendments to certain negative covenants in the Existing Credit Agreement to (amongst other things): (i) increase the size of certain baskets that permit the incurrence of additional indebtedness and related liens and (ii) expand the Company’s ability to make dividends, equity repurchases and other distributions, in each case subject to specified conditions (including compliance with the applicable financial covenant and the absence of a continuing default).

The Credit Agreement contains customary representations and warranties and customary affirmative and negative covenants. In connection with Booz Allen Hamilton obtaining investment grade ratings from both Moody’s and S&P, certain activities previously restricted by certain negative covenants are permitted subject to pro forma compliance with the financial covenants and no events of default having occurred or are continuing. In addition, Booz Allen Hamilton is required to meet certain financial covenants at each quarter end, namely the Consolidated Net Total Leverage Ratio. As of March 31, 2026 and March 31, 2025, Booz Allen Hamilton was in compliance with all financial covenants associated with its debt.

Borrowings under the Credit Agreement incur interest at a variable rate. As of March 31, 2026, Booz Allen Hamilton had interest rate swaps with an aggregate notional amount of \$350 million. These instruments hedge the variability of cash outflows for interest payments on these variable rate facilities. 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 11, “Derivatives,” to the consolidated financial statements for additional information about these interest rate swaps).

Term Loans

Prior to the Eleventh Amendment Effective Date, approximately \$1,464 million of tranche A term loans (the “Term Loan A-1”) were outstanding under the Existing Credit Agreement. Pursuant to the Eleventh Amendment, certain lenders made term loans under a new tranche of term loans (the “Term Loan A-2”) with a maturity of February 27, 2031 under which the Company borrowed an aggregate principal amount of \$750 million. The proceeds of such borrowings under Term Loan A-2 were used to repay \$750 million of the aggregate principal outstanding under the Term Loan A-1.

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The terms of the remaining Term Loan A-1 debt remain unchanged and it is still governed under the Tenth Amendment to the Existing Credit Agreement (the “Tenth Amendment”), entered into on July 27, 2023. Pursuant to the Tenth Amendment, the rate at which Term Loan A-1 bears interest is based either on Term SOFR (subject to a 0.10% adjustment and a floor of zero) for the applicable interest period or a base rate (equal to the highest of (i) the administrative agent’s prime corporate rate, (ii) the overnight federal funds rate plus 0.50% and (iii) three-month Term SOFR (subject to a 0.10% adjustment and 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-1 ranges from 1.00% to 2.00% for Term SOFR loans and zero to 1.00% for base rate loans, in each case based on the lower of (i) the applicable rate per annum determined pursuant to a consolidated total net leverage ratio grid and (ii) the applicable rate per annum determined pursuant to a ratings grid. Term Loan A-1 amortizes in consecutive quarterly installments in an amount equal to 1.25% of the stated principal amount of Term Loan A-1 and the remaining balance of Term Loan A-1 is payable upon maturity.

Pursuant to the Eleventh Amendment, the rate at which Term Loan A-2 and the Revolving Credit facility bears interest is based either on Term SOFR for the applicable interest period or a base rate (equal to the highest of (i) the administrative agent’s prime corporate rate, (ii) the overnight federal funds rate plus 0.50% and (iii) three-month Term SOFR (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-2 and the Revolving Credit facility ranges from 1.00% to 1.63% for Term SOFR loans and zero to 0.63% for base rate loans, in each case based on the lower of (i) the applicable rate per annum determined pursuant to a consolidated total net leverage ratio grid and (ii) the applicable rate per annum determined pursuant to a ratings grid. Unused New Revolving Commitments are subject to a quarterly fee ranging from 0.10% to 0.25% based on the lower of (i) the applicable fee rate per annum determined pursuant to a consolidated total net leverage ratio grid and (ii) the applicable fee rate per annum determined pursuant to a ratings grid. Term Loan A-2 amortizes in consecutive quarterly installments in an amount equal to 0.625% of the stated principal amount for the first two years after funding, and 1.25% of the stated principal amount thereafter and the remaining balance of the Term Loan A-2 is payable upon maturity.

Revolving Credit Facility

Prior to the Eleventh Amendment Effective Date, the Existing Credit Agreement provided for \$1.0 billion of revolving commitments (the “Existing Revolving Commitments”). Pursuant to the Eleventh Amendment, the Existing Revolving Commitments were replaced in full with new revolving commitments and then increased by \$500 million, resulting in aggregate revolving commitments under the Credit Agreement (the “Revolving Credit Facility”) of \$1.5 billion, treated as a single revolving tranche with a maturity of February 27, 2031. The Revolving Credit Facility is expected to be used for general corporate purposes, including working capital as needed.

While the Company occasionally borrows under the Revolving Credit Facility for our working capital needs, there were no borrowings during the fiscal year ended March 31, 2026. During the fourth quarter of fiscal 2025, the Company borrowed \$200 million under the Revolving Credit Facility for our working capital needs, which was subsequently repaid with the proceeds from the bond offering in the same quarter. As of March 31, 2026 and March 31, 2025, respectively, there was no outstanding balance on the Revolving Credit Facility.

Booz Allen Hamilton has also agreed to pay customary letter of credit and agency fees.

Senior Notes

The following table summarizes additional material terms of the senior notes issued by Booz Allen Hamilton as of March 31, 2026:

	Indenture Date	Principal (in millions)	Interest Payable	Issuance Costs (in millions)
Senior Notes due 2028	8/24/2020	\$700	March and September 1	\$9
Senior Notes due 2029	6/17/2021	\$500	July and January 1	\$7
Senior Notes due 2033	8/4/2023	\$650	February and August 4	\$12
Senior Notes due 2035	3/14/2025	\$650	April and October 15	\$6
Total Senior Notes		<u>\$2,500</u>		

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The Senior Notes due 2035 and 2033 are fully and unconditionally guaranteed on an unsecured and unsubordinated basis by Booz Allen Hamilton Holding Corporation and rank equally and ratably in right of payment with all of Booz Allen Hamilton's and Booz Allen Hamilton Holding Corporation's other unsecured and unsubordinated indebtedness outstanding from time to time, pursuant to the relevant indenture. The Senior Notes due 2029 and 2028 are unsecured and are guaranteed by certain subsidiaries of Booz Allen Hamilton and rank equally in right of payment with all of Booz Allen Hamilton's and the respective subsidiary guarantors' existing and future senior indebtedness and rank senior in right of payment to any of Booz Allen Hamilton's future subordinated indebtedness, pursuant to the relevant indenture. We refer to the Senior Notes due 2028, Senior Notes due 2029, Senior Notes due 2033 and Senior Notes due 2035 together, as the "Senior Notes" herein.

Interest is payable on the Senior Notes semi-annually in cash in arrears, with the principal due at maturity. Issuance Costs were recorded as an offset against the carrying value of respective debt and are being amortized to interest expense over the term of the respective debt.

All the Senior Notes' indentures contain certain covenants, events of default, and other customary provisions. In connection with the Senior Notes obtaining investment grade ratings from Moody's and S&P, in January 2023, certain negative covenants in the indentures governing the Senior Notes 2028 and Senior Notes 2029 were suspended.

The Senior Notes are generally subject to redemption, in whole or in part, at Booz Allen Hamilton's option, in whole or in part, at any time and from time to time, at the redemption prices specified in their respective indenture and outlined below:

	Optional Redemption Date	Redemption Price
Senior Notes due 2028	present - 8/31/2025	100.969% of the principal amount being redeemed*
	9/1/2025 - maturity	100% of the principal amount being redeemed*
Senior Notes due 2029	present - 6/30/2025	102% of the principal amount being redeemed*
	7/1/2025 - 6/30/2026	101% of the principal amount being redeemed*
	7/1/2026 - maturity	100% of the principal amount being redeemed*
Senior Notes due 2033	present - 5/3/2033	The greater of 1) the present value of the remaining payments plus 100% of the principal being redeemed, less accrued interest and 2) 100% of the principal amount being redeemed*
	5/4/2033 - maturity	100% of the principal amount being redeemed*
Senior Notes due 2035	present - 1/14/2035	The greater of 1) the present value of the remaining payments plus 100% of the principal being redeemed, less accrued interest and 2) 100% of the principal amount being redeemed*
	1/15/2035 - maturity	100% of the principal amount being redeemed *

*plus any unpaid interest

Scheduled Maturities and Interest Expense

The following table summarizes required future debt repayments:

	Payments Due By March 31,						
	Total	2027	2028	2029	2030	2031	Thereafter
Term Loan A-1	\$ 714	\$ —	\$ 714	\$ —	\$ —	\$ —	\$ —
Term Loan A-2	750	19	18	37	38	638	—
Senior Notes due 2028	700	—	—	700	—	—	—
Senior Notes due 2029	500	—	—	—	500	—	—
Senior Notes due 2033	650	—	—	—	—	—	650
Senior Notes due 2035	650	—	—	—	—	—	650
Interest on indebtedness	1,017	198	176	146	120	106	271
Total	\$ 4,981	\$ 217	\$ 908	\$ 883	\$ 658	\$ 744	\$ 1,571

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Interest expense consisted of the following:

	Fiscal Year Ended March 31,		
	2026	2025	2024
Term Loan A-1	\$ 83	\$ 100	\$ 108
Term Loan A-2	—	—	—
Revolving Credit Facility	—	1	1
Senior Notes	125	88	73
Amortization of Debt Issuance Cost (DIC) and Original Issue Discount (OID) ⁽¹⁾	5	6	5
Interest Rate Swaps	(1)	(10)	(15)
Other	—	1	1
Total Interest Expense	<u>\$ 212</u>	<u>\$ 186</u>	<u>\$ 173</u>

⁽¹⁾ DIC and OID on the Term Loans and Senior Notes 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.

11. Derivatives

The Company utilizes interest rate swaps to manage interest rate risk related to its variable rate debt. The Company's objectives in using these interest rate swaps, which were designated as cash flow hedges, are to manage its exposure to interest rate movements and reduce volatility of interest expense. The Company's outstanding interest rate swaps have a total notional amount of \$350 million as of March 31, 2026 and mature from June 30, 2026 to June 30, 2027. The variable-to-fixed interest rate swaps effectively convert a portion of the variable rate debt into fixed interest rate debt.

The changes in the fair value of the Company's interest rate swaps are recorded in Accumulated Other Comprehensive Income (Loss) ("AOCI"), net of taxes, and are subsequently reclassified into interest expense, net in the period that the hedged forecasted interest payments are made on the Company's variable-rate debt. See Note 10, "Debt," to the consolidated financial statements for additional information on interest payments related to the interest rate swaps, and Note 17, "Investments and Fair Value Measurements," to the consolidated financial statements for additional information on the fair values and location of the interest rate swaps on the consolidated balance sheets.

Over the next 12 months, the Company estimates that \$1 million will be reclassified as an increase to interest expense. Cash flows associated with periodic settlements of interest rate swaps are 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 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.

12. Leases

The Company's leases are generally for facilities and office space. The Company's total lease cost is recorded primarily within general and administrative expenses on the consolidated statement of operations and consisted of the following:

	Fiscal Year Ended March 31,		
	2026	2025	2024
Operating lease cost	\$ 61	\$ 64	\$ 64
Short-term lease cost	1	1	1
Variable lease cost	13	14	13
Total operating lease costs	<u>\$ 75</u>	<u>\$ 79</u>	<u>\$ 78</u>

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Future minimum operating lease payments for noncancelable operating leases as of March 31, 2026 are as follows:

For the Fiscal Year Ending March 31,	Operating Lease Payments	
2027	\$	62
2028		53
2029		35
2030		29
2031		24
Thereafter		9
Total future lease payments		212
Less: imputed interest		(30)
Total lease liabilities	\$	182

Supplemental cash flow information related to leases was as follows:

	Fiscal Year Ended March 31,		
	2026	2025	2024
Cash paid for amounts included in the measurement of lease liabilities	\$ 67	\$ 71	\$ 76
Operating lease liabilities arising from obtaining ROU assets ⁽¹⁾	\$ 21	\$ 54	\$ 40

⁽¹⁾ Includes all noncash increases and decreases arising from new or remeasured operating lease arrangements

Other information related to leases was as follows:

	March 31,	
	2026	2025
Weighted average remaining lease term (in years)	3.9	4.3
Weighted average discount rate	5%	5%

Leases Not Yet Commenced

On November 12, 2025, the Company entered into two 15-year lease agreements for corporate office space in Reston, Virginia that have not yet commenced as of March 31, 2026. The Company plans to relocate its headquarters to the office space in the fall of 2027, dependent upon the timing of the completion of various tenant improvements. Under these lease agreements, which were entered into by Booz Allen Hamilton and are guaranteed by the Company, the estimated total undiscounted base lease payments are \$222 million and the agreements provide for up to \$57 million in tenant improvement allowances.

13. Income Taxes

Income Tax Provision

The components of income tax expense were as follows:

	Fiscal Year Ended March 31,		
	2026	2025	2024
Current			
U.S. Federal	\$ (94)	\$ 280	\$ 229
State and local	67	90	117
Foreign	3	5	3
Total current	(24)	375	349
Deferred			
U.S. Federal	61	(73)	(94)
State and local	(26)	(18)	(6)
Foreign	—	—	(1)
Total deferred	35	(91)	(101)
Total income tax expense	\$ 11	\$ 284	\$ 248

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Reconciliation of Effective Income Tax Rate

As discussed in Note 2, “Summary of Significant Accounting Policies,” to the consolidated financial statements, the Company adopted ASU 2023-09, Income Taxes (Topic 740): Improvements to Income Tax Disclosures, prospectively as of March 31, 2026. Differences between the effective income tax rate and the statutory U.S. federal income tax rate are as follows:

	2026	
	Amount	Rate
Income tax expense computed at U.S. Federal statutory rate	\$ 181	21.0%
State and local income taxes, net of federal income tax effect ⁽¹⁾	31	3.6%
Effect of Cross Border Taxation:		
Foreign Derived Intangible Income (FDII)	(29)	(3.4)%
Other	(3)	(0.3)%
Research and development and other federal credits	(103)	(12.0)%
Nontaxable and non-deductible items	10	1.2%
Changes in uncertain tax positions	(80)	(9.3)%
Other adjustments	4	0.5%
Income tax expense at the effective income tax rate	<u>\$ 11</u>	<u>1.3%</u>

⁽¹⁾ State taxes in Virginia and Maryland made up the majority (greater than 50%) of the tax effect in this category for fiscal 2026.

The reconciliation from federal income tax expense computed using the statutory federal income tax rate to federal income tax expense at our effective income tax rate, prior to the adoption of ASU 2023-09, is shown below for the comparative periods:

	2025	2024
	Income tax expense computed at U.S. Federal statutory rate	\$ 256
Increases (reductions) resulting from:		
State and local income taxes, net of federal income tax effect	55	85
Foreign income taxes, net of federal tax	—	(8)
Non-deductible expenses, including non-deductible penalties	7	5
Excess tax benefits from stock-based compensation	(6)	(10)
Research and development and other federal credits	(40)	(31)
Executive compensation - 162(m)	7	6
Foreign Derived Intangible Income (FDII)	(13)	(14)
Changes in uncertain tax positions (including indirect effects)	27	38
Other	(9)	(2)
Income tax expense at the effective income tax rate	<u>\$ 284</u>	<u>\$ 248</u>

Tax Receivables and Payables

The Company has both a current income tax receivable (\$88 million classified as prepaid taxes) and an income tax payable (\$10 million classified as other current liabilities) on its consolidated balance sheet as of March 31, 2026. In addition, as of March 31, 2026, the Company has \$178 million classified as other long-term assets on its consolidated balance sheet related to the amended U.S. federal return refund claims for research and development tax credits and the carryback claim for the fiscal 2021 net operating loss.

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Cash paid for taxes

The amount of cash income taxes paid by the Company were as follows:

	Fiscal Year Ended March 31,	
	2026	
U.S. Federal	\$	—
State and local:		
District of Columbia		24
Maryland		17
Virginia		37
All other states		20
Foreign		5
Total income taxes paid, net of refunds received	\$	<u>103</u>

Income tax payments, net of refunds received, were \$379 million and \$336 million for the years ended March 31, 2025 and 2024, respectively.

Deferred Income Taxes

The significant components of the Company's deferred income tax assets and liabilities consisted of the following on the dates below:

	March 31,	
	2026	2025
Deferred tax assets:		
Accrued expenses	\$ 68	\$ 66
Deferred compensation	60	59
Stock-based compensation	12	12
Postretirement benefits	46	47
Net operating loss and other carryforwards	206	9
Research and development expenditures and indirect effects	98	335
State tax credits	45	1
Operating lease liabilities	52	62
Other	6	12
Total gross deferred tax assets	<u>593</u>	<u>603</u>
Less: valuation allowance	(10)	(9)
Total net deferred income tax assets	<u>583</u>	<u>594</u>
Deferred tax liabilities:		
Unbilled receivables	(90)	(89)
Intangible assets	(112)	(100)
Property and equipment	(33)	(25)
Operating lease right-of-use assets	(38)	(46)
Other	(16)	(2)
Total deferred tax liabilities	<u>(289)</u>	<u>(262)</u>
Net deferred tax asset	<u>\$ 294</u>	<u>\$ 332</u>

In July 2025, the One Big Beautiful Bill Act ("OBBA") was enacted, introducing significant amendments to the U.S. federal income tax code, including the permanent extension of certain expiring provisions of the Tax Cuts and Jobs Act, restoration of favorable tax treatment for certain business provisions including the immediate expensing of domestic research and development expenditures, a change in the benefit of the research and development tax credit, restoration of full expensing for qualified machinery, equipment and other short-lived assets, as well as several modifications to international tax provisions. Certain provisions are effective for fiscal 2026 and the Company has recognized the income tax effects of those provisions herein, while other provisions are effective in future fiscal years.

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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.

Tax Credit, Loss and Other Carryforwards

As of March 31, 2026 and 2025, the Company had available federal, state, and foreign net operating loss (“NOL carryforwards”) of \$206 million and \$9 million, respectively, that may be applied against future taxable income. The federal net operating loss consists of \$1 million attributable to an acquisition and will begin to expire in fiscal 2037 and \$192 million generated in fiscal 2026 that do not expire. The Company recorded a partial valuation allowance against those federal, state and foreign net operating losses it believes will expire prior to utilization.

As of March 31, 2026 and 2025, the Company had tax credit carryforwards of \$45 million and \$1 million, respectively, that may be applied against future taxable income. These credits include \$40 million of research and development and other credits that begin to expire in fiscal 2029, and the majority expire in fiscal 2046.

Uncertain Tax Positions

The Company maintains reserves for uncertain tax positions (“UTP”) related to unrecognized income tax benefits. These reserves involve 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, 2026, 2025, and 2024, the Company has recorded \$75 million, \$142 million, and \$115 million, respectively, of reserves for UTPs which include potential tax benefits of \$71 million, \$125 million, and \$104 million, respectively, that, when recognized, impact the effective tax rate. As of March 31, 2026 and 2025, \$20 million and \$3 million, respectively, of the reserve is reflected as a reduction to deferred taxes and the remaining balance is recorded as a component of other long-term liabilities in the consolidated balance sheet.

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

	March 31,		
	2026	2025	2024
Beginning of year	\$ 125	\$ 104	\$ 548
Increases in prior year position	21	4	41
Increases in current year position	17	17	13
Decreases in prior year position	(20)	—	(474)
Settlements with taxing authorities	(63)	—	(24)
Lapse of statute of limitations	(9)	—	—
End of year	<u>\$ 71</u>	<u>\$ 125</u>	<u>\$ 104</u>

In addition to the unrecognized tax benefits noted above, the Company recognized accrued interest and penalties of \$(16) million for fiscal 2026, and \$7 million for both fiscal 2025 and 2024, related to the reserves for uncertain tax positions in the income tax provision. The total reserve for uncertain tax positions includes accrued penalties and interest of approximately \$4 million, \$20 million and \$13 million at March 31, 2026, 2025, and 2024, respectively.

With respect to significant current year activity, the UTP reduction during fiscal 2026 is primarily related to an \$86 million adjustment (including interest) from the completion of Internal Revenue Service (the “IRS”) examination procedures of the Company's amended federal income tax returns through fiscal year 2021 recorded in the first quarter. The Company also accrued \$(24) million of interest income (net of tax effect) on the related long-term receivable for the refund requested in the amended returns. Due to the magnitude of the refund requested in the amended returns, the case will be referred to the Joint Committee on Taxation (the “JCT”) for further evaluation, as required by law for tax refunds or reductions exceeding \$5 million. While the JCT has not yet reviewed this case, management does not anticipate that the resolution of this review will have a material adverse effect on the Company's financial position or results of operations.

During fiscal 2024, the Company reversed reserves for uncertain tax positions related to the required capitalization of research and development expenditures originally recorded in fiscal 2023, which was reversed in fiscal 2024 as a result of additional guidance provided by the IRS.

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The Company is subject to taxation in the United States and various state and foreign jurisdictions. As of March 31, 2026, the Company's tax years ended March 31, 2016 and forward are open and subject to examination by the federal tax authorities. The Company is currently under federal audit by the Internal Revenue Service ("IRS") for fiscal years 2016, 2017 and 2019-2021. The other jurisdictions currently open or under examination are not considered to be material.

It is difficult to predict the ultimate outcome or the timing of resolution for uncertain tax positions. It is reasonably possible that the amount of unrecognized tax benefits could significantly change within the next twelve months. However, an estimate of the range of reasonably possible outcomes cannot be made. Items that may cause changes to unrecognized tax benefits include the amount of research and development tax credits available in the United States and various state jurisdictions. These changes could result from the completion of the ongoing IRS examination, the expiration of the statutes of limitations, additional regulatory guidance or other unforeseen circumstances.

14. Employee Benefit Plans

Defined Contribution Plan

The total expense recognized under the ECAP for fiscal 2026, 2025, and 2024 was \$226 million, \$249 million, and \$218 million, respectively, and the Company-paid contributions were \$232 million, \$240 million, and \$213 million, respectively.

Defined Benefit Plans for Post Retirement Benefits

The weighted-average discount rate used to determine the year-end benefit obligation for the Officer Medical Plan were 5.85%, 5.55% and 5.20% for fiscal 2026, 2025, and 2024, respectively.

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

Pre-65 initial rate	2026	2025
Healthcare cost trend rate assumed for next year	8.10 %	8.25 %
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	2036	2034

Post-65 initial rate	2026	2025
Healthcare cost trend rate assumed for next year	9.20 %	8.95 %
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	2036	2034

The changes in the benefit obligation of the unfunded Officer Medical Plan were as follows:

	Fiscal Year Ended March 31,		
	2026	2025	2024
Benefit obligation, beginning of the year ⁽¹⁾	\$ 174	\$ 127	\$ 106
Service cost	7	6	5
Interest cost	10	6	5
Net actuarial (gain) loss	(3)	41	17
Benefits paid	(6)	(6)	(6)
Gain due to curtailment	(2)	—	—
Benefit obligation, end of the year ⁽¹⁾	<u>\$ 180</u>	<u>\$ 174</u>	<u>\$ 127</u>

⁽¹⁾ The short term and long term portion of the Officer Medical Plan's benefit obligation is included in accrued compensation and other long-term liabilities, respectively, in the accompanying consolidated balance sheets.

The net actuarial gain related to the benefit obligation in fiscal 2026 was primarily driven by an increase in interest rates, partially offset by unfavorable changes in medical trends. The net actuarial loss related to the benefit obligation in fiscal 2025 was primarily due to unfavorable updates in estimated medical claims and medical inflation, partially offset by an increase in the discount rate. The net actuarial loss related to the benefit obligation in fiscal 2024 was primarily due to unfavorable updates in estimated medical claims, medical inflation, and demographic assumptions, partially offset by increases in discount rate.

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

For the Fiscal Year Ending March 31,	
2027	\$ 8
2028	8
2029	9
2030	10
2031	11
2032 - 2036	64
Total	<u>\$ 110</u>

15. Stockholders' Equity

Common Stock

Holders of Class A Common Stock are entitled to one vote for each share. Each share of Class A Common is entitled to participate equally in all dividends and other distributions declared on and payable with respect to the Class A Common Stock, subject to the preferences and rights of any preferred stock and the General Corporation Law of the State of Delaware. The Company's ability to pay dividends to stockholders is limited as a practical matter by restrictions in the agreements governing the Company's indebtedness.

The authorized and unissued shares of Class A Common Stock are available for future issuance upon stock option exercises and vesting of restricted stock units without additional stockholder approval.

Share Repurchase Program

On December 12, 2011, the Board of Directors initially approved a share repurchase program, which was most recently increased by \$500 million to \$4,085 million on October 22, 2025. A special committee of the Board evaluates market conditions and other relevant factors and initiates 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. During fiscal 2026, the Company purchased 5.6 million shares of Class A Common Stock in a series of open market transactions for \$561 million. During fiscal 2025, the Company purchased 5.6 million shares of Class A Common Stock in a series of open market transactions for \$764 million. As of March 31, 2026, the Company had \$684 million remaining under the share repurchase program.

Dividends

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

	Fiscal Year Ended March 31,		
	2026	2025	2024
Recurring dividends ⁽¹⁾	\$ 276	\$ 268	\$ 254

⁽¹⁾ Amounts represent recurring quarterly dividends that were declared and paid for during each quarter of fiscal 2026, 2025, and 2024.

16. Stock-based Compensation

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

	Fiscal Year Ended March 31,		
	2026	2025	2024
Cost of revenue	\$ 27	\$ 35	\$ 44
General and administrative expenses	42	59	51
Total ⁽¹⁾	<u>\$ 69</u>	<u>\$ 94</u>	<u>\$ 95</u>

⁽¹⁾ Tax benefits recognized from stock-based compensation were \$12 million, \$22 million, and \$31 million for fiscal 2026, 2025, and 2024, respectively.

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Our stock-based compensation expense, primarily related to stock options, time-based and performance-based restricted stock awards, is measured at the grant date fair value and recognized ratably over the vesting period. The Company uses the Black-Scholes option-pricing model to determine the estimated fair value for stock option awards. The fair value of the Company's restricted stock awards are generally based on the closing price of its common stock on the New York Stock Exchange on the date of grant. The fair value of performance-based awards that also have market conditions is measured using a Monte Carlo model. Compensation expense for performance-based awards is estimated at each reporting date using management's expectation of the probable achievement of the specified performance criteria of each tranche during the respective performance periods.

As of March 31, 2026 and 2025, there was \$47 million and \$68 million, respectively, of total unrecognized compensation cost related to unvested stock-based compensation agreements. The unrecognized compensation cost as of March 31, 2026 is expected to be fully amortized over the next five years. As of March 31, 2026 and 2025, absent the effect of forfeiture or acceleration of stock compensation cost for departures of employees, the weighted average period over which the cost is expected to be amortized (excluding any future awards) is 2.0 years and 1.7 years, respectively.

Equity Incentive Plan

Awards under the Company's Equity Incentive Plan (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; deferred share units; dividend equivalents; and other stock-based awards. As of March 31, 2026 and 2025, there were 4.3 million and 5.1 million shares, respectively, available for future grants under the EIP.

Stock Options

Stock options under the EIP are granted at the discretion of the Board of Directors or its Compensation, Culture and People 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 date. All options under the EIP are exercisable, upon vesting, for shares of Class A Common Stock of the Company.

As of both March 31, 2026 and 2025, 0.1 million options were unvested under the EIP, with a weighted average grant date fair value of \$24.37 and \$20.60, respectively. There were 0.5 million and 0.7 million EIP options outstanding as of March 31, 2026 and 2025, with a weighted average exercise price of \$73.63 and \$69.88, respectively.

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 and a portion of the bonus may be paid in the form of equity (including stock and other awards under the EIP).

The Company maintains annual incentive programs for officers and key employees. 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 Class A Common Stock. Dividend equivalents are paid in respect of the service-based restricted stock units when dividends are paid on the Company's Class A Common Stock. The related expense is recognized in the accompanying consolidated statements of operations based on the grant date fair value over the vesting period.

Performance-based awards vest at the end of a three-year period, subject to certain specified financial performance criteria, the grantee's continued service through the period, and certification of final performance by the Compensation, Culture and People Committee of the Board of Directors. Certain performance-based awards included additional market conditions related to the Company's total stockholder return relative to its peer group over the three-year performance period. The Company recognizes compensation expense for these performance-based awards with market conditions based on the grant-date fair value calculated using a Monte Carlo model. These awards are settled for 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.

The Company also issues equity awards under other programs in the form of restricted stock units that would vest immediately after issuance or over an applicable vesting period subject to the employee's continued service for the Company. The associated expenses are recognized in the accompanying consolidated statements of operations based on the grant date fair value.

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Grants of Class A Restricted Common Stock and Restricted Stock Units

During fiscal 2026, the Board of Directors granted an aggregate of 0.9 million Restricted Stock Units with service-based and performance-based vesting conditions to officers, vice presidents, and other employees and non-employees of the Company. The awards will vest based on the applicable vesting period for the specific award subject to the employees' continued employment with the Company. The Board also granted Class A Restricted Common Stock to members of the Board during fiscal 2026. These awards generally vest over one year.

The aggregate fair value of all awards issued during fiscal 2026 was \$90 million and will be recognized in the accompanying consolidated statements of operations over the applicable vesting period of the awards. As permitted under the terms of the EIP, the Compensation, Culture and People Committee, as Administrator of the Plan, authorized the withholding of taxes not in excess of such amount as may be necessary to avoid liability award accounting, 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 Company repurchased 0.3 million shares and recorded them as treasury shares at a total cost of \$25.5 million in fiscal 2026.

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

<i>Unvested Restricted Stock Awards</i>	Number of Shares	Weighted Average Grant Date Fair Value
Unvested at March 31, 2025	1,003,794	\$ 120.89
Granted	860,646	104.11
Vested	735,591	106.04
Forfeited	168,292	121.39
Unvested at March 31, 2026 ⁽¹⁾	960,557	\$ 117.14

⁽¹⁾ Unvested restricted stock includes 0.2 million shares of performance-based awards that completed the three-year performance period but remained unsettled at March 31, 2026, subject to the certification of final performance by the Compensation, Culture and People Committee of the Board of Directors.

The weighted average grant date fair value of restricted stock awards granted during fiscal 2026, 2025, and 2024 was \$104.11, \$151.85, and \$98.94, respectively. The total grant date fair value of restricted stock shares vested during fiscal 2026, 2025, and 2024 was \$78 million, \$81 million, and \$86 million, respectively.

Employee Stock Purchase Plan

The Company offers a tax qualified Employee Stock Purchase Plan (the "ESPP") which is designed to enable eligible employees to periodically purchase shares of the Class A Common Stock at a five percent discount from the fair market value of the Class A Common Stock. The ESPP provides for quarterly offering periods. For the year ended March 31, 2026, 0.4 million shares of Class A Common Stock were purchased by employees under the ESPP. Since the program's inception, 4.4 million shares of the total 10.0 million shares available have been purchased by employees.

17. Investments and Fair Value Measurements

Investments

Our investments related to unconsolidated entities included in other long term assets of the Company's consolidated balance sheets at March 31 were:

<i>Investments</i>	2026	2025
Equity method investments	\$ 184	\$ 5
Other investments	160	85
Total Investments	\$ 344	\$ 90

The net gains of our investments are not material to the consolidated financial statements for the periods presented.

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Equity Method Investments

During fiscal 2026, Booz Allen Hamilton Inc., a wholly owned subsidiary of the Company, committed to invest up to \$400 million and \$100 million, respectively, as a limited partner in two separate venture capital funds (the “Funds”), which are accounted for as equity method investments and considered related parties. The commitments are subject to capital calls to be funded over the Funds’ 10-year terms, which may be extended in accordance with the Funds’ governing documents. The Company funded a total investment of \$178 million in the Funds in the fourth quarter, and believes that future capital calls will be concentrated in the earlier years of the Funds’ operation as the Funds execute on their expected investment strategy. As of March 31, 2026, the Company’s unfunded capital commitments as a limited partner in the Funds was \$322 million.

Other Investments - Nonrecurring Fair Value Measurements

As of March 31, 2026 and 2025, the total of our investments that are accounted for at fair value on a non-recurring basis under the measurement alternative were \$146 million and \$85 million, respectively. While these assets are not measured at fair value on an ongoing basis, they are subject to fair value adjustments in certain circumstances (e.g., observable price changes or impairment).

Recurring Fair Value Measurements

The financial instruments measured at fair value on a recurring basis in the accompanying consolidated balance sheets consist of the following:

	March 31, 2026		
	Level 1	Level 2	Total
Assets:			
Money market funds	\$ 307	\$ —	\$ 307
Long term deferred compensation plan asset ⁽²⁾	40	—	40
Total Assets	\$ 347	\$ —	\$ 347
Liabilities:			
Current derivative instruments ⁽¹⁾	—	1	1
Long term deferred compensation plan liability ⁽²⁾	40	—	40
Total Liabilities	\$ 40	\$ 1	\$ 41
March 31, 2025			
	Level 1	Level 2	Total
Assets:			
Money market funds	\$ 802	\$ —	\$ 802
Current derivative instruments ⁽¹⁾	—	1	1
Long term deferred compensation plan asset ⁽²⁾	\$ 35	\$ —	\$ 35
Total Assets	\$ 837	\$ 1	\$ 838
Liabilities:			
Current derivative instruments ⁽¹⁾	\$ —	\$ 1	\$ 1
Long-term derivative instruments ⁽¹⁾	—	2	2
Long term deferred compensation plan liability ⁽²⁾	35	—	35
Total liabilities	\$ 35	\$ 3	\$ 38

⁽¹⁾ The Company’s interest rate swaps are considered over-the-counter derivatives which are recorded in the consolidated balance sheet on a gross basis at estimated fair value. 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 11, “Derivatives,” to the consolidated financial statements for further information on the Company’s derivative instruments designated as cash flow hedges.

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⁽²⁾ Investments in this category consist primarily of mutual funds whose fair values are determined by reference to the quoted market price per unit in active markets multiplied by the number of units held without consideration of transaction costs. These assets are recorded in other long-term assets and represent investments held in a consolidated trust to fund the Company's non-qualified deferred compensation plan, which is recorded in other long-term liabilities on our consolidated balance sheets.

The Company did not have any Level 3 assets or liabilities as of March 31, 2026 or 2025.

Cash and Cash Equivalents

As of March 31, 2026 and 2025, the Company's cash and cash equivalents presented on the accompanying consolidated balance sheets include the money market funds disclosed in the table above. As of both March 31, 2026 and 2025, the fair value of the Company's cash and cash equivalents approximated its carrying value.

Long-term Debt

The Company's long-term debt is carried at amortized cost and fair value is presented quarterly for disclosure purposes. The estimated fair values of debt are determined using quoted prices or other market information obtained from recent trading activity of the debt 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 the Senior Notes are determined using quoted prices or other market information obtained from recent trading activity in the high-yield bond market (Level 2 inputs). The carrying amount and estimated fair value of debt consists of the following:

	March 31, 2026		March 31, 2025	
	Carrying Amount	Estimated Fair Value	Carrying Amount	Estimated Fair Value
Term Loan A-1	\$ 714	\$ 712	\$ 1,526	\$ 1,521
Term Loan A-2	750	743	—	—
3.875% Senior Notes due 2028	700	680	700	666
4.000% Senior Notes due 2029	500	484	500	471
5.950% Senior Notes due 2033	650	663	650	651
5.950% Senior Notes due 2035	650	655	650	645
Total Debt	\$ 3,964	\$ 3,937	\$ 4,026	\$ 3,954

18. Commitments and Contingencies

Letters of Credit and Third-Party Guarantees

As of both March 31, 2026 and 2025, 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 \$3 million and \$4 million, respectively. These letters of credit and bank guarantees primarily support insurance and bid and performance obligations. At both March 31, 2026 and 2025, approximately \$1 million of these instruments reduce the available borrowings under the Revolving Credit Facility. The remainder is guaranteed under a separate \$3 million facility, of which \$1 million and less than a million were available to the Company at March 31, 2026 and 2025, respectively.

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Litigation

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 customers 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 both March 31, 2026 and 2025, there were no material amounts accrued in the consolidated financial statements related to these proceedings.

During the second quarter of fiscal 2025, the Company secured insurance recoveries of \$115 million from claims related to the Company's settlement described in Note 20, "Commitments and Contingencies," to the consolidated financial statements contained within our Annual Report on Form 10-K for the fiscal year ended March 31, 2024. The insurance recoveries offset our general and administrative expenses in our Consolidated Statements of Operations.

Government Contracting Matters - Provision for Claimed Costs

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, including the Defense Contract Audit Agency ("DCAA"), audit the Company's claimed 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.

Management believes it has recorded the appropriate provision for claimed costs for any audit, inquiry, or investigation of which it is aware that may be subject to any reductions and/or penalties. As of March 31, 2026 and 2025, the Company had recorded liabilities (included in accounts payable and other accrued expenses) of approximately \$248 million and \$245 million, respectively, for estimated adjustments to claimed costs based on its historical DCAA audit results, including the final resolution of such audits with the Defense Contract Management Agency ("DCMA"), for claimed costs incurred subsequent to fiscal 2011.

19. Business Segment Information

The Company reports operating results and financial data in one operating and reportable segment. The Company manages its business and allocates resources as a single profit center in order to promote collaboration, provide comprehensive functional service offerings across its entire customer base, and provide incentives to employees based on the success of the organization as a whole.

The Company's chief operating decision maker ("CODM") is its Chairman and Chief Executive Officer. Consolidated net income is the primary measure of profit used by the CODM to allocate resources and assess performance of the Company. Significant expense categories regularly provided to the CODM to manage operations are those disclosed in the consolidated statements of operations.

20. Supplemental Consolidated Financial Information

Severance and Related Charges

The Company incurs costs related to employee severance and related charges including stock-based compensation, employee benefits, and payroll taxes related to employees terminated pursuant to cost management initiatives. The Company records these costs when it is probable that employees will be entitled to termination benefits and the amounts can be reasonably estimated.

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The Company recorded \$61 million of severance and related charges in the fiscal year ended March 31, 2026 as a result of cost management initiatives and the restructuring of the Civil business in fiscal 2026, including the Company's actions to reduce costs as a result of the slowed procurement and funding environment. These expenses are recorded in the consolidated statements of operations as follows:

	Twelve Months Ended	
	March 31, 2026	
Cost of revenue	\$	46
General and administrative expenses		15
Total severance and related charges	\$	<u>61</u>

21. Subsequent Events

Acquisition of Defy Security

On April 6, 2026, the Company acquired Defy Security as a wholly-owned subsidiary for \$235 million subject to customary adjustments including net working capital. Defy Security will enable the Company to deliver end-to-end, tech-enabled cybersecurity solutions and products for U.S. and foreign customers.

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, 2026.

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 the Board 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, 2026. 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, 2026, 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 Independent Registered Public Accounting Firm

To the Stockholders and the 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, 2026, 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 (the Company) maintained, in all material respects, effective internal control over financial reporting as of March 31, 2026, 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 the Company as of March 31, 2026 and 2025, 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, 2026, and the related notes and our report dated May 22, 2026 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 22, 2026

Item 9B. Other Information.**Fiscal Year 2027 Compensation Adjustments**

On May 19, 2026, the Compensation, Culture and People Committee (the “Committee”) of the Board of Directors of Booz Allen Hamilton Holding Corporation (the “Company”) approved for fiscal year 2027 certain changes to the target total direct compensation of certain named executive officers of the Company.

The target total direct compensation for Horacio D. Rozanski, Chief Executive Officer of the Company, was increased to \$15,500,000, which reflects an increase of \$2,000,000 in his long-term equity incentive.

The target total direct compensation for Kristine M. Anderson, President and Chief Operating Officer of the Company, was increased to \$6,000,000, which reflects an increase of \$325,000 in her target cash bonus and an increase of \$2,000,000 in her long-term equity incentive.

Item 9C. Disclosure Regarding Foreign Jurisdictions that Prevent Inspections.

None.

PART III**Item 10. Directors, Executive Officers and Corporate Governance.**

Information related to our directors is set forth under the caption “Proposal 1: Election of Directors” of our Proxy Statement for our Annual Meeting of Stockholders scheduled for July 22, 2026 (the “2026 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 “Information about our Executive Officers.”

Information relating to compliance with Section 16(a) of the Exchange Act, to the extent required, is set forth in our 2026 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 2026 Proxy Statement. Such information is incorporated herein by reference.

Information related to our insider trading policy is set forth under the caption “Insider Trading Policy and Policy on Hedging, Short Sales, and Speculative Transactions” of our 2026 Proxy Statement. Such information is incorporated herein by reference.

Information relating to the Audit Committee required by Item 407(d)(4) of Regulation S-K and relating to 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 2026 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” of our 2026 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, 2026:

Plan Category	(a) Number of Securities to Be Issued Upon Exercise of Outstanding Options, Warrants and Rights	(b) Weighted Average Exercise Price of Outstanding Options, Warrants and Rights	(c) Number of Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a))
Equity compensation plans approved by securityholders	1,460,296 ⁽¹⁾	\$ 73.63	4,266,126
Equity compensation plans not approved by securityholders	—	N/A	—
Total	1,460,296 ⁽¹⁾	\$ 73.63	4,266,126

⁽¹⁾ Column (a) includes: 946,327 shares that have been granted as restricted stock units (RSUs) and 513,969 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 2026 Proxy Statement under the caption “Security Ownership of Certain Beneficial Owners” 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 2026 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 2026 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

Exhibit Number	Description
2.1	Membership Interest Purchase Agreement, dated May 3, 2021, among (i) Booz Allen Hamilton Inc., (ii) Liberty IT Solutions, LLC, (iii) William Greene, Christopher Bickell, and Jeff Denniston, and (iv) Southpaw Representative, LLC, in its capacity as Members' Representative (Incorporated by reference to Exhibit 2.1 to the Company's Form 8-K filed on May 4, 2021 (File No. 001-34972)).
3.1	Seventh Amended and Restated Certificate of Incorporation of Booz Allen Hamilton Holding Corporation (Incorporated by reference to Exhibit 3.1 to the Company's Current Report on Form 8-K filed on July 28, 2023 (File No. 001-34972)).
3.2	Amended and Restated Bylaws of Booz Allen Hamilton Holding Corporation (Incorporated by reference to Exhibit 3.2 to the Company's Current Report on Form 8-K filed on July 28, 2023 (File No. 001-34972)).
4.1	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)).

- 4.2 [Indenture, dated August 24, 2020, 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 August 24, 2020 \(File No. 001-34972\)\)](#)
- 4.3 [First Supplemental Indenture, dated August 24, 2020, 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 August 24, 2020 \(File No. 001-34972\)\)](#)
- 4.4 [Second Supplemental Indenture, dated as of November 5, 2021, among Booz Allen Hamilton Inc., the New Subsidiary Guarantors party thereto and Wilmington Trust, National Association \(Incorporated by reference to Exhibit 4.1 to the Company's Quarterly Report for the period ended December 31, 2021 on Form 10-Q \(File No. 001-34972\)\)](#)
- 4.5 [Indenture, dated June 17, 2021, 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 June 17, 2021 \(File No. 001-34972\)\)](#)
- 4.6 [First Supplemental Indenture, dated June 17, 2021, 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 June 17, 2021 \(File No. 001-34972\)\)](#)
- 4.7 [Second Supplemental Indenture, dated as of November 5, 2021, among Booz Allen Hamilton Inc., the New Subsidiary Guarantors party thereto and Wilmington Trust, National Association \(Incorporated by reference to Exhibit 4.2 to the Company's Quarterly Report for the period ended December 31, 2021 on Form 10-Q \(File No. 001-34972\)\)](#)
- 4.8 [Indenture dated as of August 4, 2023, among Booz Allen Hamilton Inc., Booz Allen Hamilton Holding Corporation, as parent guarantor, and U.S. Bank Trust Company, National Association, as trustee \(Incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed on August 4, 2023 \(File No. 001-34972\)\)](#)
- 4.9 [First Supplemental Indenture \(including the form of 5.950% Senior Notes due 2033\), dated as of August 4, 2023, among Booz Allen Hamilton Inc., Booz Allen Hamilton Holding Corporation, as parent guarantor, and U.S. Bank Trust Company, National Association, as trustee \(Incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on August 4, 2023 \(File No. 001-34972\)\)](#)
- 4.10 [Second Supplemental Indenture \(including the form of 5.950% Senior Notes due 2035\), dated as of March 14, 2025, among Booz Allen Hamilton Inc., Booz Allen Hamilton Holding Corporation, as parent guarantor, and U.S. Bank Trust Company, National Association, as trustee \(Incorporated by reference to Exhibit 4.2 to the Company's Current Report on Form 8-K filed on March 14, 2025 \(File No. 001-34972\)\)](#)
- 4.11 [Form of 5.950% Senior Note due 2035 \(included as Exhibit A to Exhibit 4.10 hereof\)](#)
- 4.12 [Form of 5.950% Senior Note due 2033 \(included as Exhibit A to Exhibit 4.9 hereof\)](#)
- 4.13 [Form of 4.000% Senior Note due 2029 \(included as Exhibit A to Exhibit 4.5 hereof\)](#)
- 4.14 [Form of 3.875% Senior Note due 2028 \(included as Exhibit A to Exhibit 4.2 hereof\)](#)
- 4.15 [Description of Capital Stock*](#)
- 10.1† [2023 Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Appendix C to the Company's Definitive Proxy Statement on Schedule 14A, filed with the Commission on June 15, 2023 \(File No. 001-34972\)\)](#)
- 10.2† [Third 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 December 31, 2019 on Form 10-Q \(File No. 001-34972\)\)](#)
- 10.3† [Second Amended and Restated Booz Allen Hamilton Holding Corporation Annual Incentive Plan \(Incorporated by reference to Exhibit 10.3 to the Company's Quarterly Report for the period ended December 31, 2019 on Form 10-Q \(File No. 001-34972\)\)](#)
- 10.4† [Booz Allen Hamilton Holding Corporation Officers' Retirement Policy \(Incorporated by reference to Exhibit 10.4 to the Company's Annual Report for the year ended March 31, 2025 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.5† [Form of Booz Allen Hamilton Inc. Named Executive Officer Retirement Letter*](#)
- 10.6† [Officer's Comprehensive Medical and Dental Choice Plans*](#)
- 10.7† [Retired Officer Medical Plan \(Incorporated by reference to Exhibit 10.7 to the Company's Annual Report for the year ended March 31, 2024 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.8† [Retired Officer's Comprehensive Medical and Dental Choice Plans*](#)

- 10.9† [Group Variable Universal Life Insurance*](#)
- 10.10† [Group Personal Excess Liability Insurance \(Incorporated by reference to Exhibit 10.10 to the Company's Annual Report for the year ended March 31, 2025 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.11† [Officer Annual Performance Bonus Policy \(Incorporated by reference to Exhibit 10.11 to the Company's Annual Report for the year ended March 31, 2018 on Form 10-K \(File No. 001-34972\)\)](#)
- 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† [Officer Transition Policy \(Incorporated by reference to Exhibit 10.13 to the Company's Annual Report for the year ended March 31, 2025 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.14 [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 \(File No. 001-34972\)\)](#)
- 10.15 [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 \(File No. 001-34972\)\)](#)
- 10.16 [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 \(File No. 001-34972\)\)](#)
- 10.17 [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 \(File No. 001-34972\)\)](#)
- 10.18 [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 \(File No. 001-34972\)\)](#)
- 10.19 [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 \(File No. 001-34972\)\)](#)
- 10.20 [Sixth Amendment to Credit Agreement, dated as of July 23, 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 and Collateral Agent 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 24, 2018 \(File No. 001-34972\)\)](#)

- 10.21 [Seventh Amendment to the Credit Agreement, dated as of November 26, 2019, 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 November 26, 2019 \(File No. 001-34972\)\)](#)
- 10.22 [Eighth Amendment to Credit Agreement, dated as of June 24, 2021, among Booz Allen Hamilton Inc., as Borrower, Booz Allen Hamilton Investor Corporation, eGov Holdings, Inc. and Aquilent, Inc., as Guarantors, Bank of America, N.A., as Administrative Agent and Collateral Agent 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 June 25, 2021 \(File No. 001-34972\)\)](#)
- 10.23 [Ninth Amendment to Credit Agreement, dated as of September 7, 2022, among Booz Allen Hamilton Inc., as Borrower, Booz Allen Hamilton Investor Corporation, eGov Holdings, Inc., Aquilent, Inc. and Liberty IT Solutions, LLC, as Guarantors, Bank of America, N.A., as Administrative Agent and Collateral Agent 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 September 7, 2022 \(File No. 001-34972\)\)](#)
- 10.24 [Tenth Amendment to Credit Agreement, dated as of July 27, 2023, among Booz Allen Hamilton Inc., as borrower, Bank of America, N.A., as administrative agent and the other lenders and financial institutions party thereto. \(Incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report for the period ended June 30, 2023 on Form 10-Q \(File No. 001-34972\)\)](#)
- 10.25 [Eleventh Amendment to Credit Agreement, dated as of February 27, 2026, among Booz Allen Hamilton Inc., as borrower, Bank of America, N.A., as administrative agent and the other lenders and financial institutions party thereto \(Incorporated by reference to Exhibit 10.1 to the Company's Current Report on Form 8-K filed on March 2, 2026 \(File No. 001-34972\)\)](#)
- 10.26 [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 \(File No. 001-34972\)\)](#)
- 10.27 [Assumption Agreement, dated as of November 5, 2021, by Liberty IT Solutions, LLC, 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 10.1 to the Company's Quarterly Report for the period ended December 31, 2021 on Form 10-Q \(File No. 001-34972\)\)](#)
- 10.28 [Guarantee Agreement made by Booz Allen Hamilton Holding Corporation, and the Subsidiary Guarantors party hereto, in favor of Bank of America, N.A., as Administrative Agent, dated as of July 27, 2023. \(Incorporated by reference to Exhibit 10.2 to the Company's Quarterly Report for the period ended September 30, 2023 on Form 10-Q \(File No. 001-34972\)\)](#)
- 10.29† [Booz Allen Hamilton Inc. Nonqualified Deferred Compensation Plan \(Incorporated by reference to Exhibit 10.7 to the Company's Quarterly Report for the period ended December 31, 2018 on Form 10-Q \(File No. 001-34972\)\)](#)
- 10.30† [First Amendment to the Nonqualified Deferred Compensation Plan \(Incorporated by reference to Exhibit 10.1 to the Company's Quarterly Report for the period ended September 30, 2019 on Form 10-Q \(File No. 001-34972\)\)](#)
- 10.31† [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 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.32† [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 10.59 to the Company's Annual Report for the year ended March 31, 2019 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.33† [Form of Stock Option Agreement under the Third Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.61 to the Company's Annual Report for the year ended March 31, 2020 on Form 10-K \(file No. 001-34972\)\)](#)
- 10.34† [Officer Perquisites Policy \(Incorporated by reference to Exhibit 10.45 to the Company's Annual Report for the year ended March 31, 2018 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.35† [Form of Stock Option Agreement under the Third Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.65 to the Company's Annual Report for the period ended March 31, 2022 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.36† [Form of Performance Restricted Stock Unit Agreement under the Third Amended and Restated Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.40 to the Company's Annual Report for the period ended March 31, 2023 on Form 10-K \(File No. 001-34972\)\)](#)

- 10.37† [Form of Stock Option Agreement under the 2023 Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.8 to the Company's Quarterly Report for the period ended September 30, 2023 on Form 10-Q \(File No. 001-34972\)\)](#)
- 10.38† [Form of Restricted Stock Agreement for Directors under the 2023 Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.6 to the Company's Quarterly Report for the period ended September 30, 2023 on Form 10-Q \(File No. 001-34972\)\)](#)
- 10.39† [Form of Stock Option Agreement under the 2023 Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.44 to the Company's Annual Report for the period ended March 31, 2024 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.40† [Form of Restricted Stock Unit Agreement under the 2023 Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.45 to the Company's Annual Report for the period ended March 31, 2024 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.41† [Form of Performance Restricted Stock Unit Agreement under the 2023 Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.46 to the Company's Annual Report for the period ended March 31, 2024 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.42† [Form of Special Performance Restricted Stock Unit Agreement under the 2023 Equity Incentive Plan of Booz Allen Hamilton Holding Corporation \(Incorporated by reference to Exhibit 10.47 to the Company's Annual Report for the period ended March 31, 2024 on Form 10-K \(File No. 001-34972\)\)](#)
- 10.43† [Form of Stock Option Agreement under the 2023 Equity Incentive Plan of Booz Allen Hamilton Holding Corporation*](#)
- 10.44† [Form of Restricted Stock Unit Agreement under the 2023 Equity Incentive Plan of Booz Allen Hamilton Holding Corporation*](#)
- 10.45† [Form of Performance Restricted Stock Unit Agreement under the 2023 Equity Incentive Plan of Booz Allen Hamilton Holding Corporation*](#)
- 19 [Booz Allen Hamilton Holding Corporation Insider Trading Policy*](#)
- 21 [Subsidiaries of the registrant*](#)
- 22 [List of Guarantors and Subsidiary Issuers of Guaranteed Securities \(Incorporated by reference to Exhibit 22 to the Company's Annual Report for the period ended March 31, 2025 \(File No 001-34972\)\)](#)
- 23 [Consent of 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 \(18 U.S.C. 1350\)*](#)
- 97 [Booz Allen Hamilton Holding Corporation Rule 10D-1 Clawback Policy \(Incorporated by reference to Exhibit 97 to the Company's Annual Report for the period ended March 31, 2024 on Form 10-K \(File No. 001-34972\)\)](#)
- 101 The following materials from Booz Allen Hamilton Holding Corporation's Annual Report on Form 10-K for the fiscal year ended March 31, 2026, formatted in Inline XBRL (eXtensible Business Reporting Language): (i) Consolidated Balance Sheets as of March 31, 2026 and 2025; (ii) Consolidated Statements of Operations for the fiscal years ended March 31, 2026, 2025 and 2024; (iii) Consolidated Statements of Comprehensive Income for the fiscal years ended March 31, 2026, 2025 and 2024; (iv) Consolidated Statements of Cash Flows for the fiscal years ended March 31, 2026, 2025 and 2024; (v) Consolidated Statements of Stockholders' Equity for the fiscal years ended March 31, 2026, 2025 and 2024; and (vi) Notes to Consolidated Financial Statements.
- 104 Cover Page Interactive Data File (formatted as Inline XBRL and contained in Exhibit 101)

* 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 22nd day of May, 2026.

BOOZ ALLEN HAMILTON HOLDING CORPORATION
(Registrant)

By: /s/ Horacio D. Rozanski
Name: Horacio D. Rozanski
Title: Chief Executive Officer

Pursuant to the requirements of the Securities Exchange 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	Chairman and Chief Executive Officer (Principal Executive Officer)	May 22, 2026
<u>/s/ Troy Lahr</u> Troy Lahr	Executive Vice President, Chief Financial Officer (Principal Financial Officer)	May 22, 2026
<u>/s/ Dennis Metzfield</u> Dennis Metzfield	Vice President, Controller and Chief Accounting Officer (Principal Accounting Officer)	May 22, 2026
<u>/s/ Joan Lordi C. Amble</u> Joan Lordi C. Amble	Director	May 22, 2026
<u>/s/ Debra L. Dial</u> Debra L. Dial	Director	May 22, 2026
<u>/s/ Michèle A. Flournoy</u> Michèle A. Flournoy	Director	May 22, 2026
<u>/s/ Mark E. Gaumont</u> Mark E. Gaumont	Director	May 22, 2026
<u>/s/ Ellen Jewett</u> Ellen Jewett	Director	May 22, 2026
<u>/s/ Arthur E. Johnson</u> Arthur E. Johnson	Director	May 22, 2026
<u>/s/ Gretchen W. McClain</u> Gretchen W. McClain	Director	May 22, 2026
<u>/s/ Robert C. O'Brien</u> Robert C. O'Brien	Director	May 22, 2026
<u>/s/ Rory P. Read</u> Rory P. Read	Director	May 22, 2026
<u>/s/ Charles O. Rossotti</u> Charles O. Rossotti	Director	May 22, 2026
<u>/s/ William M. Thornberry</u> William M. Thornberry	Director	May 22, 2026

DESCRIPTION OF CAPITAL STOCK

The following descriptions of our capital stock and provisions of our seventh amended and restated certificate of incorporation, which we refer to as our amended and restated certificate of incorporation, and amended and restated bylaws, are summaries of their material terms and provisions. For a complete description of our capital stock, amended and restated certificate of incorporation and amended and restated bylaws, please refer to our amended and restated certificate of incorporation, amended and restated bylaws and the applicable provisions of the General Corporation Law of the State of Delaware (the “DGCL”).

All references to “Company”, “we”, “us”, and “our” refer to Booz Allen Hamilton Holding Corporation.

Common Stock

Our amended and restated certificate of incorporation authorizes the issuance of 600,000,000 shares of Class A common stock, par value \$0.01 per share. The rights and privileges of holders of our Class A common stock are subject to any series of preferred stock that we may issue in the future.

Our Class A common stock is registered on the New York Stock Exchange under the symbol “BAH”.

Voting Rights. Holders of Class A common stock are entitled to one vote for each share on all matters to be voted on by stockholders. Except as otherwise provided by the DGCL, the entire voting power of the shares of the Company for the election of directors and for all other purposes is vested exclusively in the Class A common stock.

Election of Directors. Directors are elected by the vote of the majority of the votes cast (as defined in Section 2.02 of the amended and restated bylaws) with respect to such director’s election; unless the director has been duly nominated by a stockholder in accordance with the amended and restated bylaws. Where a director has been duly nominated by a stockholder in accordance with the amended and restated bylaws, such director shall be elected by the vote of a plurality of votes cast in connection with the election of directors at any meeting of stockholders. Any nominee who is an incumbent director and does not receive a majority of the votes cast in an election where the director was not duly nominated by a stockholder in accordance with the amended and restated bylaws must promptly tender his or her resignation contingent on the acceptance of that resignation by the Board of Directors (the “Board”) pursuant to the procedure established in the amended and restated bylaws.

Dividend Rights. Each share of Class A common stock is entitled to participate equally, when and if declared by the Board from time to time, in such dividends and other distributions in cash, stock, or property from the Company’s assets or funds as may become legally available for such purposes subject to any dividend preferences that may be attributable to preferred stock that may be authorized and outstanding.

Right to Receive Liquidation Distributions. In the event of our liquidation, dissolution or winding up, holders of our Class A common stock will be entitled to receive proportionately any of our assets remaining after the payment of liabilities and subject to the prior rights of any outstanding preferred stock. Because we are a holding company, our ability to pay dividends is subject to our subsidiaries’ ability to pay dividends to us, which is in turn subject to the restrictions set forth in our debt agreements.

Other Rights. Holders of Class A common stock have no preemptive, subscription, redemption, sinking fund, or conversion rights. All outstanding shares of Class A common stock are fully paid and non-assessable.

Preferred Stock

Our amended and restated certificate of incorporation authorizes the issuance of 54,000,000 shares of preferred stock, par value \$0.01 per share, the terms and conditions of which are determined by the Board upon issuance. The rights, preferences and privileges of holders of common stock are subject to, and may be adversely affected by, the

rights of holders of any shares of preferred stock that we may designate and issue in the future. There are no shares of preferred stock outstanding. We have no present plans to issue any shares of preferred stock.

Change of Control Related Provisions of Our Amended and Restated Certificate of Incorporation, Amended and Restated Bylaws and Delaware Law

Provisions in our amended and restated certificate of incorporation and amended and restated bylaws, and in the DGCL, may make it difficult, expensive, and time-consuming for a third party to pursue a takeover attempt even if a change in control of the Company would be beneficial to the interests of our stockholders. Any provision of our amended and restated certificate of incorporation or amended and restated bylaws or Delaware law that has the effect of delaying or deterring a change in control could limit the opportunity for our stockholders to receive a premium for their shares of our common stock, and could also affect the price that some investors are willing to pay for our common stock. These provisions are intended to:

- enhance the likelihood of continuity and stability in the composition of our Board;
- discourage some types of transactions that may involve an actual or threatened change in control of the Company;
- discourage certain tactics that may be used in proxy fights;
- ensure that our Board will have sufficient time to act in what our Board believes to be the best interests of us and our stockholders; and
- encourage persons seeking to acquire control of our company to first consult with our Board to negotiate the terms of any proposed business combination or offer.

Unissued Shares of Capital Stock

The shares of our authorized and unissued Class A common stock which are not outstanding are available for future issuance without additional stockholder approval, subject to the requirements of applicable law or regulation, including any listing requirement of the principal stock exchange on which our Class A common stock is then listed. While the additional shares are not designed to deter or prevent a change of control, under some circumstances we could use the additional shares to create voting impediments or to frustrate persons seeking to effect a takeover or otherwise gain control by, for example, issuing those shares in private placements to purchasers who might side with our Board in opposing a hostile takeover bid.

In addition, our amended and restated certificate of incorporation provides our Board with the authority, without any further vote or action by our stockholders, to designate and issue one or more series of preferred stock at their sole discretion and to fix the number of shares and the preferences, limitations and relative rights of the shares constituting any series. This provision makes it possible for our Board to issue preferred stock with super voting, special approval, dividend or other rights or preferences which could impede any attempt to acquire us. These and other provisions may have the effect of deferring, delaying or discouraging hostile takeovers or changes in control or management of our company, discouraging bids for the Class A common stock at a premium over the market price of the common stock and may adversely affect the market price of, and the voting and other rights of the holder of, Class A common stock.

Vacancies and Removal of Directors

Directors are elected for one-year terms expiring at the next succeeding annual meeting of stockholders. Each director shall hold office until his or her term expires and his or her successor is duly elected and qualified, or until such director's earlier death, resignation, retirement, disqualification or removal.

Our amended and restated certificate of incorporation and amended and restated bylaws provide that a director may be removed from office at any time, either for or without cause, by the affirmative vote of holders of at least a majority of the votes to which all the stockholders of the Company would be entitled to cast in any election of directors. Our amended and restated certificate of incorporation and amended and restated bylaws also provide that vacancies in our Board may be filled only by our Board.

Any director elected to fill a vacancy will hold office until the next succeeding annual meeting of stockholders (including a vacancy created by increasing the size of the Board) and until such director's successor shall have been duly elected and qualified.

No decrease in the number of directors will shorten the term of any incumbent director. The number of directors shall be fixed and modified, but not reduced to less than three, from time to time by resolution of our Board.

Advance Notice Provisions for Stockholder Nominations of Directors and Stockholder Proposals

Our amended and restated bylaws establish an advance notice procedure for stockholders to make nominations of candidates for election as director or to bring other business before an annual meeting of our stockholders. This procedure provides that, except as otherwise required by applicable law, only persons who are nominated by the Board, a committee appointed by the Board, or by a stockholder who (i) is entitled to vote at the meeting, (ii) has given timely written notice to our secretary prior to the meeting and (iii) is a stockholder of record when the required notice is delivered and at the date of the meeting, will be eligible for election as directors, and only business that has been brought before an annual meeting by the Board, any committee appointed by the Board, or by a stockholder who has given timely written notice to our secretary prior to the meeting, may be conducted. Under the procedure, to be timely, notice must be received by the secretary at our principal executive offices not less than 90 days and not more than 120 days prior to the first anniversary date of the annual meeting of the preceding year. In addition, a stockholder's notice proposing to nominate a person for election as director must, among other things, contain specific information about the nominating stockholder and the proposed nominee as well as the proposed nominee's written consent to be named in the proxy statement as a nominee and to serving as a director if elected. A stockholder's notice relating to the conduct of business other than the nomination of directors must contain, among other things, specific information about the proposing stockholder, the text of the proposal, the reasons for conducting such business at the meeting and any material interest in such business of such stockholder and beneficial owner, if any, on whose behalf the proposal is made.

Requiring advance notice of nominations by stockholders allows our Board an opportunity to consider the qualifications of the proposed nominees and also provides a more orderly procedure for conducting annual meetings of stockholders. It also provides the Board with the opportunity to inform stockholders of proposed business prior to the meeting, so that stockholders can better decide whether to attend the meeting or to grant a proxy regarding the disposition of the business. These provisions may also have the effect of precluding a contest for the election of directors or the consideration of stockholder proposals and of discouraging or deterring a third party from conducting a solicitation of proxies to elect its own slate of directors or to approve its own proposal without regard to whether consideration of the nominees or proposals might be harmful or beneficial to us or our stockholders.

Limitation of Liability of Directors and Officers; Indemnification of Directors and Officers

Our amended and restated certificate of incorporation contains provisions permitted under the DGCL relating to the liability of directors. These provisions eliminate a director's or officer's personal liability for monetary damages resulting from a breach of fiduciary duty, except in circumstances involving or related to:

- any breach of the director's or officer's duty of loyalty;
- acts or omissions by a director or officer not in good faith or which involve intentional misconduct or a knowing violation of the law;

- any violation of a director of Section 174 of the DGCL (including, among other things, unlawful payment of dividends);
- any transaction from which the director or officer derives an improper personal benefit; or
- liability of an officer in any action by or in right of the Company.

The principal effect of the limitation on liability provision is that a stockholder will be unable to prosecute an action for monetary damages against a director or officer unless the stockholder can demonstrate a basis for liability for which indemnification is not available under the DGCL. These provisions, however, should not limit or eliminate our rights or any stockholder's rights to seek non-monetary relief, such as an injunction or rescission, in the event of a breach of a director's or officer's fiduciary duty. These provisions will not alter a director's or officer's liability under federal securities laws. The inclusion of this provision in our certificate of incorporation may discourage or deter stockholders or management from bringing a lawsuit against directors for a breach of their fiduciary duties, even though such an action, if successful, might otherwise have benefited us and our stockholders.

Our amended and restated bylaws require us to indemnify and advance expenses to our directors and officers to the fullest extent not prohibited by the DGCL and other applicable law, except in the case of a proceeding instituted by the director without the approval of our Board. Our amended and restated bylaws also provide that we are required to indemnify our directors and officers, to the fullest extent permitted by law, for all judgments, fines, settlements, legal fees and other expenses incurred in connection with pending or threatened legal proceedings because of the director's or officer's positions with us or another entity that the director or officer serves at our request, subject to various conditions, and to advance funds to our directors and officers to enable them to defend against such proceedings. To receive indemnification, the director or officer must have been successful in the legal proceeding or have acted in good faith and in what was reasonably believed to be a lawful manner in our best interest and, with respect to any criminal proceeding, had no reasonable cause to believe his or her conduct was unlawful.

We have entered into an indemnification agreement with each of our directors and certain of our officers. The indemnification agreements provide our directors and certain of our officers with contractual rights to the indemnification and expense advancement rights provided under our amended and restated bylaws, as well as contractual rights to additional indemnification as provided in the indemnification agreement.

Exclusive Forum Provision

Our amended and restated certificate of incorporation provides that the Court of Chancery of the State of Delaware shall be the sole and exclusive forum for (i) any derivative action or proceeding brought on behalf of the Company, (ii) any action asserting a claim of breach of a fiduciary duty owed by any director or officer of the Company to the Company or the Company's stockholders, (iii) any action asserting a claim against the Company arising pursuant to any provision of the DGCL or our amended and restated certificate of incorporation or amended and restated bylaws, or (iv) any action asserting a claim against the Company governed by the internal affairs doctrine.

Transfer Agent and Registrar

Computershare serves as transfer agent and registrar for our Class A common stock.



DATE

NAME
ADDRESS

Dear NAME,

On behalf of the Leadership Team and all partners and employees at Booz Allen, thank you for your extensive contributions to our company for over **XX** years.

As you are retiring from the company effective **DATE** (your "Retirement Date"), this letter outlines your benefits and other arrangements related to your retirement.

Total Rewards Through your Retirement Date:

- You will continue to receive your current base compensation on the regular payroll cycle dates.
- You will continue to be eligible for participation and coverage under the company's medical and other insurance programs in which you are enrolled in as of the date of this letter as well as the company's Employee Capital Accumulation Program (ECAP).
- [You will remain eligible for reimbursement of currently approved perquisites such as, financial and estate planning. All expenses must be submitted prior to your Retirement Date.]¹
- You will not be eligible for any new equity grants as of the date of this letter.

After your Retirement Date:²

- Your coverage under the Officer Medical/Dental Plan and the Executive Medical plan will end upon your Retirement Date, but you may personally continue coverage through COBRA for up to 18 months from your Retirement Date.
- The premiums for your company-paid life insurance coverage of **XX** will be paid through your Retirement Date. After that date, the insurance vendor will contact you regarding your options to convert to an individual policy.
- Any vested stock options that you do not exercise within 90 days following your Retirement Date shall be forfeited.
- Any stock, units, or stock options granted or issued to you pursuant to the company's Equity Incentive Plan, as amended ("EIP") shall be governed by, as applicable, the terms of the EIP and any applicable Award Agreement, except as otherwise provided in this agreement.
- [Performance RSUs that were granted on **DATE** will continue to vest on schedule as permitted under the "Qualifying Permanent Retirement" provision of the applicable Award Agreement. If a

¹ Provided pursuant to the Officer Perquisites Policy, filed as Exhibit 10.45 to Booz Allen Hamilton's Annual Report on Form 10-K for the year ended March 31, 2018.

² Unless otherwise stated herein, all payments and benefits set forth in this section are provided pursuant to the Officer's Retirement Policy, filed as Exhibit 10.4 to Booz Allen Hamilton's Annual Report on Form 10-K for the year ended March 31, 2025.

Exhibit 10.5

Qualified Permanent Retirement, as defined in your applicable Performance RSU Award Agreement, shall cease to exist prior to the vesting of your Performance RSUs, the unvested Performance RSUs will be forfeited. All other unvested Performance RSUs will forfeit upon your Retirement Date.]

Total Rewards in Exchange for Confidential Separation and General Release Agreement:

As outlined in the Officer Retirement Policy, you are eligible for additional payments and benefits in exchange for signing a Confidential Separation and General Release Agreement. Provided you execute and return the Confidential Separation Agreement and General Release included with this Letter as Attachment A to me on **DATE**, do not revoke such Confidential Separation Agreement and General Release, and otherwise comply with the requirements of that Agreement, this Retirement Letter, and satisfy any final conditions as determined by management, the following arrangements will apply after your Retirement Date:

- The company will provide you with continued eligibility to receive health and dental insurance coverage under the U.S. Retired Officer Medical and Dental Plan and such continuation/conversion rights as are provided under the terms of the Booz Allen sponsored welfare benefit plans. Only dependents of a retired Officer on the date of retirement are eligible for coverage under the Retired Officer Medical Plan. Should you become employed at a new employer following retirement from Booz Allen, you must enroll in their medical/dental plan at which point coverage under the Booz Allen Medical Plan will be secondary to the plan in which you participate as an active employee.
- The company will provide you with a one-time, lump sum Retirement Payment for each year of service as an Officer since **DATE**, prorated accordingly. This gross payment of **XX**, less applicable taxes and withholdings will be made no later than 60 days following your Retirement Date.
- Senior management will recommend the Compensation, Culture and People Committee of the Board of Directors to:
 - [If applicable, issue a [prorated **FYXX** bonus for the period of **DATE**, to **DATE**] to be paid on the normal payment date for annual bonuses and subject to Company performance results. The issuance of a bonus payment and the associated value is subject to approval by the Compensation, Culture and People Committee of the Board of Directors in its sole discretion and would be paid no later than two-and one-half months from fiscal year end.]³
 - [Waive the forfeiture provisions of certain outstanding time-vested Restricted Stock Unit Agreements under the terms of the Equity Incentive Plan, which provide for forfeiture and/or disgorgement in certain circumstances. This waiver will permit Time-RSU grants made in calendar years **XXXX** and **XXXX** which are specifically associated with your standard annual compensation to continue to vest on schedule after your retirement so long as you do not engage in “Competitive Activity” or take certain other actions described in the EIP. All other Time RSUs outstanding as of your Retirement Date will forfeit.]⁴

The payments and benefits referenced above are expressly contingent upon (i) your execution, non-revocation, and adherence to the terms and conditions of the Agreement and General Release

³ Provided in the discretion of the Compensation, Culture and People Committee of the Board of Directors pursuant to the Bonus Awards for Departing Officers Policy.

⁴ Provided in the discretion of the Compensation, Culture and People Committee of the Board of Directors pursuant to the EIP.

Exhibit 10.5

documents, as described above, (ii) your submission of expense reports for any not yet expensed business related expenditures and payment of any outstanding balance on your Booz Allen issued American Express account, and (iii) your continued adherence to Booz Allen policies and all other legal duties to the Company and restrictive covenants with the Company to which you are bound. Should you be separated from the Company pursuant to the Company's Discipline for Misconduct policy prior to the Retirement Date, you will forfeit all benefits outlined in this Retirement Letter following the date of separation.

Please review the terms and conditions of the Non-Solicit, Non-Recruitment, and Non-Competition Agreement and the EIP, as applicable, both of which contain information relative to potential restrictions on or impacts of any future employment opportunities. This can include, but is not limited to, potential forfeiture, disgorgement, and clawback of vested shares or proceeds in the event you engage in a "Competitive Activity" as defined in the EIP, and in certain other circumstances described in the EIP. Additionally, the Non-Solicit, Non-Recruitment, and Non-Competition Agreement includes a requirement to provide written notice to the Company at least ten (10) business days prior to commencing employment at a Restricted Competitor, as such term is defined in the Non-Solicit, Non-Recruitment, and Non-Competition Agreement.

Please note that the submission for reimbursement of any expense referenced in this Retirement Letter must be received no later than your Retirement Date. Each payment made pursuant to this Retirement Letter agreement shall be considered a separate payment within the meaning of Treas. Reg. Section 1.409A2(b)(2)(iii).

Once your employment with the company ends, please be aware that you will still be subject to the federal insider trading laws and regulations. These laws and regulations prohibit your trading in the company's stock while in possession of material non-public information. I encourage you to carefully consider the material non-public information that you possess at the time you wish to trade in the company's stock and review the company's public filings to determine when material non-public information has been publicly disclosed. In addition, due to your senior position in the company, it is important to note that a transaction following retirement is reportable to the SEC if it is subject to Section 16(b) and takes place within six months of a pre-retirement opposite-way transaction that is also subject to Section 16(b). For example, if you sold Booz Allen securities within six months before your retirement and then purchased Booz Allen securities within six months following such transaction and vice versa, you could be subject to Form 4 reporting obligations and short-swing profit recovery.

NAME, thank you again for your many contributions to the company and congratulations on your retirement. Please don't hesitate to reach to me if you have any questions or need any assistance.

Sincerely,

BOOZ ALLEN HAMILTON INC.

ATTACHMENT A

CONFIDENTIAL SEPARATION AGREEMENT AND GENERAL RELEASE

Booz Allen Hamilton Inc., 8283 Greensboro Drive, McLean, VA 22102, its parent corporation, affiliates, subsidiaries, divisions, successors and assigns and the employees, officers, directors, and agents thereof (collectively "Booz Allen" or the "Company"), and **NAME** ("Mr./Ms. **NAME** " or "I") agree as follows:

Retirement. **NAME** will retire from Booz Allen on **DATE** (referred to throughout this Agreement as "Retirement Date"), as described in the **DATE** Retirement Letter from Chief People Officer, **NAME**, to **NAME**.

I acknowledge that Booz Allen advised me to read this Confidential Separation Agreement and General Release (the "Agreement") and carefully consider all its terms before signing it. Booz Allen has given me 21 calendar days to consider this Agreement. I further acknowledge that:

-) I carefully read this Agreement, fully understand it, and am entering into it knowingly and voluntarily;
-) to the extent I decide to sign and return this Agreement to Booz Allen prior to the 21 days that I have been provided to consider it; I acknowledge that I have done so voluntarily;
-) I have seven days after signing to revoke my agreement ("Revocation Period") by providing written notice to Booz Allen's Chief People Officer;
-) this Agreement will not be effective until the Revocation Period has expired without my revoking (the "Effective Date");
-) in the event Booz Allen makes changes to the consideration in this Agreement, whether material or immaterial, I understand that any such changes will not restart the 21-day consideration period provided above;

Booz Allen advised me to discuss this Agreement with an attorney (at my own expense) before signing it and I decided to seek legal advice or not seek legal advice to the extent I deemed appropriate, and;

-) I understand that the waivers and releases contained in this Agreement do not apply to any rights or claims that may arise after the date that I execute the Agreement.

Consideration. As consideration for my agreement to the terms herein, Booz Allen will continue my employment with my current salary and benefits until the Retirement Date, as well as provide the additional consideration outlined in the letter dated **DATE** from **NAME**, Chief People Officer, to which I would not otherwise be entitled upon separation of employment.

Nothing in this Agreement shall be construed to modify the "at-will" nature of my employment with Booz Allen, whereby either Booz Allen or I may terminate my employment at any time.

Acknowledgments. I: (a) would not receive the monies and benefits specified in Section 3 above, except for the execution of this Agreement, and the fulfillment of the promises contained herein; (b) acknowledge receipt of all compensation and benefits due as a result of services performed for Booz Allen except as provided in this Agreement; (c) have reported to Booz Allen any and all work-related injuries incurred during employment; (d) have had the opportunity to provide Booz Allen with written notice of any and all concerns regarding suspected ethical and compliance issues or violations on the part of Booz Allen or any other released party; and (e) have not raised a claim, including but not limited to, unlawful discrimination, harassment, sexual harassment, abuse, assault, other criminal conduct, or retaliation in a court or government agency proceeding, involving Booz Allen or any other released party.

Exhibit 10.5

General Release of Claims. I knowingly and voluntarily release and forever discharge Booz Allen of and from any and all claims, whether now known or not known, against Booz Allen, which includes my heirs, executors, administrators, successors, and assigns (referred to collectively throughout this Agreement as "NAME" or "I") that I have or may have arising out of or in any way connected to my employment with Booz Allen as of the date I sign this Agreement. My release of claims includes, but is not limited to any alleged violation of: the Civil Rights Act of 1964; the Civil Rights Act of 1866, 42 USC § 1981; the Americans with Disabilities Act; the Equal Pay Act; the Age Discrimination in Employment Act ("ADEA"); the Employee Retirement Income Security Act ("ERISA"); the National Labor Relations Act ("NLRA"), any amendments to the foregoing, any other federal, state or local civil or human rights law or any other local, state or federal law, regulation or ordinance, any public policy, contract, tort, or common law, and any claim for back pay, front pay, compensatory damages for medical expenses, pain and suffering, emotional distress, or mental anguish, punitive damages, interest, tax, costs, fees, or other expenses including attorneys' fees incurred in these matters.

Cooperation. I agree to assist and cooperate in the transition of any and all client and/or Booz Allen work. In addition, I agree to cooperate fully with the Company in any government and/or Company-directed investigations, as well as in the defense or prosecution of any claims or actions now in existence or that may be brought or threatened in the future against or on behalf of the Company. I also agree that if contacted (directly or indirectly) by any individual or entity, other than by law enforcement or regulatory authorities, about matters that may be related to the Company's business interests, I will promptly (within 48 hours) notify the Company of such contact(s) and provide information including, but not limited to, identification of the contacting entity and the substance of any such (or related) communications.

Confidentiality. I understand and agree that the terms and conditions of this Agreement are confidential. I will not disclose the existence or substance of this Agreement to anyone except my spouse, financial advisor, law enforcement or regulatory authorities and any attorney with whom I may choose to consult regarding consideration of this Agreement, except as agreed to in writing by Booz Allen or as required by law or pursuant to Court Order. I agree to advise any person(s) permitted to receive information about this Agreement of the Confidentiality terms and that such person(s) must maintain the strict confidentiality of such information and must not disclose it unless otherwise required by law.

Venue, Governing Law, and Interpretation. I acknowledge that a substantial portion of Booz Allen's business is based out of and directed from the Commonwealth of Virginia. I also acknowledge that during my employment, I have had substantial contacts with the Commonwealth of Virginia. Therefore, Booz Allen and I agree that the exclusive forum for any action, demand, claim, or counterclaim relating to the terms and provisions of this Agreement, or to their breach, shall be in the appropriate state or federal court located in the Commonwealth of Virginia. Booz Allen and I consent that such courts shall have personal jurisdiction over the parties to this Agreement. This Agreement should be governed and conformed in accordance with the laws of the Commonwealth of Virginia without regard to its conflict of laws provision. Should any provision of this Agreement be declared illegal or unenforceable by any court of competent jurisdiction and cannot be modified to be enforceable, excluding the General Release of Claims, such provision shall immediately become null and void, leaving the remainder of this Agreement in full force and effect.

Proprietary Information. I agree not to directly or indirectly use, disclose, or reproduce, other than to law enforcement or regulatory authorities, Booz Allen "Proprietary Information," which includes, but is not limited to proprietary know-how; operational, competitive, financial, technical, and personnel information; inventions; techniques; computer software; and related documentation and materials and that I shall otherwise comply with the Agreement Concerning Proprietary Information and Intellectual Property that I executed upon hire with the Company, other than as required by law or pursuant to Court Order.

Exhibit 10.5

- . Nonadmission of Wrongdoing and No Negative Statements. I understand and agree that this Agreement is not an admission of guilt or wrongdoing by Booz Allen, and I acknowledge that Booz Allen does not believe or admit that it has done anything wrong. I will not represent that this Agreement is an admission of guilt or wrongdoing by Booz Allen and also will not do anything to criticize, denigrate, or disparage Booz Allen
- . Compliance with Section 409A. This Agreement is intended to comply with Section 409A of the Internal Revenue Code of 1986, as amended (the "Code") and will be interpreted in a manner intended to comply with Section 409A of the Code. Notwithstanding anything herein to the contrary, (i) if at the time of my termination of employment with the Company, I am a "specified employee" as defined in Section 409A of the Code (and any related regulations or other pronouncements thereunder) and the deferral of the commencement of any payments or benefits otherwise payable hereunder as a result of such termination of employment is necessary in order to prevent any accelerated or additional tax under Section 409A of the Code, then the Company will defer the commencement of the payment of any such payments or benefits under the Agreement (without any reduction in such payments or benefits ultimately paid or provided to me) until the date that is six months following my termination of employment with the Company (or the earliest date as is permitted under Section 409A of the Code) and (ii) if any other payments of money or other benefits due hereunder could cause the application of an accelerated or additional tax under Section 409A of the Code, such payments or other benefits shall be deferred if deferral will make such payment or other benefits compliant under Section 409A of the Code, or otherwise such payment or other benefits shall be restructured, to the extent possible, in a manner, determined by the Company, that does not cause such an accelerated or additional tax. To the extent any reimbursements or in-kind benefits due to me under the Agreement constitute "deferred compensation" under Section 409A of the Code, any such reimbursements or in-kind benefits shall be paid in a manner consistent with Treas. Reg. Section 1.409A-3(i)(1)(iv). Each payment made under the Agreement shall be designated as a "separate payment" within the meaning of Section 409A of the Code. All payments to be made upon a termination of employment under the Agreement may only be made upon a "separation from service" within the meaning of such term under Section 409A of the Code.
- . Entire Agreement. This Agreement sets forth the entire agreement between me and Booz Allen, and fully supersedes any prior agreements or understandings between the parties on the matters set forth herein. However, this Agreement is not intended to supersede obligations under the Agreement Concerning Proprietary Information and Intellectual Property, the Non-Recruitment, Non-Solicitation and Non-Competition Agreement, the **DATE** Letter Agreement, the Director and Officer Indemnification Agreement, or any other agreements related to inventions, business ideas, confidentiality of corporate information, unfair competition, or dispute resolution, the obligations under which are made in addition to, not in lieu of, this Agreement. I have not relied on any representations, promises, or agreements of any kind, except for those set forth in this Agreement. This Agreement may not be modified, amended, or otherwise changed except with express written consent of both parties with specific reference made to this Agreement. The headings in this Agreement are provided for reference only and shall not affect the substance of this Agreement.
- . Exceptions and No Interference with Rights. **Nothing in this Agreement is intended to waive claims that may arise after I sign this Agreement, or which cannot be released by private agreement. In addition, nothing in this Agreement including but not limited to the acknowledgments, general release of claims, cooperation, confidentiality, no negative statements, and proprietary information, limits or affects my right to challenge the validity of this Agreement under the ADEA or the OWBPA, prevents me from communicating with, filing a charge or complaint with; providing documents or information voluntarily or in response to a subpoena or other information request to; or from participating in an investigation or proceeding conducted by the Equal Employment Opportunity Commission, National Labor Relations Board, the Securities and Exchange Commission, law enforcement, or any other any**

Exhibit 10.5

federal, state or local agency charged with the enforcement of any laws, or from responding to a subpoena or discovery request in court litigation or arbitration, although by signing this Agreement I am waiving rights to individual relief (including backpay, frontpay, reinstatement or other legal or equitable relief) in any charge, complaint, or lawsuit or other proceeding brought by me or on my behalf by any third party, except for any right I may have to receive a payment or award from a government agency (and not Booz Allen) for information provided to the government agency or otherwise where prohibited.

In exchange for the consideration in Section 3 and other promises contained in this Agreement, I am entering into this Agreement voluntarily, deliberately, and with all information needed to make an informed decision to enter this Agreement. I have been given the opportunity to ask any questions regarding this Agreement and have been given notice of and an opportunity to retain an attorney or already am represented by an attorney.

Signature – **NAME**

Date: _____

In exchange for the promises contained in this Agreement, Booz Allen promises to provide the benefits set forth in this Agreement.

BOOZ ALLEN HAMILTON INC.

By: _____

Title: _____

Date: _____

Certificate of coverage

Prepared for:

Policyholder: Booz Allen Hamilton
Policyholder number:
Plan name: Open Choice - Retired Officers Plan
Booklet-certificate: 4
Group policy effective date: January 1, 2019
Plan effective date: January 1, 2022
Plan issue date: February 6, 2026
Plan revision effective date: January 1, 2026

Underwritten by Aetna Life Insurance Company



This certificate of coverage is made part of the group policy

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Schedule of benefits Issued with your certificate of coverage



Welcome

At Aetna®, your health goals lead the way, so we're joining you to put them first. We believe that whatever you decide to do for your health, you can do it with the right support. And no matter where you are on this personal journey, it's our job to enable you to feel the joy of achieving your best health.

Welcome to Aetna.

Introduction

This is your certificate of coverage or "certificate." It describes your **covered services** – what they are and how to get them. It also describes how we manage the plan, according to our policies, federal and state laws and regulations. The schedule of benefits tells you how we share expenses for **covered services** and explains any limits. Along with the group policy, they describe your Aetna plan. Each may have riders or amendments attached to them. These change or add to the document. This certificate takes the place of any others sent to you before.

It's really important that you read the entire certificate and your schedule of benefits.

If your coverage under any part of this plan replaces coverage under another plan, your coverage for benefits provided under the other coverage may reduce benefits paid by this plan. See the *Coordination of benefits - Effect of prior plan coverage* section.

We are regulated in Virginia by both the State Corporation Commission Bureau of Insurance under Title 38.2 of the Code of Virginia and the Virginia Department of Health under Title 32.1 of the Code of Virginia.

If you need help or more information, see the *Contact us* section below.

How we use words

When we use:

- "You" and "your", we mean you and any covered dependents (if your plan allows dependent coverage)
- "Us," "we," and "our", we mean Aetna Life Insurance Company (Aetna)
- Words that are in bold, these are defined in the *Glossary* section

Contact us – important information regarding your insurance

If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions about your plan, you can contact us by:

- Calling the toll-free number on your ID card
- Writing us at 151 Farmington Ave, Hartford, CT, 06156
- Visiting <https://www.aetna.com> to register and access your member website

Your member website is available 24/7. With your member website, you can:

- See your coverage, benefits and costs
- Print an ID card and various forms
- Find a **provider**, research **providers**, care and treatment options
- View and manage claims
- Find information on health and wellness

If you have been unable to contact or obtain satisfaction from us or the agent, you can contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
(804) 371-9741, local
(800) 552-7945, in-state toll-free number
(877) 310-6560, national toll-free number

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting us, the agent or the BOI, have your policy number available.

Your ID card

Show your ID card each time you get **covered services** from a **provider**. Only members on your plan can use your ID card. We will mail you your ID card. If you haven't received it before you need **covered services**, or if you lose it, you can print a temporary one using your member website.

Wellness and other rewards

You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to access certain health services or categories of healthcare **providers**, participate in programs, including but not limited to financial wellness programs; utilize tools, improve your health metrics or continue participation as an Aetna member through incentives. Talk with your **provider** about these and see if they are right for you. We may provide incentives based on your participation and outcomes such as:

- Modifications to **copayment, deductible** or **coinsurance** amounts
- Contributions to a health savings account
- Merchandise
- Coupons
- Gift cards or debit cards
- Any combination of the above

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third-party service providers”. These third-party service providers may pay us so that they can offer you their services.

Third-party service providers are independent contractors. The third-party service provider is responsible for the goods or services they deliver. We are not responsible; but we have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third-party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

Coverage and exclusions

Providing covered services

Your plan provides **covered services**. These are:

- Described in this section
- Not listed as an exclusion in this section or the *General plan exclusions* section
- Not beyond any limits in the schedule of benefits
- **Medically necessary**. See the *How your plan works – Medical necessity and, precertification requirements* section and the *Glossary* for more information.
- Services that are not prohibited by law. See *Services not permitted by law in the General plan exclusions* section for more information.

For **covered services** under the outpatient **prescription** drug plan:

- You need a **prescription** from the prescribing **provider**
- You need to show your ID card to the **network pharmacy** when you get a **prescription** filled

This plan provides insurance coverage for many kinds of **covered services**, such as a doctor's care and **hospital stays**, but some services aren't covered at all or are limited. For other services, the plan pays more of the expense. For example:

- **Physician** care generally is covered but **physician** care for cosmetic **surgery** is an exclusion and not covered, except where described in *Coverage and exclusions* under the *Reconstructive breast surgery and supplies* and *Reconstructive surgery and supplies* sections.
- Home health care is generally covered but may only be covered up to a set number of visits per year. This is a limitation.
- Your **provider** may recommend services that considered **experimental, investigational, or unproven** services. But an **experimental, investigational, or unproven** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of services below.
- Preventive services. Usually the plan pays more, and you pay less. Preventive services are designed to help keep you healthy, supporting you in achieving your best health. To find out what these services are, see the *Preventive care* section in the list of services below. To find out how much you will pay for these services, see *Preventive care* in your schedule of benefits.

Some services require **precertification** from us. For more information see the *How your plan works – Medical necessity and, precertification requirements* section.

The **covered services** and exclusions below appear alphabetically to make it easier to find what you're looking for. If a service isn't listed here as a **covered service** or is listed as not covered under a specific service, it still may be covered. If you have questions, ask your **provider** or contact us. You can find out about limitations for **covered services** in the schedule of benefits.

Abortion

Covered services include services provided and supplies used in connection with an abortion.

Acupuncture

Covered services include manual or electro acupuncture.

The following are not **covered services**:

- Acupressure
-

Ambulance services

An ambulance is a vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Emergency

Covered services include emergency transport to a **hospital** by a licensed ambulance:

- To the first **hospital** to provide **emergency services**
- From one **hospital** to another if the first **hospital** can't provide the **emergency services** you need
- When your condition is unstable and requires medical supervision and rapid transport

Non-emergency

Covered services also include **precertified** transportation to a **hospital** by a licensed ambulance:

- From a **hospital** to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a **hospital** if an ambulance is the only safe way to transport you; 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 treatment

The following are not **covered services**:

- Ambulance services for routine transportation to receive outpatient or inpatient services

Applied behavior analysis

Covered services include applied behavior analysis for a diagnosis of autism spectrum disorder. Applied behavior analysis means the design, implementation and evaluation of environmental changes by applying interventions using behavioral stimuli and consequences that:

- Systematically change behavior
- Are responsible for observable improvements in behavior, including the use of:
 - Direct observation
 - Measurement
 - Functional analysis of the relationship between environment and behavior

Autism spectrum disorder

Autism spectrum disorder means any pervasive developmental disorder or autism spectrum disorder, as defined in the most recent edition or the most recent edition at the time of diagnosis of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association. It includes:

- Autistic disorder
- Asperger's syndrome
- Rett's syndrome
- Childhood disintegrative disorder
- Pervasive developmental disorder not otherwise specified

Covered services include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

We will cover treatment ordered by a **physician** or **behavioral health provider** as part of a treatment plan they develop:

- Following a complete evaluation or re-evaluation
 - In accordance with the most recent clinical report or recommendation on one of the following:
-

- American Academy of Pediatrics
- American Academy of Child and Adolescent Psychiatry.

The care within a treatment plan includes:

- Applied behavior analysis
- Behavioral health treatment
- Pharmacy care
- Psychiatric care
- Psychological care
- Therapeutic care

Medically necessary as used here means in accordance with the generally accepted standards of mental disorder or condition care and clinically appropriate in terms of type, frequency, site, and duration, based on evidence and reasonably expected to do any of the following:

- Prevent the onset of an illness, condition, injury or disability;
- Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability; or
- Assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individual of the same age.

Behavioral health

Mental health treatment

Covered services include the treatment of **mental health disorders** provided by a **hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider** including:

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or residential treatment facility**, including:
 - Office visits to a **physician or behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
 - Individual, group, and family therapies for the treatment of **mental health disorders**
 - Other outpatient mental health treatment such as:
 - Mobile crisis response services when experiencing an acute mental health crisis. Mobile crisis response services in this section means services delivered to provide for rapid response to, assessment of, and early intervention when experiencing an acute mental health crisis that are deployed at the location of the individual who is experiencing an acute mental health crisis.
 - Short-term residential program or crisis receiving center providing behavioral crisis intervention and stabilization for observation and assessment of an acute mental health crisis to determine whether admission to an inpatient or outpatient setting is necessary.
 - Residential crisis stabilization unit in this section means a short-term residential program providing support and stabilization when experiencing an acute mental health crisis.
 - Crisis receiving center means a community-based facility licensed by the Department of Behavioral Health and Developmental Services to provide short term assessment, observation, and crisis stabilization services.

- **Partial hospitalization** treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
- Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
 - You are homebound
 - Your **physician** orders them
 - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- Observation
- Peer counseling support by a peer support specialist (including telemedicine consultation)

Substance use disorders treatment

Covered services include the treatment of **substance use disorders** provided by a **hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider** as follows:

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or residential treatment facility**, including:
 - Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
 - Individual, group, and family therapies for the treatment of **substance use disorders**
 - Other outpatient **substance use disorders** treatment such as:
 - Mobile crisis response services when experiencing an acute mental health crisis. Mobile crisis response services in this section means services delivered to provide for rapid response to, assessment of, and early intervention when experiencing an acute mental health crisis that are deployed at the location of the individual who is experiencing an acute mental health crisis.
 - Short-term residential program or crisis receiving center providing behavioral crisis intervention and stabilization for observation and assessment of an acute mental health crisis to determine whether admission to an inpatient or outpatient setting is necessary.
 - Residential crisis stabilization unit in this section means a short-term residential program providing support and stabilization when experiencing an acute mental health crisis.
 - Crisis receiving center means a community-based facility licensed by the Department of Behavioral Health and Developmental Services to provide short term assessment, observation, and crisis stabilization services.
 - **Partial hospitalization** treatment provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
 - Intensive outpatient program provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
 - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
 - You are homebound

- Your **physician** orders them
- The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
- Ambulatory or outpatient **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
- Observation
- Peer counseling support by a peer support specialist (including **telemedicine** consultation)

Behavioral health important note:

A peer support specialist serves as a role model, mentor, coach, and advocate. A peer support specialist must be supervised by a **behavioral health provider**.

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as a qualified individual for cancer or other life-threatening disease or condition.

“Routine patient cost” means the cost of a health care service incurred as a result of treatment being provided to the covered person for purposes of a clinical trial.

“Life threatening condition” means any disease or condition from which death is likely unless the course of disease or condition is interrupted.

“Qualified individual” means a covered person who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to treatment of cancer or other life-threatening disease or condition, and the referring health care professional has concluded that the individual’s participation in such trial is appropriate to treat the disease or condition, or the individual’s participation is based on medical and scientific information.

The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** under an “approved clinical trial” only when you have cancer or other life-threatening disease or condition. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- We determine you may benefit from the treatment

An approved clinical trial is a phase I, phase II, phase III or phase IV clinical trial conducted to prevent, detect, or treat cancer or other life-threatening disease or condition. It must meet all of these requirements:

- The clinical trial is a federally funded or approved trial

- The clinical trial is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA), or is a drug that is exempt from having an investigational new drug application

Dental anesthesia

Covered services include anesthesia and hospitalization or outpatient facility charges for dental care if:

- Your **provider** determines that you require general anesthesia and admission to a **hospital** or outpatient surgery center to effectively and safely provide the underlying dental care; and
- You are severely disabled; or
- You have a medical need for general anesthesia; or
- You are under 7 years of age.

For purposes of this review, a determination of **medical necessity** includes but is not limited to a consideration of whether your age, physical condition or mental condition requires the utilization of general anesthesia and the admission to a **hospital** or outpatient surgery center to safely provide the underlying dental care.

Diabetic services, supplies, equipment, and self-care programs

Covered services include:

- Services
 - Foot care to minimize the risk of infection
- Supplies
 - Injection devices including syringes, needles and pens
 - Test strips - blood glucose, ketone and urine
 - Blood glucose calibration liquid
 - Lancet devices and kits
 - Alcohol swabs
- Equipment
 - External insulin pumps and pump supplies
 - Blood glucose monitors without special features, unless required due to blindness
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training, including medical nutrition therapy

Durable medical equipment (DME)

Covered services are DME and the accessories needed to operate it when:

- Made to withstand prolonged use
- Mainly used in the treatment of illness or injury
- Suited for use in the home
- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

Your plan only covers the same type of DME that Medicare covers. But there are some DME items Medicare covers that your plan does not.

Covered services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. If you purchase DME, that purchase is only covered if you need it for long-term use.

Covered services also include:

- One item of DME for the same or similar purpose
 - Repairing DME due to normal wear and tear
-

- A new DME item you need because your physical condition has changed
- Buying a new DME item to replace one that was damaged due to normal wear, if it would be cheaper than repairing it or renting a similar item

The following are not **covered services**:

- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Covered services include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room or free-standing emergency department, including:

- Diagnostic x-ray
- Lab services
- Medical supplies
- Advanced diagnostic imaging, such as MRIs and CAT scans

Emergency services for behavioral health conditions may be obtained from a facility and staff credentialed to provide behavioral health crisis services. These services include the following when they are within the capabilities of the staff and facilities available at the behavioral health crisis **provider**:

- A behavioral health assessment, including ancillary services routinely available to evaluate an **emergency medical condition**, and
- Further examination and treatment as are required so that your condition does not deteriorate

You can get **emergency services** from network **providers** or **out-of-network providers**.

Your coverage for **emergency services** will continue until the following conditions are met:

- You are evaluated and your condition is stabilized
- Post-stabilization: Your attending **physician** determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another **provider** or facility located within a reasonable travel distance, taking into account your medical condition

If your **physician** decides you need to stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. See the *How your plan works – Medical necessity and precertification requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your network **physician** or **primary care physician (PCP)**.

Non-emergency services

See the schedule of benefits for this information.

Gender affirming treatment

Covered services include certain services and supplies for gender affirming treatment.

Medically necessary transition-related services can include:

- Outpatient psychotherapy and mental health services for gender dysphoria and associated comorbid psychiatric diagnoses
- Continuous hormone replacement therapy
- Outpatient laboratory testing to monitor continuous hormone therapy
- Gender reassignment surgeries

Important note:

Visit <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html> for detailed information about this benefit, including eligibility and **medical necessity** requirements. You can also call the toll-free number on your ID card.

Habilitation therapy services

Habilitation therapy services are services needed to keep, learn or improve your skills and functioning for daily living (e.g., therapy for a child who isn't walking or talking at the expected age). The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a:

- Licensed or certified physical, occupational or speech therapist
- **Hospital, skilled nursing facility** or hospice facility
- **Home health care agency**
- **Physician**

Outpatient physical, occupational, and speech therapies

Covered services include:

- Physical therapy if it is expected to develop any impaired function
- Occupational therapy if it is expected to develop any impaired function
- Speech therapy if it is expected to develop speech function that resulted from delayed development (Speech function is the ability to express thoughts, speak words and form sentences.)

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Early intervention services

Early intervention services are available to children from birth to age 3. They are services that help a child develop, learn or keep skills to function age appropriately within their home or normal everyday settings and shall include services that enhance functional ability without effecting a cure. To receive services, your child must be certified by the Department of Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Education Act.

Covered services include:

- Speech and language therapy
 - Occupational therapy
 - Physical therapy
 - Assistive technology services and devices
-

Hearing aids for minors

Hearing aid means:

- Any wearable, non-disposable instrument or device designed or offered to aid or make up for impaired hearing
- Parts, attachments, or accessories, including earmolds, initial batteries, and other necessary equipment, maintenance, and adaptation training

Covered services for children 18 years of age or younger include services and equipment recommended by an otolaryngologist and provided by the following:

- A **physician** certified as an otolaryngologist, otologist or licensed hearing aid **provider**
- An audiologist who:
 - Is legally qualified in audiology
 - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
- Hearing aid installed in accordance with a **prescription** written
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not **covered services**:

- Replacement of a hearing aid that is lost, stolen, or damaged through neglect
- Batteries after the initial is provided or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Hearing exams

Covered services include hearing exams for evaluation and treatment of illness, injury or hearing loss when performed by a hearing **specialist**.

The following are not **covered services**:

- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**

Hemophilia and congenital bleeding disorders

Covered services for home treatment of routine bleeding episodes associated with hemophilia and other congenital disorders include:

- Blood infusion equipment, including but not limited to, syringes and needles
- Blood products, including but not limited to, Factor VII, Factor VIII, Factor IX and cryoprecipitate
- Training to provide infusion therapy at home

The home treatment must be supervised by a state-approved hemophilia treatment center.

Home health care

Covered services include home health care provided by a **home health care agency** in the home, but only when all of the following criteria are met:

- You are homebound
 - Your **physician** orders them
 - The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**, or you are unable to receive the same services outside your home
 - The services are a part of a home health care plan
-

- The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker

Skilled nursing services are services provided by a registered nurse or licensed practical nurse within the scope of their license.

If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services. See the schedule of benefits for more information on the intermittent requirement.

Short-term physical, speech, and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home. See *Rehabilitation services* and *Habilitation therapy services* in this section and the schedule of benefits.

The following are not **covered services**:

- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities)
- Transportation

Hospice care

Covered services include inpatient, outpatient, and home hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

- **Room and board**
- Services and supplies furnished to you on an inpatient, outpatient, or home basis
- Services by a hospice care agency or hospice care provided in a **hospital**
- Psychological, psychosocial and dietary counseling
- Pain management and symptom control
- Bereavement counseling
- Respite and palliative care

Hospice care services provided by the **providers** below will be covered, even if the **providers** are not an employee of the hospice care agency responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
 - Physical and occupational therapy
 - Medical supplies
 - Outpatient **prescription** drugs
 - Psychological and psychosocial counseling
 - Dietary counseling

The following are not **covered services**:

- Funeral arrangements
 - Pastoral counseling
 - Financial or legal counseling including estate planning and the drafting of a will
-

- Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
 - Sitter or companion services for you or other family members
 - Transportation
 - Maintenance of the house

Hospital care

Covered services include inpatient and outpatient **hospital** care. This includes:

- Semi-private **room and board** (your plan will cover the extra expense of a private room when appropriate because of your medical condition)
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge
- Services of **physicians** employed by the **hospital**
- Administration of blood and blood products
- Services and supplies for a hysterectomy, for a minimum stay of not less than:
 - 23 hours following a laparoscopy-assisted vaginal hysterectomy
 - 48 hours following a vaginal hysterectomy
 A shorter inpatient stay will be allowed if the attending **provider** and you determine that a shorter length of stay is appropriate.

The following are not **covered services**:

- All services and supplies provided in:
 - Rest homes
 - Any place considered a person’s main residence or providing mainly custodial or rest care
 - Health resorts
 - Spas
 - Schools or camps

Infertility services

Basic infertility

Covered services include seeing a **provider**:

- To diagnose and evaluate the underlying medical cause of infertility.
- To do **surgery** to treat the underlying medical cause of infertility. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.
- For artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination.

See the *Coverage and exclusions-Prescription drugs – outpatient* section for information on coverage of infertility **prescription** drugs.

Advanced reproductive technology (ART)

Advanced reproductive technology, also called “assisted reproductive technology”, is a more advanced type of infertility treatment.

Covered services include the following services provided by an ART **specialist**

- Ovulation induction cycle(s) using medication to stimulate the ovaries. This may include the use of ultrasound and lab tests.
- In vitro fertilization (IVF).
- Zygote intrafallopian transfer (ZIFT).
- Gamete intrafallopian transfer (GIFT).
- Cryopreserved (frozen) embryo transfers (FET).
- Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These

- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)

ART **covered services** may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your plan.

For plans with ovulation induction cycle limits, an ovulation induction cycle is defined as an attempt at ovulation induction while on medication to stimulate the ovaries with or without artificial insemination.

For plans with ART cycle limits, an ART “cycle” is defined as:

ART service	Procedure	Cycle count
IVF	One complete fresh cycle with transfer (egg retrieval, fertilization, and transfer of embryo)	One full cycle
IVF	One fresh cycle with attempted egg aspiration (with or without egg retrieval) but without transfer of embryo	One half cycle
IVF	Fertilization of egg and transfer of embryo	One half cycle
IVF	One cryopreserved (frozen) embryo transfer	One half cycle
GIFT	One complete cycle	One full cycle
ZIFT	One complete cycle	One full cycle

Aetna’s National Infertility Unit

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with determining eligibility for benefits and **precertification**. They can also give you information about our infertility Institutes of Excellence™(IOE) facilities. You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your infertility services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

Fertility preservation

Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use.

Covered services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned medical services that are proven to result in infertility such as:
 - Chemotherapy or radiation therapy that is established in medical literature to result in infertility
 - Other gonadotoxic therapies
 - Removing the uterus
 - Removing both ovaries or testicles
- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the FSH level and ovarian responsiveness criteria outlined in Aetna’s infertility clinical policy

Premature ovarian insufficiency

If your infertility has been diagnosed as premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services using donor eggs/embryos through age 45 regardless of FSH level.

Infertility services exclusions:

The following are not **covered services**:

- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- Infertility **medication** not injected by your **provider**, including but not limited to menotropins, hCG, and GnRH agonists. See the *Coverage and exclusions-Prescription drugs – outpatient* section for information on coverage of infertility **prescription** drugs for your plan.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when either partner has had voluntary sterilization **surgery**, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's infertility clinical policy.
- Treatment for dependent children, except for fertility preservation as described above.

Jaw joint disorder treatment

Covered services include the diagnosis, surgical and non-surgical treatment of **jaw joint disorder** by a **provider**, including:

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)

Lymphedema

Covered services include the diagnosis, evaluation and treatment of lymphedema. Your plan will cover:

- Equipment
- Supplies
- Complex decongestive therapy
- Self-management training and education by a licensed **health professional**

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. After your child is born, **covered services** include:

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery
 - No less than 96 hours of inpatient care in a **hospital** after a cesarean delivery
-

- 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 home visits after delivery by a health care **provider** according to the guidelines recommended by the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists. **Covered services** also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Nutritional support

Covered services include formula and enteral nutrition products for the treatment of an inherited metabolic disorder.

An inherited metabolic disorder is an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids.

Covered services include:

- Formula and enteral nutrition products that:
 - Are liquid or solid formulas and enteral nutrition products for the partial or exclusive feeding by means of oral intake or enteral feeding by tube
 - A **physician** or other **health professional** that is qualified for the management of an inherited metabolic disorder has issued a written notice stating that the formula or enteral nutrition product is **medically necessary**
 - Are a critical source of nutrition as certified by the **physician** by diagnosis, but do not need to be your primary source of nutrition
 - Are proven effective as your treatment regimen
 - Are used under medical supervision which may include a home setting
- Medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products

The following are not **covered services**:

Any other food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- Medical foods
- Other nutritional items

Obesity surgery and services

Obesity **surgery** is a type of procedure performed on people who are **morbidly obese** for the purpose of losing weight. Your **physician** will determine whether you qualify for obesity **surgery**.

Covered services include:

- An initial medical history and physical exam
 - Diagnostic tests given or ordered during the first exam
 - Outpatient **prescription** drugs included under the *Prescription drugs - outpatient* section
 - An obesity **surgical procedure**, such as gastric bypass, or other method as recognized by the National
-

Institutes of Health as effective for the long-term reversal of **morbid obesity**

- A multi-stage procedure when planned and approved by us
- Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

The following are not **covered services**:

- Weight management treatment
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate.
- Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:
 - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
 - Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Oral and maxillofacial treatment (mouth, jaws and teeth)

Covered services include the following when provided by a **physician**, dentist and **hospital**:

- Cutting out:
 - Cysts, tumors, or other diseased tissues
- Cutting into gums and tissues of the mouth:
 - Only when not associated with the removal, replacement or repair of teeth

Outpatient surgery

Covered services include services provided and supplies used in connection with outpatient **surgery** performed in a **surgery** center or a **hospital's** outpatient department.

Important note:

Some **surgeries** can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician, PCP** services and not for a separate fee for facilities.

The following are not **covered services**:

- A **stay** in a **hospital** (see *Hospital care* in this section)
- Services of another **physician** for the administration of a local anesthetic

Physician services

Covered services include services by your **physician** to treat an illness or injury. You can get services:

- At the **physician's** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine**

Important note:

For behavioral health services, all in-person, **covered services** with a **behavioral health provider** are also **covered services** if you use **telemedicine** instead.

Other services and supplies that your **physician** may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Prescription drugs - outpatient

Read this section carefully. This plan does not cover all **prescription** drugs and some coverage may be limited. This doesn't mean you can't get **prescription** drugs that aren't covered; you can, but you have to pay for them yourself. For more information about **prescription** drug benefits, including limits, see the schedule of benefits.

Important note:

A pharmacy may refuse to fill or refill a **prescription** when, in the professional judgement of the pharmacist, it should not be filled or refilled.

Your plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication's U.S. Food and Drug Administration (FDA) approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

Covered services are based on the drugs in the **drug guide**. We exclude **prescription** drugs listed on the formulary exclusions list unless we approve a medical exception. The formulary exclusions list is a list of **prescription** drugs not covered under the plan. This list is subject to change. If it is **medically necessary** for you to use a **prescription** drug that is not on this **drug guide**, you or your **provider** must request a medical exception. See the *Requesting a medical exception* section or just contact us.

Your **provider** can give you a **prescription** in different ways including:

- A written **prescription** that you take to a network pharmacy
- Calling or e-mailing a **prescription** to a network pharmacy
- Submitting the **prescription** to a network pharmacy electronically

The pharmacy may substitute a **generic prescription drug** for a **brand-name prescription drug**. Your cost share may be less if you use a **generic drug** when it is available.

Any **prescription** drug made to work beyond one month shall require the **copayment** amount that equals the expected duration of the medication.

Prescription drug synchronization

If you are prescribed multiple maintenance medications, including **specialty prescription drugs**, and would like to have them each dispensed on the same fill date for your convenience, your **network pharmacy** may be able to coordinate that for you, provided that:

- Your pharmacy or **provider** tells us that the synchronization of the dates is in your best interest
- You request or agree to the synchronization

We will apply a prorated daily cost share rate, to a partial fill of a maintenance drug, if needed, to synchronize your **prescription** drugs. We will not perform this proration more often than annually.

How to access network pharmacies

A **network pharmacy** will submit your claim. You will pay your cost share to the pharmacy. You can find a **network pharmacy** either online or by phone. See the *Contact us* section for how. You may go to any of our network pharmacies. A **network pharmacy** also includes an out-of-network pharmacy or its intermediary that has agreed in writing to accept payment at the same rate as a **network pharmacy**.

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 90 day supply of a **prescription** drug.

Mail order pharmacy

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. A **mail order pharmacy** may be used for up to a 90 day supply of a **prescription** drug.

Prescriptions can be filled at a network **mail order pharmacy**.

Specialty pharmacy

A **specialty pharmacy** may be used for up to a 30 day supply of a **specialty prescription drug**. You can view the list of **specialty prescription drugs**. See the *Contact us* section for how.

Specialty prescription drug fills may be filled only at pharmacies that have agreed to accept our reimbursement terms for **specialty prescription drugs**. Pharmacies that have accepted our reimbursement terms are listed on our online **provider** directory at www.aetna.com/formulary. You can also call the toll-free number on your ID card to request a printed directory.

All **specialty prescription drug** fills including the first fill must be filled at a network **specialty pharmacy** or an out-of-network **specialty pharmacy** or its intermediary that has agreed in writing to accept payment at the same rate as a network **specialty pharmacy**, unless it is an urgent situation.

Prescription drugs covered by this plan are subject to misuse, waste, or abuse utilization review by us, your **provider**, and/or your **network pharmacy**. The outcome of this review may include:

- Limiting coverage of a drug to one prescribing **provider** or one **network pharmacy**
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

How to access out-of-network pharmacies

You can directly access an out-of-network pharmacy to get covered outpatient **prescription** drugs.

When you use an out-of-network pharmacy, you pay your in-network **copayment** or **coinsurance** then you pay any remaining **deductible** and then you pay your out-of-network **coinsurance**. If you use an out-of-network pharmacy to obtain outpatient **prescription** drugs, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your in-network outpatient **prescription** drug cost share
- Paying any applicable out-of-network outpatient **prescription** drug **deductible**
- Your out-of-network **coinsurance**
- Any charges over the **allowable amount**
- Submitting your own claims

Other covered services

Abortion drugs

Covered services include **prescription** drugs used for elective termination of pregnancy.

Anti-cancer drugs taken by mouth

Covered services include any drug prescribed for cancer treatment, including chemotherapy drugs. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

Contraceptives (birth control)

For females who are able to reproduce, **covered services** include any drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at a **network pharmacy**. At least one form of each FDA-approved contraception method is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for how.

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the **brand-name prescription drug** or device at no cost share.

Preventive contraceptives important note:

You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review. If the exception is approved, the **brand-name prescription drug** contraceptive will be covered at 100%.

Diabetic supplies

Covered services include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid
- Diabetic syringes, needles and pens
- Continuous glucose monitors
- Insulin infusion disposable pumps
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine

See the *Diabetic services, supplies, equipment, and self-care programs* provision for medical **covered services**.

Immunizations

Covered services include preventive immunizations as required by the ACA when given by a **network pharmacy**. You can find a participating **network pharmacy** by contacting us. Check with the pharmacy before you go to make sure the vaccine you need is in stock. Not all pharmacies carry all vaccines.

Infertility drugs

Covered services include oral and injectable ovulation induction **prescription** drugs.

Obesity drugs

Covered services include **prescription** drugs used only for the purpose of weight loss. These are sometimes called anti-obesity agents.

Off-label use

FDA approved **prescription** drugs may be covered when the off-label use of the drug has not been approved by the FDA for your condition. Eligibility for coverage is subject to the following:

- The drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.
-

- The drug is prescribed for the treatment of cancer and it is recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendium even if the drug is not approved by the FDA for a particular indication.
- The drug is approved by the FDA for use in the treatment of cancer pain and the dosage is in excess of the recommended dosage for a patient with intractable cancer pain.

Over-the-counter (OTC) drugs

Covered services include certain OTC medications when you have a **prescription** from your **provider**. You can see a list of covered OTC drugs by logging on to your member website.

Risk reducing breast cancer prescription drugs

Covered services include **prescription** drugs used to treat people who are at:

- Increased risk for breast cancer
- Low risk for medication side effects

Sexual enhancement or dysfunction prescription drugs

Covered services include **prescription** drugs for the treatment of sexual dysfunction or enhancement.

For the most up-to-date information on covered **prescription** drugs and doses, contact us.

Tobacco cessation prescription drugs

Covered services include FDA-approved **prescription** drugs, OTC drugs, and OTC aids to help stop the use of tobacco products, including nicotine replacement therapy. A **provider** must prescribe all OTC aids.

A tobacco product is something that contains tobacco or nicotine. Examples of this are:

- Candy-like products with tobacco as an ingredient
- Cigarettes
- Cigars
- Smoking tobacco
- Smokeless tobacco
- Snuff

Nicotine replacement therapy is a **prescription** drug or aid that:

- Delivers nicotine to a person who is trying to stop using tobacco products
- Is prescribed by a **provider**

Prescription drug exclusions:

The following are not **covered services**:

- Allergy sera and extracts given by injection
 - Any services related to providing, injecting or application of a drug
 - Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
 - Cosmetic drugs including medication and preparations used for cosmetic purposes
 - Devices, products and appliances unless listed as a **covered service**
 - Dietary supplements including medical foods
 - Drugs or medications
 - Administered or entirely consumed at the time and place they are prescribed or provided
 - Which do not require a **prescription** by law, even if a **prescription** is written, unless we have approved a medical exception
 - That are therapeutically the same or an alternative to a covered **prescription** drug, unless we approve a medical exception
-

- Not approved by the FDA or not proven safe or effective
 - Provided under your medical plan while inpatient at a healthcare facility
 - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
 - That are used 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 alter the shape or appearance of a sex organ unless listed as a **covered service**
 - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-**prescription** appetite suppressants or other medications except as described in the certificate
 - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies
 - Duplicative drug therapy; for example, two antihistamines for the same condition
 - Genetic care including:
 - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as a **covered service**
 - Immunizations related to travel or work
 - Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
 - Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
 - Injectables including:
 - Any charges for the administration or injection of **prescription** drugs
 - Needles and syringes except for those used for insulin administration
 - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
 - Off-label drug use except as described in the *Prescription drugs – outpatient, Off-label use* section
 - **Prescription** drugs:
 - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or **prescription** drugs for the treatment of a dental condition
 - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
 - That are used for the purpose of improving visual acuity or field of vision
 - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the member as identified on the ID card
 - Replacement of lost or stolen **prescriptions**
 - Test agents except diabetic test agents
 - We reserve the right to exclude:
 - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
 - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**
-

Preventive care

Preventive **covered services** are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing, you may pay more as these services aren't preventive. If a **covered service** isn't listed here under preventive care, it still may be covered under other **covered services** in this section. For more information, see your schedule of benefits.

The following agencies set forth the preventive care guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When updated, they will apply to this plan. The updates are effective on the first day of the year, one year after the updated recommendation or guideline is issued.

For frequencies and limits, contact your **physician** or us. This information is also available at <https://www.healthcare.gov/>

Important note:

Gender-specific preventive care benefits include **covered services** described regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

Counseling services

Covered services include preventive screening and counseling by your **health professional** for:

- Alcohol or drug misuse
 - Preventive counseling and risk factor reduction intervention
 - Structured assessment
- Genetic risk for breast and ovarian cancer
- Obesity and healthy diet
 - Preventive counseling and risk factor reduction intervention
 - Nutritional counseling
 - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- Sexually transmitted infection
- Tobacco cessation
 - Preventive counseling to help stop using tobacco products
 - Treatment visits
 - Class visits

Family planning services – female contraceptives

Covered services include family planning services as follows:

- Contraceptive devices (including any related services or supplies) when they are prescribed, provided, administered, or removed by a **health professional**.
 - Voluntary sterilization including charges billed separately by the [**provider**] for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.
-

The following are not preventive **covered services**:

- Services provided as a direct result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA
- Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a **health professional**

Immunizations

Covered services include preventive immunizations for infectious diseases.

The following are not preventive **covered services**:

- Immunizations that are not considered preventive care, such as those required due to your employment or travel

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, anesthesia, removal of polyps during a screening procedure, and a pathology exam on any removed polyp, as recommended by the American College of Gastroenterology in association with the American Cancer Society
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT), as recommended by the American College of Gastroenterology in association with the American Cancer Society
- Follow-up colonoscopies after a positive noninvasive stool-based (FOBT) screening test or direct visualization test
- Lung cancer screenings
- Mammograms
 - One mammogram if you are 35-39
 - One mammogram every 2 years if you are age 40-49
 - One mammogram per year if you are age 50 or older
- Prostate specific antigen (PSA) tests per year if you are either:
 - Younger than age 50 but considered to be high risk
 - Age 50 or older
- Sigmoidoscopies, as recommended by the American College of Gastroenterology in association with the American Cancer Society
- Radiologic imaging in appropriate circumstances for colorectal cancer screening, as recommended by the American College of Gastroenterology in association with the American Cancer Society

Routine physical exams

A routine preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
 - Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
 - Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
 - Screening and counseling services on topics such as:
 - Interpersonal and domestic violence
-

- Sexually transmitted diseases
- Human immune deficiency virus (HIV) infections
- High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

- Office visit to a **physician**
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns, an initial **hospital** checkup

Well woman preventive visits

A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Office visit to a **physician, PCP, OB, GYN** or **OB/GYN** for services including an annual cervical cancer screening (Pap smear) and testing using any FDA approved gynecologic cytology screening technologies
- Preventive care breast cancer (BRCA) gene blood testing
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

Private duty nursing - outpatient

Covered services include private duty nursing care provided by an R.N. or L.P.N. when:

- You are homebound
- Your **physician** orders services as part of a written treatment plan
- Services take the place of a **hospital** or **skilled nursing facility stay**
- Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care
- Periodic skilled nursing visits are not adequate

The following are not **covered services**:

- Inpatient private duty nursing care
- Care provided outside the home
- Maintenance or custodial care
- Care for your convenience or the convenience of the family caregiver

Prosthetic device

A prosthetic device is a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects.

Covered services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

Coverage includes:

- Any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that peer-reviewed medical literature has determined to be medically appropriate on the basis of the clinical assessment of your rehabilitation potential
 - Instruction and other services (such as components, fittings, attachment or insertion) so you can properly use the device
 - Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
 - Replacements required by ordinary wear and tear or damage
-

Component means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

If you receive a prosthetic device as part of another **covered service**, it will not be covered under this benefit.

The following are not **covered services**:

- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Reconstructive breast surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
 - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
 - Treatment of physical complications of all stages of the mastectomy, including lymphedema
 - Prostheses

Unless you and your [**physician**] decide that a shorter time period for inpatient care is appropriate, **covered services** for reconstructive breast surgery include:

- 48 hours of inpatient care following a mastectomy
- 24 hours of inpatient care after a lymph node dissection for treatment of breast cancer

Reconstructive surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a birth defect, including but not limited to cleft lip and cleft palate or ectodermal dysplasia. The **surgery** will be covered if:
 - The defect results in facial disfigurement or functional impairment of a body part, and
 - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in facial disfigurement or functional impairment of a body part, and your **surgery** will improve function.

Accidental injury to natural teeth

Covered services also include the procedures or **surgery** to sound natural teeth, injured due to an accident and performed as soon as medically possible, when:

- The teeth were stable, functional and free from decay or disease at the time of the injury
- The **surgery** or procedure returns the injured teeth to how they functioned before the accident

These accident-related dental services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth
 - The first placement of dentures or bridgework to replace lost teeth
 - Orthodontic therapy to pre-position teeth
-

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

Covered services include cardiac rehabilitation services you receive at a **hospital, skilled nursing facility** or **physician's office**, but only if those services are part of a treatment plan determined by your risk level and ordered by your **physician**.

Pulmonary rehabilitation

Covered services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if they are part of a treatment plan ordered by your **physician**. A course of outpatient pulmonary rehabilitation may also be covered if it is performed at a **hospital, skilled nursing facility, or physician's office** and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services are services needed to restore or develop your skills and functioning for daily living. The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a:

- Licensed or certified physical, occupational, or speech therapist
- **Hospital, skilled nursing facility, or hospice facility**
- **Home health care agency**
- **Physician**

Covered services include:

- Spinal manipulation to correct a muscular or skeletal problem. Your **provider** must establish or approve a treatment plan that details the treatment and specifies frequency and duration.

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure**
- Occupational therapy, but only if it is expected to do one of the following:
 - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or **surgical procedure**
 - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to do one of the following:
 - Significantly improve or restore lost speech function or correct a speech impairment resulting from an acute illness, injury, or **surgical procedure**
 - Improve delays in speech function development caused by a birth defect
(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 rehabilitation associated with physical rehabilitation, but only when:
 - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
 - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the *Short-term rehabilitation services* section in the schedule of benefits.

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Skilled nursing facility

Covered services include inpatient **skilled nursing facility** care. This includes:

- **Room and board**, up to the **semi-private room rate**
- Services and supplies provided during a **stay** in a **skilled nursing facility**

Specialty prescription drugs

Covered services include **specialty prescription drugs** when they are:

- Purchased by your **provider**
- Injected or infused by your **provider** in an outpatient setting such as:
 - A freestanding outpatient facility
 - The outpatient department of a **hospital**
 - A **physician** in the office
 - A home care **provider** in your home

Certain injected and infused medications may be covered under the outpatient **prescription drug** benefit. Contact us to determine if coverage is under this **specialty prescription drug** or the outpatient **prescription drug** benefit.

Telemedicine

Covered services include **telemedicine** consultations when provided by a **physician, specialist, behavioral health provider** or other **telemedicine provider** acting within the scope of their license.

Covered services for **telemedicine** consultations are available from a number of different kinds of **providers** under your plan. Log in to your member website at <https://www.aetna.com/> to review our **telemedicine provider** listing and contact us to get more information about your options, including specific cost sharing amounts.

The following are not **covered services**:

- Telephone calls
- **Telemedicine** kiosks

Tests, images and labs - outpatient

Diagnostic complex imaging services

Covered services include:

- Computed tomography (CT) scans, including for preoperative testing
- Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans
- Other imaging service where the billed charge exceeds \$500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

These are covered only when you get them from a licensed radiology **provider** or lab.

Diagnostic x-ray and other radiological services

Covered services include x-rays, scans and other services (but not complex imaging) only when you get them from a licensed radiology **provider**. See *Diagnostic complex imaging services* above for more information.

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

Covered services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

Gene-based, cellular and other innovative therapies (GCIT)

Covered services include GCIT provided by a **physician, hospital** or other **provider**.

Key Terms

Here are some key terms we use in this section. These will help you better understand GCIT.

Gene

A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Molecular

Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Therapeutic

Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind, adding to a sense of well-being.

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. We call these "GCIT services."

GCIT **covered services** include:

- Cellular immunotherapies.
- Genetically modified viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for treatment of certain conditions.
- All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
 - Luxturna® (Voretigene neparvovec)
 - Zolgensma® (Onasemnogene abeparvovec-xioi)
 - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
 - Antisense. An example is Spinraza (Nusinersen).
 - siRNA.
 - mRNA.
 - microRNA therapies.

Facilities/providers for gene-based, cellular and other innovative therapies

We designate facilities to provide GCIT services or procedures. GCIT **physicians, hospitals** and other **providers** are GCIT-designated facilities/**providers** for Aetna and CVS Health.

Important note:

You must get GCIT **covered services** from a GCIT-designated facility/**provider**. If there are no GCIT-designated facilities/**providers** assigned in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your GCIT services at the facility/**provider** we designate, they will not be **covered services**.

Infusion therapy

Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions.

Covered services include infusion therapy you receive in an outpatient setting including but not limited to:

- A freestanding outpatient facility
- The outpatient department of a **hospital**
- A **physician's** office
- Your home from a home care **provider**

You can access the list of preferred infusion locations by contacting us.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care maximums.

Certain infused medications may be covered under the outpatient **prescription** drug benefit. You can access the list of **specialty prescription drugs** by contacting us.

Radiation therapy

Covered services include the following radiology services provided by a **health professional**:

- Accelerated particles
 - Gamma ray
 - Mesons
 - Neutrons
 - Radioactive isotopes
-

- Radiological services
- Radium

Transplant services

Covered services include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy for FDA-approved treatments
- Thymus tissue for FDA-approved treatments

Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as IOE facilities in your **provider** directory.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the network **copayment, coinsurance, deductible, maximum out-of-pocket** and limits, unless stated differently in this certificate and schedule of benefits. You may also get transplant services at a non-IOE facility, but your cost share will be higher. Transplant services received from a non-IOE facility are subject to the out-of-network **copayment, coinsurance, deductible, maximum out-of-pocket**, and limits, unless stated differently in this certificate and schedule of benefits.

Important note:

If there are no IOE facilities assigned to perform your transplant type in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your transplant services at the facility we designate, your cost share will be higher.

Many pre and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. If your transplant care is being coordinated by the National Medical Excellence® (NME) program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the **covered service** is not directly related to your transplant.

The following are not **covered services**:

- Services and supplies furnished to a donor when the recipient is not a covered person
 - Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
 - Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness
-

Urgent care services

Covered services include services and supplies to treat an urgent condition at an urgent care center. An urgent condition is an illness or injury that requires prompt medical attention but is not a life-threatening **emergency medical condition**. An urgent care center is a facility licensed as a freestanding medical facility to treat urgent conditions.

If you need care for an urgent condition, you should first seek care through your **physician, PCP**. If your **physician** is not reasonably available, you may access urgent care from an urgent care center.

The following are not **covered services**:

- Non-urgent care in an urgent care center

Virtual primary care (VPC)

VPC provides coverage for eligible in-network **covered services** for persons 18 years of age or older. **Covered services** include basic medical and preventive health care services when provided by a Virtual Primary Care (VPC) **telemedicine provider**.

A VPC **telemedicine provider** is a **provider** who is contracted with us to provide you with VPC **covered services** by **telemedicine**. This **provider** can also be your **PCP**.

Covered services include:

- Preventive care
 - Preventive care screening and counseling
 - Preventive care biometric review and analysis:
 - If you will perform self-assessments, when you schedule your first VPC consultation, you'll get tools to do so at no cost to you
 - Your results will be reviewed with your VPC **telemedicine provider**
- Basic medical services
 - General primary care consultations
 - Consultations for non-emergency illness or injury, including **prescriptions**, when needed
 - **Prescription** drug coordination to encourage safe and appropriate use of medications
 - Follow-up care and coordination with **network providers**

Your VPC **telemedicine provider** can help you access **network providers** and **specialists** for **covered services** ordered during your virtual consultation, including:

- Diagnostic lab tests
- Preventive care immunizations
- In-person preventive care
- In-person biometric screenings such as cholesterol and blood sugar testing

Your regular cost share will apply for services not provided by a VPC **telemedicine provider** and for any **prescription** drugs you may need. See the schedule of benefits.

The following are not **covered services**:

- VPC **telemedicine** consultations received from a **provider** who is not a VPC **telemedicine provider**.
-

Vision care

Covered services include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not **covered services**:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Walk-in clinic

Covered services include, but are not limited to, health care services provided through a **walk-in clinic** for:

- Scheduled and unscheduled visits for illnesses and injuries that are not **emergency medical conditions**
 - Preventive care immunizations administered within the scope of the clinic's license
 - Individual screening and counseling services that will help you:
 - With obesity or healthy diet
 - To stop using tobacco products
-

General plan exclusions

The following are not **covered services** under your plan:

Blood and blood products

Blood, blood products, and related services which are supplied to your **provider** free of charge

This exception does not apply:

- If services are **medically necessary** and you incur a charge for the expense
- For treatment of hemophilia and congenital bleeding disorders

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, except where described in the *Coverage and exclusions* section

Cost share waived

Any cost for a service when any **out-of-network provider** waives all or part of your **copayment, coinsurance, deductible**, or any other amount

Court-ordered services and supplies

This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a **covered service** under your plan

Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs.

Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of 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 bladder catheter, including emptying or 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 walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and **substance use disorder** treatment):
 - Services provided when you have reached the greatest level of function expected with the current level of care
 - Services given mainly to:
 - Provide a place free from conditions that could make your physical or mental state worse

Dental services

The following are not **covered services**:

- Services normally covered under a dental plan
-

- Dental implants except when part of an approved treatment plan for a **covered service** described in the *Coverage and exclusions - Reconstructive surgery and supplies* section

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing, except as described in the *Coverage and exclusions* section. This includes:
 - Special education
 - Remedial education
 - Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
 - Job training
 - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, sporting event, or to join in a sport or other recreational activity.

Experimental, investigational, or unproven

Experimental, investigational, or unproven drugs, devices, treatments or procedures unless otherwise covered under clinical trials

Foot care

Routine services and supplies for the following:

- Routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails
- Supplies (including orthopedic shoes), ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
- Treatment of calluses, bunions, toenails, hammertoes or fallen arches
- Treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working, or wearing shoes

Foot orthotic devices

Foot orthotics or other devices to support the feet, such as arch supports and shoe inserts, unless **medically necessary** or required for the treatment of or to prevent complications of diabetes

Gene-based, cellular and other innovative therapies (GCIT)

The following are not **covered services** unless you receive prior written approval from us:

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**
- All associated services when GCIT services are not covered. Examples include:
 - Infusion
 - Lab
 - Radiology
 - Anesthesia
 - Nursing services

See the *How your plan works – Medical necessity and precertification requirements* section

Growth/height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- **Surgical procedures**, devices and growth hormones to stimulate growth

Maintenance care

Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services and services for the treatment of autism spectrum disorder

Medical supplies – outpatient disposable

Any outpatient disposable supply or device. Examples of these include:

- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages
- Bedpans
- Home test kits not related to diabetic testing
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Missed appointments

Any cost resulting from a canceled or missed appointment

Other non-covered services

- Services you have no legal obligation to pay
- Services that would not otherwise be charged if you did not have the coverage under the plan
- Stay in a facility for treatment for dementia and amnesia

Other primary payer

Payment for a portion of the charges that Medicare or another party is responsible for as the primary payer

Personal care, comfort or convenience items

Any service or supply primarily for your convenience and personal comfort or that of a third party

Prescription or non-prescription drugs and medicines - outpatient

- Outpatient **prescription** or non-**prescription** drugs and medicines provided by the policyholder or through a third party vendor contract with the policyholder
- **Specialty prescription drugs** except as stated in the *Coverage and exclusions* section

Routine exams and preventive services and supplies

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Coverage and exclusions* section

Services not permitted by law

Some laws restrict the range of health care services a **provider** may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

Services provided by a family member

Services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law, or any household member

Services, supplies and drugs received outside of the United States

Non-emergency medical services, outpatient **prescription** drugs or supplies received outside of the United States. They are not covered even if they are covered in the United States under this certificate.

Sexual dysfunction and enhancement

Any treatment, **prescription** drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- **Surgery, prescription** drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape of a sex organ
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

Therapies and tests

- Full body CT scans, unless **medically necessary**
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Tobacco cessation

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, medications, nicotine patches and gum.

This also includes:

- Counseling, except as specifically provided in the *Coverage and exclusions* section
 - Hypnosis and other therapies
 - Medications, except as specifically provided in the *Coverage and exclusions* section
 - Nicotine patches
 - Gum
-

Treatment in a federal, state, or governmental entity

Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity unless coverage is required by applicable laws

Voluntary sterilization

- Reversal of voluntary sterilization procedures, including related follow-up care

Wilderness treatment programs

See *Educational services* in this section

Work related illness or injuries

Coverage available to you under workers' compensation or a similar program under local, state or federal law for any illness or injury related to employment or self-employment

Important note:

A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

How your plan works

How your medical plan works while you are covered in-network

Your in-network coverage helps you get and pay for a lot of, but not all, health care services.

Your cost share is lower when you use a **network provider**.

Providers

Our **provider** network is there to give you the care you need. The easiest way to find **providers** and see important information about them is by logging in to your member website. There you'll find our online **provider** directory. See the *Contact us* section for more information.

You may choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care. You don't have to get care through your **PCP**. You may go directly to **network providers**.

For more information about the network and the role of your **PCP**, see the *Who provides the care* section.

How your medical plan works while you are covered out-of-network

With your out-of-network coverage:

- You can get care from **providers** who are not part of the Aetna network
- You may have to pay the full cost for your care, and then submit a claim to be reimbursed
- You are responsible to get any required **precertification**
- Your cost share will be higher

Who provides the care

Network providers

We have contracted with **providers** to provide **covered services** to you. These **providers** make up the network for your plan.

To get network benefits, you must use **network providers**. There are some exceptions:

- **Emergency services** – see the description of **emergency services** in the *Coverage and exclusions* section.
- Non-emergency surgical or ancillary services provided by an **out-of-network provider** at a **network** facility.
- **Out-of-network** air ambulance services.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

You may select a **network provider** from the online directory through your member website.

You will not have to submit claims for services received from **network providers**. Your **network provider** will take care of that for you. And we will pay the **network provider** directly for what the plan owes.

Your PCP

We encourage you to get **covered services** through a **PCP**. They will provide you with primary care.

How you choose your PCP

You can choose a **PCP** from the list of **PCPs** in our directory. Each covered family member is encouraged to select a **PCP**. You may each choose a different **PCP**. You should select a **PCP** for your covered dependent if they are a minor or cannot choose a **PCP** on their own.

What your PCP will do for you

Your **PCP** will coordinate your medical care or may provide treatment. They may send you to other **network providers**.

Changing your PCP

You may change your **PCP** at any time by contacting us.

Out-of-network providers

You can also get care from **out-of-network providers**. When you use an **out-of-network provider**, your cost share is higher. You are responsible for:

- Your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over the **allowable amount**
- Submitting your own claims and getting any required **precertification**

Keeping a provider you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the network
- You are already an Aetna member and your **provider** stops being in our network

When you have an existing **provider**-patient relationship with the **provider**, you can keep going to your current **provider**. This is called continuity of care. An existing **provider**-patient relationship means the **provider** or **provider** group has provided you with health care services or admitted or discharged you in the previous 12 months.

If this situation applies to you, contact us for details.

If the **provider** didn't leave the network for cause, you'll be able to receive transitional care from your **provider**:

- For a period of at least 90 days from when we notified you of their network status
- For a period of up to 180 days from when we notified you of their network status, if medically determined to have a life-threatening condition

Important note:

If you have been medically confirmed to be pregnant at the time of the **provider's** termination, transitional care will be through the postpartum period.

If you have been admitted and receiving treatment in an inpatient facility, treatment will continue until you are discharged.

If you are terminally ill, the transitional period is the remainder of your life for care directly related to treatment of the terminal illness.

You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.

Medical necessity and precertification requirements

Your plan pays for its share of the expense for **covered services** only if the general requirements are met. They are:

- The service is **medically necessary**
-

- For in-network benefits, you get the service from a **network provider**
- You or your **provider precertifies** the service when required. **Precertification** includes determining that services are not more costly than an alternative service or sequence of services or site of service 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.

Medically necessary, medical necessity

The **medical necessity** requirements are in the *Glossary* section, where we define “**medically necessary, medical necessity.**” That is where we also explain what our medical directors or a **physician** they assign consider when determining if a service is **medically necessary**.

Important note:
We cover **medically necessary, sex-specific covered services** regardless of identified gender.

Precertification

You need pre-approval from us for some **covered services**. Pre-approval is also called **precertification**.

In-network

Your network **physician** is responsible for obtaining any necessary **precertification** before you get the care. **Network providers** cannot bill you if they fail to ask us for **precertification**. But if your **physician** requests **precertification** and we deny it, and you still choose to get the care, you will have to pay for it yourself.

Out-of-network

When you go to an **out-of-network provider**, you are responsible to get any required **precertification** from us. If you don’t **precertify**:

- Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details.
- You will be responsible for the unpaid bills.
- Your additional out-of-pocket expenses will not count toward your **deductible** or **maximum out-of-pocket limit**, if you have any.

Timeframes for **precertification** are listed below. For **emergency services**, **precertification** is not required, but you should still notify us as shown. That includes an emergency interhospital transfer for a life-threatening condition for a newborn and for the mother to accompany the newborn.

To obtain **precertification**, contact us. You, your **physician** or the facility must call us within these timelines:

Type of care	Timeframe
Non-emergency admission	Call at least 14 days before the date you are scheduled to be admitted
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted
Urgent admission	Call before you are scheduled to be admitted
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment or procedure is scheduled

An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an illness, the diagnosis of an illness, or injury.

We will tell you and your **physician** in writing of the **precertification** decision, where required by state law. An approval is valid for 180 days as long as you remain enrolled in the plan.

For an inpatient **stay** in a facility, we will tell you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that you stay longer, the extra days will need to be **precertified**. You, your **physician**, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your **physician** in writing of an approval or denial of the extra days.

If you or your **provider** request **precertification** and we don't approve coverage, we will tell you why and explain how you or your **provider** may request review of our decision. See the *Complaints, claim decisions and appeal procedures* section.

Types of services that require precertification

Precertification is required for inpatient **stays** and certain outpatient services and supplies.

Precertification is required for the following types of services and supplies:

Inpatient -

- Gender affirming treatment
- Gene-based, cellular and other innovative therapies (GCIT)
- Obesity (bariatric) **surgery**
- **Stays** in a hospice facility
- **Stays** in a **hospital**
- **Stays** in a rehabilitation facility
- **Stays** in a **residential treatment facility** for treatment of **mental health disorders** and **substance use disorders**
- **Stays** in a **skilled nursing facility**

Contact us to get a complete list of the services that require **precertification**. The list may change from time to time.

Sometimes you or your **provider** may want us to review a service that doesn't require **precertification** before you get care. This is called a predetermination, and it is different from **precertification**. Predetermination means that you or your **provider** requests the pre-service clinical review of a service that does not require **precertification**.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help determine medical necessity under our plans. You can find the bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>

For certain drugs covered under your medical plan or **prescription** drug plan, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**.

Step therapy is a type of **precertification** where you must try one or more prerequisite drugs before a step therapy drug is covered. A 'prerequisite' is something that is required before something else. Prerequisite drugs are FDA-approved, may cost less and treat the same condition. If you don't try the prerequisite drugs first, the step therapy drug may not be covered.

Contact us or go online to get the most up-to-date **precertification** requirements and list of step therapy drugs.

Requesting a medical exception

Sometimes you or your **provider** may ask for a medical exception to get coverage for drugs that are not covered or for **brand name** or **specialty drugs** or for which coverage was denied through **precertification** or **step therapy**. You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. For directions on how you can submit a request for a review:

- Call the toll-free number on your ID card
- Go online at <https://www.aetna.com>
- Submit the request in writing to:
CVS Health
ATTN: Aetna PA
1300 E Campbell Road
Richardson, TX 75081

You, someone who represents you, or your **provider** may seek a quicker medical exception when the situation is urgent. It's an urgent situation when you have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug.

After we receive your step therapy exception request, we will tell you and your **provider** of our coverage decision within 72 hours (including hours on weekends) or within 24 hours (including hours on weekends) if the situation is urgent.

We will grant your step therapy exception request if we determine that your request has met any of the following conditions:

- The prerequisite drug is contraindicated
- The prerequisite drug would be ineffective based on your known clinical characteristics and the drug regimen's known characteristics
- You have tried the prerequisite drug under this plan or a previous plan, and the drug was discontinued due to its ineffectiveness, reduced effect, or an adverse event
- You are currently receiving a good result on a drug recommended by your **provider** for your condition while under this plan or the plan immediately earlier

You may obtain coverage without additional cost sharing beyond that which is required of formulary **prescription** drugs for a non-formulary drug if:

- We determine, after consultation with the prescribing **provider**, that the formulary drugs are inappropriate for your condition; or
- You have been taking or using the non-formulary **prescription** drug for at least six months prior to its exclusion from the formulary; and
- The prescribing **provider** determines that either the formulary drugs are inappropriate therapy for your condition, or that changing drug therapy presents a significant health risk.

We will act upon your request within one business day of receipt.

If we deny your request for a medical exception, including a step-therapy exception request, you will have the right to request an external review by an independent review organization (IRO). If our coverage decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send you. That notice will also describe the external review process.

If the medical exception is approved by us or the IRO, the exception will apply for the entire time of the prescription, or in the case of an expedited exception, for the entire time you have an urgent situation. The cost share will be applied the same as for a drug listed in the drug guide.

What the plan pays and what you pay

Who pays for your **covered services** – this plan, both of us, or just you? That depends.

The general rule

The schedule of benefits lists what you pay for each type of **covered service**. In general, this is how your benefit works:

- You pay the **deductible**, when it applies.
- Then the plan and you share the expense. Your share is called a **copayment** or **coinsurance**.
- Then the plan pays the entire expense after you reach your **maximum out-of-pocket limit**.

When we say “expense” in this general rule, we mean the **negotiated charge** for a **network provider**, and **allowable amount** for an **out-of-network provider**.

Negotiated charge

For health coverage:

This is the amount a **network provider** has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid).

We may enter into arrangements with **network providers** or others related to:

- The coordination of care for members
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing
- Accountable care arrangements

These arrangements will not change the **negotiated charge** under this plan.

For prescription drug services:

When you get a **prescription** drug, we have agreed to this amount for the **prescription** or paid this amount to the network pharmacy or third party vendor that provided it. The **negotiated charge** may include a rebate, additional service or risk charges and administrative fees. It may include additional amounts paid to or received from third parties under price guarantees.

Allowable amount

This is the amount of an **out-of-network provider’s** charge that is eligible for coverage. You are responsible for all charges above this amount. The **allowable amount** depends on the geographic area where you get the service or supply.

Allowable amount doesn’t apply to involuntary services. These are services or supplies that are:

- Provided at a network facility by an **out-of-network provider**
- Not available from a **network provider**
- An **emergency service**

We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**. See the *Surprise bill* section for more information on some of these services.

The table below shows the method for calculating the **allowable amount** for specific services or supplies:

Service or supply:	Allowable amount is based on:
Professional services and other services or supplies not mentioned below	Reasonable amount rate
Services of hospitals and other facilities	Reasonable amount rate
Prescription drugs	110% of average wholesale price (AWP)

Important note:

See *Special terms used* below, for a description of what the **allowable amount** is based on.

If the **provider** bills less than the amount calculated using a method above, the **allowable amount** is what the **provider** bills.

If your ID card displays the National Advantage Program (NAP) logo, your cost share may be lower when you get care from a NAP **provider**. These are **out-of-network providers** and third party vendors who have contracts with us but are not **network providers**. When you get care from a NAP **provider**, your out-of-network cost share applies. Contact us or the policyholder for more information.

Special terms used:

- Average wholesale price (AWP) is the current average wholesale price of a **prescription** drug as listed in the Facts & Comparisons®, Medi-Span daily price updates or any other similar publication we choose to use.
- Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific **provider** performance. We update our system with revised rates within 180 days of receiving them from CMS. If Medicare doesn't have a rate, we use one or more of the items below to determine the rate for a service or supply:
 - The method CMS uses to set Medicare rates
 - How much other **providers** charge or accept as payment
 - How much work it takes to perform a service
 - Other things as needed to decide what rate is reasonable

We may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) programs
- Our rate may exclude other payments that CMS may make directly to **hospitals** or other **providers** and backdated adjustments
- For anesthesia, our rate may be at least 100% of the rate CMS establishes
- For lab, our rate may be 75% of the rate CMS establishes
- For DME, our rate may be 75% of the rate CMS establishes
- For medications that are paid as a medical benefit instead of a pharmacy benefit, our rate may be 100% of the rates CMS establishes

When the **allowable amount** is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to **providers** under Medicare programs.

Reasonable amount rate means your plan has established a rate amount as follows:

Service or supply:	Reasonable amount rate is:
Professional services	The percentile value reported in a database prepared by FAIR Health
Inpatient and outpatient hospital charges	200% of Medicare allowed rate

Service or supply:	Reasonable amount rate is:
Inpatient and outpatient charges that are not from a hospital	200% of Medicare allowed rate

Our reimbursement policies

We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the **allowable amount**. When we do this, we consider:

- The length and difficulty of a service
- Whether additional expenses are needed, when multiple procedures are billed at the same time
- Whether an assistant surgeon is needed
- If follow up care is included
- Whether other conditions change or make a service unique
- Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
- The educational level, licensure or length of training of the **provider**

We base our reimbursement policies on our review of:

- CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and aren't appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in relevant clinical areas

We use commercial software to administer some of these policies. Policies may differ for professional services and facility services.

These reimbursement policies will comply with Virginia state law.

Get the most from your benefits:

We have online tools to help you decide whether to get care and if so, where. Log in to your member website. The website contains additional information that can help you determine the cost of a service or supply.

Balance billing protection for out-of-network services

You are protected from balance billing by an **out-of-network provider** for certain services.

Surprise bill

There may be times when you receive **emergency services** and treatment to stabilize or services after stabilization from an **out-of-network provider**, even when you try to stay in the network for your **covered services**. You may get a bill at the out-of-network rate that you didn't expect. This is called a surprise bill.

An **out-of-network provider** can't balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirement, such as **deductibles**, **copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider** and ancillary services initiated from your **emergency services**
- Non-emergency surgical or ancillary services provided by an **out-of-network provider** at an in-network facility
- Out-of-network air ambulance services

Surgical or ancillary services mean any professional services including:

- Items and services related to emergency medicine

- Surgery
- Anesthesiology
- Hospitalist services
- Laboratory services
- Neonatology
- Pathology
- Radiology
- Services provided by an **out-of-network provider** because there was no **network provider** available to perform the service

A facility in this section means an institution providing health care related services, or a health care setting. This includes the following:

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory, and imaging centers
- Rehabilitation facilities
- Other therapeutic health settings

A surprise bill claim is paid based on the median contracted rate for all plans offered by us in the same insurance market for the same or similar item or service that is all of the following:

- A commercially reasonable amount
- Provided by a **provider** in the same or similar specialty or facility of the same or similar facility type
- Provided in the geographic region in which the item or service is furnished

The median contracted rate is subject to additional adjustments as specified in federal regulations.

Any cost share paid with respect to the items and services will apply toward your in-network **deductible** and **maximum out-of-pocket limit** if you have one.

You may request external review if you want to know if the federal surprise bill law applies to your situation.

If you are billed an amount that exceeds your payment responsibility stated on your explanation of benefits or you believe you've been wrongly billed, you can call the federal agencies responsible for enforcing the federal balance billing protection law at: 1-800-985-3059 and/or file a complaint with the State Corporation Commission's Virginia Bureau of Insurance at <https://scc.virginia.gov/pages/File-Complaint-Consumers> or call 1-877-310-6560.

If you receive a surprise bill or have any questions about what a surprise bill is, contact us.

Paying for covered services – the general requirements

There are several general requirements for the plan to pay any part of the expense for a **covered service**. For in-network coverage, they are:

- The service is **medically necessary**
- You get your care from a **network provider**
- You or your **provider precertifies** the service when required

For out-of-network coverage:

- The service is **medically necessary**
- You get your care from an **out-of-network provider**
- You or your **provider precertifies** the service when required

For outpatient **prescription** drugs, your costs are based on:

- The type of **prescription** you're prescribed
- Where you fill the **prescription**

The plan may make some **brand-name prescription drugs** available to you at the **generic prescription drug** cost share.

Generally, your plan and you share the cost for **covered services** when you meet the general requirements. But sometimes your plan will pay the entire expense, and sometimes you will. For details, see your schedule of benefits and the information below.

You pay the entire expense when:

- You get services or supplies that are not **medically necessary**.
- Your plan requires **precertification**, your **physician** requests it, we deny it and you get the services without **precertification**.
- You get care and the **provider** waives all or part of your cost share.

In all these cases, the **provider** may require you to pay the entire charge. Any amount you pay will not count towards your **deductible** or your **maximum out-of-pocket limit**.

Where your schedule of benefits fits in

The schedule of benefits shows any out-of-pocket costs you are responsible for when you receive **covered services** and any benefit limitations that apply to your plan. It also shows any **maximum out-of-pocket limits** that apply.

Limitations include things like maximum age, visits, days, hours, and admissions. Out-of-pocket costs include things like **deductibles**, **copayments** and **coinsurance**.

Keep in mind that you are responsible for paying your part of the cost sharing. You are also responsible for costs not covered under this plan.

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work with your other plan to decide how much each plan pays. This is called coordination of benefits (COB).

Key Terms

Here are some key terms we use in this section. These will help you understand this COB section.

Allowable expense means a health care expense that any of your health plans cover.

In this section when we talk about “plan” through which you may have other coverage for health care expenses we mean:

- Group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- Medicare or other government benefits
- Any group health insurance contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

How COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
 - We pay benefits after the primary plan and coordinate our payment based on any amount the primary plan paid.
 - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
 - Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
 - The amount that the secondary plan saved due to COB
 - Used to cover any unpaid allowable expenses
 - Erased at the end of the year

Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information. A plan that does not contain a COB provision is always the primary plan.

COB rule	Primary Plan	Secondary plan
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together	<ul style="list-style-type: none"> • Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent’s plan if there is no court order 	<ul style="list-style-type: none"> • Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent’s plan
Child – covered by individuals who are not parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent

COB rule	Primary Plan	Secondary plan
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

How COB works with Medicare

If your other coverage is under Medicare, federal laws explain whether Medicare will pay first or second. COB with Medicare will always follow federal requirements. Contact us if you have any questions about this.

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. If you are eligible due to age but not covered, and Medicare would be your primary payer, we may still pay as if you are covered by Medicare and coordinate with the benefits Medicare would have paid. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered.

You are eligible for Medicare if you are covered under it. You are also eligible for Medicare even if you are not covered or if you refused it, dropped it, or didn't make a request for it.

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. Your current and prior plan must be offered through the same policyholder.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

Our rights

We have the right to:

- Release or obtain any information we need for COB purposes, including information we need to recover any payments from your other health plans
- Reimburse another health plan that paid a benefit we should have paid
- Recover any excess payment from a person or another health plan, if we paid more than we should have paid

Benefit payments and claims

A claim is a request for payment that you or your health care **provider** submits to us when you want or get **covered services**. There are different types of claims. You or your **provider** may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

It is important that you carefully read the previous sections within *How your plan works*. When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have

to tell you about our decision on a claim depends on the type of claim.

Claim type and timeframes

Urgent care claim

An urgent claim is one for which the doctor treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 72 hours. We will make a decision within 24 hours for appeals that related to a **prescription** to alleviate cancer pain.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. We will make a decision within 15 days.

Post-service claim

A post-service claim is a claim that involves health care services you have already received. We will make a decision within 30 days.

Concurrent care claim extension

A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

Concurrent care claim reduction or termination

A concurrent care claim reduction or termination occur when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an independent review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as **copayments**, **coinsurance** and **deductibles** that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

Filing a claim

This section will give you instruction on filing a claim that is not subject to surprise bill protection. All surprise bill claims will be paid in 30 days. See *Surprise bill* provision.

When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider** must send us the bill within 15 months of the date you received services, unless you are legally unable to notify us. You must send it to us with a claim form. Please see the *Claim forms* section for more information. You should always keep your own record of the date, **providers** and cost of your services.

The benefit payment determination is made based on many things, such as your **deductible** or **coinsurance**, the **medical necessity** of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your **provider** for some more information to make a final

decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. In no event will benefits be paid later than 60 days after we receive the proof of loss. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions, and appeal procedures* section for that information.

Claim forms

You are required to submit a claim form to us in writing. Claim forms will be furnished by us within 15 days of notification of the claim. If we fail to provide a claim form within 15 days of notification of a claim, proof of loss will be met by giving us a written statement of the nature and extent of the loss within the time limit in the *Proof of loss* section.

Notice of claim

You must give us written notice of claim within 20 days after you have incurred expenses for **covered services**. If you don't notify us within that time and can show that it was not reasonably possible to do so, we won't void or reduce your claim. But you must send us notice as soon as reasonably possible.

Proof of loss

You should give us written proof of loss no later than 90 days after you have incurred expenses for **covered services**. We won't void or reduce your claim if it was not reasonably possible to send us proof of loss within the required time. But you must send us the proof as soon as reasonably possible. Proof of loss may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

Appeal

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

Claim decisions and appeal procedures

Your **provider** may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in *Benefit payments and claims* in the *How your plan works* section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an “adverse benefit determination” or “adverse decision.” For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don’t agree, you can also appeal that decision. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an independent review.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves. We will give you an answer within 72 hours of receipt of your concurrent claim appeal.

Any other claim appeal

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

- Your name
- The plan sponsor’s name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 calendar days for a post-service claim.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us you are allowing someone to appeal for you. You can get this form on your member website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

At your last available level of appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision. This decision is called the final adverse benefit determination. You can respond to the information before we tell you what our final decision is.

Prescription drug exception request

See the *Medical necessity, referral, and precertification requirements* section for information on requesting and gaining access to clinically appropriate **prescription drugs** that are not covered under this policy.

Exhaustion of appeal process

In most situations, you must complete the two levels of appeal with us before you can take these other actions:

- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding

Sometimes you do not have to complete the two levels of appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment, or a claim that involves treatment of cancer. You can have your claim reviewed internally and through the external review process at the same time.
- We did not follow all of the claim determination and appeal requirements of Virginia. But you will not be able to proceed directly to external review if:
 - The rule violation was minor and not likely to influence a decision or harm you
 - The violation was for a good cause or beyond our control
 - The violation was part of an ongoing, good faith exchange between you and us; or
 - You filed an appeal and did not receive a written decision within 30 days unless you requested or agreed to a delay.

The Virginia Bureau of Insurance is also available to help you at any time during the appeal process. You are not required to complete the appeal process with us before you contact them. See the *Managed Care Ombudsman* section below for additional information.

External review

External review is a review done by people in an organization outside of Aetna. This is called an independent review organization (IRO).

You have a right to external review only if all the following conditions are met:

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental, investigational, or proven**
- You have exhausted the internal appeal process (in most cases)

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the request for external review form at the final adverse determination level.

You must submit the request for external review form:

- To the Virginia Bureau of Insurance
- Within 120 calendar days of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

You will pay the postage and/or delivery fees for any information that you send and want reviewed by the IRO. We will pay for information we send to the IRO plus the cost of the review.

The Virginia Bureau of Insurance will contact the IRO that will conduct the review of your claim.

The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the IRO makes.

How long will it take to get an IRO decision?

We will give you the IRO decision not more than 45 calendar days after we receive your notice of external review form with all the information you need to send in.

Sometimes you can get a faster external review decision. Your **provider** must submit a request for external review form to the Virginia Bureau of Insurance.

There are two scenarios when you may be able to get a faster external review:

For initial adverse benefit determinations

- Your treatment is for cancer or your **provider** tells the Virginia Bureau of Insurance a delay in receiving health care services for your medical condition would:
 - Jeopardize your life, health or ability to regain maximum function

- Be much less effective if not started right away (in the case of **experimental or investigational** treatment)

For final adverse determinations

Your treatment is for cancer or your **provider** tells the Virginia Bureau of Insurance a delay in receiving health care services for your medical condition would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment), or
- The final adverse determination concerns an admission, availability of care, continued **stay** or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of the IRO's receipt of the request.

Managed Care Ombudsman

If you have any questions regarding an appeal which have not been satisfactorily addressed by us, you may contact the Office of the Managed Care Ombudsman for assistance.

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157

Toll-free: (877) 310-6560
Richmond Metropolitan Area: (804) 371-9741
Email: ombudsman@scc.virginia.gov

Virginia Department of Health, Office of Licensure and Certification

Your or your **provider** can contact the Office of Licensure and Certification to file a complaint regarding quality of care, choice and accessibility of **providers**, or network adequacy. The contact information is shown below:

Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Richmond, VA 23233-1463

Toll-free: (800) 955-1819
Richmond Metropolitan Area: (804) 367-2104
E-mail: OLC-Complaints@vdh.virginia.gov
Fax: (804) 527-4503

Utilization review

Prescription drugs covered under this plan are subject to misuse, waste or abuse utilization review by us, your **provider** or your network pharmacy. The outcome of the review may include:

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

The policyholder decides and tells us who is eligible for health coverage.

When you can join the plan

You must live or work in the service area to enroll in this plan.

You can enroll:

- At the end of any waiting period the policyholder requires
- Once each year during the annual enrollment period
- At other special times during the year (see the *Special times you can join the plan* section below)

You can enroll eligible family members (these are your “dependents”) at this time too.

If you don’t enroll when you first qualify for benefits, you may have to wait until the next annual enrollment period to join.

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Your domestic partner who meets policyholder rules and requirements under state law
- Dependent children – yours or your spouse’s or partner’s
 - Dependent children must be:
 - Under 26 years of age
 - Dependent children include:
 - Natural children
 - Stepchildren
 - Adopted children including those placed with you for adoption
 - Foster children
 - Children you are responsible for under a qualified medical support order or court order
 - Grandchildren in your legal custody

Adding new dependents

You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage or domestic partnership
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 31 days after the event date.

Special times you can join the plan

You can enroll in these situations:

- You didn't enroll before because you had other coverage and that coverage has ended
-

- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan
- When your dependent moves outside the service area for your employee plan

We must receive the completed enrollment information within 31 days of the date when coverage ends.

You can also enroll in these situations:

- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You are now eligible for state premium assistance under Medicaid or S-CHIP which will pay your premium contribution under this plan

We must receive the completed enrollment information within 60 days of the date when coverage ends.

Notification of change in status

Tell us of any changes that may affect your benefits. Please contact us as soon as possible when you have a:

- Change of address
- Dependent status change
- Dependent who enrolls in Medicare or any other health plan

Starting coverage

Your coverage under this plan has a start and an end. You must start coverage after you complete the eligibility and enrollment process. You can ask your policyholder to confirm your effective date.

Stopping coverage

Your coverage typically ends when you leave your job; but it can happen for other reasons. Ending coverage doesn't always mean you lose coverage with us. There will be circumstances that will still allow you to continue coverage. See the *Special coverage options after your coverage ends* section.

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends.

When will your coverage end

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The policyholder asks to end coverage
- You are no longer eligible for coverage
- Your work ends
- You stop making required contributions, if any apply
- We end your coverage as described under the *Why would we end your coverage* section.
- You start coverage under another medical plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage.
- You stop making premium contributions, if any apply.
- Your coverage ends for any of the reasons listed above except:
 - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.
- The date this plan no longer allows coverage for domestic partners.

- The date the domestic partnership ends.
 - You will need to complete a Declaration of Termination of Domestic Partnership.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your coverage ends* section for more information.

Why would we end your coverage?

We may end your coverage if you act in a way that affects our business operations. We will give you 30 days notice in writing if we end your coverage for any of these reasons.

We will give you a 31 day advance notice if we end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

On the date your coverage ends, we will refund to your employer any prepayment for periods after the date your coverage ended.

Special coverage options after your coverage ends

When coverage may continue under the plan

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have. Contact the policyholder to see what options apply to you.

In some cases, premium payment is required for coverage to continue. Your coverage will continue under the plan as long as the policyholder and we have agreed to do so. It is the policyholder responsibility to let us know when your work ends. If the policyholder and we agree in writing, we will extend the limits.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The federal COBRA law usually applies to employers of group sizes of 20 or more and gives employees and most of their covered dependents the right to keep their health coverage for 18, 29 or 36 months after a qualifying event. The qualifying event is something that happens that results in you losing your coverage.

The qualifying events are:

- Your active employment ends for reasons other than gross misconduct
- Your working hours are reduced
- You divorce or legally separate and are no longer responsible for dependent coverage
- You become entitled to benefits under Medicare
- Your covered dependent children no longer qualify as dependents under the plan
- You die
- You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy

Talk with your employer if you have questions about COBRA or to enroll.

Continuation of coverage

If your coverage ends under this plan, you can continue coverage for yourself and your covered dependents if:

- Your employer is not required to offer COBRA coverage
 - You are not eligible for Medicare
 - You are not eligible for any other replacement group coverage
 - You are not eligible for or have benefits available under another health care plan
 - You have had 3 months of continuous coverage prior to your termination
-

- Your employer did not end your employment because of gross misconduct, as determined by your employer and Virginia law

To continue coverage, you must:

- Apply through your employer's normal process
- Pay the required premium within 31 days of the written notice from your employer (but no later than 60 days following the date of the termination of your coverage)

Evidence of insurability is not required for you to continue coverage.

The premium will be the current premium rate for the policy. Your employer may charge an administrative fee of no more than 2.0% of the current rate.

You can continue your coverage for 12 months. Each premium must be paid on a monthly basis during the 12-month period.

Extension of coverage for other reasons

How you can extend coverage if you are totally disabled when coverage ends

Your coverage may be extended if you are totally disabled when coverage ends. You are "totally disabled" if you cannot work at your occupation or any other occupation for pay or profit.

Your covered dependent is "totally disabled" if they can't engage in most normal activities like a healthy person of the same age and gender.

You may extend coverage until the earliest of:

- When you or your dependent are no longer totally disabled
- When you become covered by another health benefits plan
- 12 months of coverage

How you can extend coverage for your disabled child beyond the plan age limits

You have the right to extend coverage for your dependent child beyond plan age limits, if the child is not able to be self-supporting because of intellectual or physical disability and depends mainly on you for support.

Proof of incapacity and dependency must be furnished to us within 31 days of the child's attainment of the specified age.

Subsequent proof may be required but not more frequently than annually after the 2-year period following the child's attainment of the specified age.

How you can extend coverage when getting inpatient care when coverage ends

Your coverage may be extended if you are getting inpatient care in a **hospital** or **skilled nursing facility** when coverage ends.

Benefits are extended for the condition that caused the **hospital** or **skilled nursing facility stay** or for complications from the condition. Benefits aren't extended for other medical conditions.

You can continue to get care for this condition until the earliest of:

- When you are discharged
 - When you no longer need inpatient care
 - When you become covered by another health benefits plan
 - 12 months of coverage
-

How you can extend coverage for hearing services and supplies when coverage ends

If you are not totally disabled when your coverage ends, coverage for hearing services and supplies may be extended for 30 days after your coverage ends:

- If the **prescription** for the hearing aid is written during the 30 days before your coverage ends
- If the hearing aid is ordered during the 30 days before your coverage ends

How you can extend coverage for your child in college on medical leave

You have the right to extend coverage for your dependent college student who takes a medically necessary leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins
- The date coverage would otherwise end

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious illness or injury
- Cause the dependent child to lose status as a full-time student under the plan
- Be certified by the treating **physician** as medically necessary due to serious illness or injury

The **physician** treating your child will be asked to keep us informed of any changes.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this certificate

We prepared this certificate according to ERISA and other federal and state laws that apply. You and we will interpret it according to these laws. Our interpretation of this certificate applies when we administer your coverage. But you have the right to appeal our decisions as described in the *Complaints, claim decisions and appeal procedures* section.

How we administer this plan

We administer this plan to comply with all applicable laws and regulations. We also apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. Even **network providers** are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the group policy. This document may have amendments and riders too. Under certain circumstances, we, the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive **precertification**, **prescription** quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the policyholder or **provider**, can do this.

Physical examination

At our expense, we have the right to have a **physician** of our choice examine you. This will be done at reasonable times while a claim is pending.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim. Important things to keep are:

- Names of **physicians** and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional misrepresentation

Honest mistakes

You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years from the date of the group policy.

Intentional misrepresentation

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Rescission of coverage
-

- Denial of benefits
- Recovery of amounts we already paid

You have special rights if we rescind your coverage:

- We will give you 30 days advance written notice of any rescission of coverage and the notice will:
 - Identify the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact
 - Explain why the act, practice, or omission was fraud, an omission or an intentional misrepresentation of a material fact
 - advise you, or your authorized representative, of your right to an **Aetna** appeal
 - describe our internal appeal process, including any applicable time limits
 - provide the date the advance notice ends, and the day back to which coverage is lost
- We will refund all premiums you paid

See the *Complaints, claim decisions and appeal procedures* section for information on how to submit an appeal.

Some other money issues

Legal action

You cannot take any action until 60 days after we receive written proof of loss.

No legal action can be brought to recover payment under any benefit after 3 years from the date written proof of loss was required to be filed. See the *Proof of loss* section.

Assignment of benefits

When you see a **network provider**, they will usually bill us directly. When you see an **out-of-network provider**, we may choose to pay you or to pay the **provider** directly. If services are related to balance billing protection, we will always pay the **out-of-network provider** and not require an assignment of benefits. If we pay you, you are responsible for applying any payment to the claim from the **out-of-network provider**. Except for dental, oral surgery or ambulance services, to the extent allowed by law, we will not accept an assignment to an **out-of-network provider**.

Member cost share paid by a third party

We will apply amounts paid on your behalf toward your member cost share or maximum out-of-pocket limit.

Payment of benefits

All benefits are payable to you. Or we will pay your beneficiary designated by you. If any **covered services** are payable to either:

- Your estate, or
- A person who is a minor or otherwise not competent to give a valid release

We may pay up to \$5,000 to a person related to you by blood or marriage that we believe is fairly entitled to the benefits.

We may also pay all or any portion of the benefits to the provider who performed the services.

Financial sanctions exclusions

If coverage provided under this certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **covered services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting <https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Grace period

You have a grace period of 31 days after the due date to pay your contribution for coverage under the plan, except the first contribution. Your coverage will remain in force during the grace period. If you haven't paid your contribution by the end of the grace period, we will end your coverage at the end of the grace period.

Premium contribution

Your plan requires that the policyholder make premium contribution payments. After the expiration of the grace period, we will not pay for benefits if premium contributions are not made. Any decision to not pay benefits can be appealed.

Recovery of overpayments

We sometimes pay too much for **covered services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid, you or your **provider**, to return what we paid. If we don't do that, we have the right to reduce any future benefit payments by the amount we paid by mistake.

Your health information

We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just contact us.

When you accept coverage under this plan, you agree to let your **providers** share information with us. We need information about your physical and mental condition and care.

Effect of benefits under other plans**Health Maintenance Organization (HMO) plan**

If you are eligible for and enrolled in coverage under an HMO plan offered by the policyholder, you will not have coverage under this plan on the date that your HMO plan coverage starts. If you are pregnant when you change plans, you may be eligible for an extension of benefits. Contact us for more information.

Glossary

Allowable amount

See *How your plan works – What the plan pays and what you pay*.

Behavioral health provider

A **health professional** who is licensed or certified to provide **covered services** for mental health and **substance use disorders** in the state where the person practices.

Brand-name prescription drug

An FDA-approved drug marketed with a specific name or trademark name by the company that manufactures it; often the same company that developed and patents it.

Coinsurance

This is the percentage of **covered services** you pay after your **deductible**.

Copay, copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit. In **prescription** drug plans, it is the amount you pay for covered drugs.

Covered service

The benefits, subject to varying cost shares, covered under the plan. These are:

- Described in the *Providing covered services* section
- Not listed as an exclusion in the *Coverage and exclusions – Providing covered services* section or the *General plan exclusions* section
- Not beyond any limits in the schedule of benefits
- **Medically necessary**. See the *How your plan works – Medical necessity and precertification requirements* section and the *Glossary* for more information

Deductible

A **deductible** is the amount you pay out-of-pocket for **covered services** per year before we start to pay.

Detoxification

The process of getting alcohol or other drugs out of an addicted person's system and getting them physically stable.

Drug guide

A list of **prescription** and OTC drugs and devices established by us or an affiliate. It does not include all **prescription** and OTC drugs and devices. This list can be reviewed and changed by us or an affiliate. A copy is available at your request. Go to <https://www.aetna.com/individuals-families/find-a-medication.html>

Emergency medical condition

Regardless of the final diagnosis rendered to you, a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that:

- Needs immediate medical care
 - Leads a prudent layperson with average knowledge of health and medicine to reasonably believe that, without immediate medical care, it could result in:
-

- Danger to physical or mental health
- Danger of serious impairment to bodily function
- Serious dysfunction to any bodily part or organ, or
- In the case of a pregnant woman, danger to the health of an unborn baby

Emergency services

A medical screening examination, including ancillary services, given in a **hospital's** emergency room or an independent freestanding emergency department to evaluate an **emergency medical condition**. This includes any further medical examination evaluation of and treatment to stabilize the patient. **Emergency services** also include behavioral health assessments and routine ancillary services by a behavioral health crisis service provider to evaluate, treat, or prevent a patient's condition from deteriorating.

An independent freestanding emergency department means a health care facility that is geographically separate, distinct, and licensed separately from a **hospital** and provides **emergency services**.

Stabilize means providing treatment to assure the condition will not get worse as a result of, or during, the transfer of the individual from a facility. For a pregnant woman, stabilize also means that the woman has delivered, including the placenta.

Experimental, investigational, or unproven

A drug, device, procedure, supply, treatment, test, or technology is considered by us to be **experimental, investigational, or unproven** if any of the following apply:

- It hasn't been shown through well-conducted clinical trials or cohort studies published in peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which it's meant.
 - A well-conducted clinical trial means a randomized, controlled trial where the experimental intervention is compared to a control group receiving care according to best practice and study participants are randomly assigned to the experimental or control group.
 - A well-conducted cohort study means a prospective cohort study from more than one institution where the experimental intervention is compared to a group of subjects receiving care according to best practice and where the comparison group is well matched to the experimental intervention group.
- There isn't FDA approval or clearance to market it for the proposed use.
- A national medical society, dental society, or regulatory agency has written that it's **experimental, investigational, or unproven**, or mainly for research purposes.
- It's the subject of a Phase I, Phase II, or the experimental or research arm of a Phase III clinical trial. The FDA and Department of Health and Human Services define these.
- Written procedures or consent form used by a facility **provider** says it's **experimental, investigational, or unproven**.

Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product, that is considered to be as effective as the brand-name product. It offers the same:

- Dosage
 - Safety
 - Strength
 - Quality
 - Performance
-

Health professional

A person who is authorized by law to provide health care services to the public; for example, **physicians**, nurses and physical therapists.

Home health care agency

An agency authorized by law to provide home health services, such as skilled nursing and other therapeutic services.

Hospital

An institution licensed as a **hospital** by applicable law and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can stay overnight for care. Or they can be treated and leave the same day. All **hospitals** must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

Jaw joint disorder

This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Mail order pharmacy

A pharmacy where **prescription** drugs are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most a covered person will pay per year in **copayments**, **coinsurance** and **deductible**, if any, for **covered services**.

Medically necessary, medical necessity

Health care services or supplies that prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are all of the following, as determined by us within our discretion:

- In accordance with “generally accepted standards of medical practice”
- Clinically appropriate, in terms of type, frequency, extent, duration, and considered effective for your illness, injury or disease
- Not primarily for your convenience, the convenience of your **physician**, or other health care **provider**

Generally accepted standards of medical practice mean:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and
- Following the standards set forth in our clinical policies and applying clinical judgment

Important note:

We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **medically necessary, experimental, investigational, or unproven**. They are subject to change. You can find these bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>. You can also contact us. See the *Contact us* section for how.

Mental health disorder

A **mental health disorder** as defined in the most recent edition of *Diagnostic and Statistical Manual of Mental Disorders (DSM)* of the American Psychiatric Association.

Morbid obesity/ morbidly obese

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
- The body mass index (BMI) is:
 - Equal to or greater than 35 kilograms per meter squared with a comorbidity or coexisting condition such as:
 - High blood pressure
 - A heart or lung condition
 - Sleep apnea, or
 - Diabetes
 - 40 kilograms per meter squared and no other severe medical conditions are present

Negotiated charge

See *How your plan works – What the plan pays and what you pay.*

Network pharmacy

A **retail pharmacy, mail order pharmacy** or **specialty pharmacy** that has contracted with us, an affiliate or a third-party vendor, to provide outpatient **prescription** drugs to you. **Network pharmacy** also includes an out-of-network pharmacy that agrees to accept payment at our contracted network level rates as payment in full. The out-of-network pharmacy or its intermediary must notify us in writing, by fax or otherwise, of their agreement.

Network provider

A **provider** listed in the directory for your plan. A NAP **provider** listed in the NAP directory is not a **network provider**.

Other health care

Other health care coverage is care you get from an **out-of-network provider** when you could not reasonably get services and supplies from an in-network **provider**.

Out-of-network provider

A **provider** who is not a **network provider**.

Partial hospitalization treatment

Clinical treatment at a minimum of 4 or more continuous hours per treatment day for **medically necessary** services provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental health disorder** or **substance use disorder** issue and may include:

- Group, individual or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Treatment includes intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of 3 or more continuous hours per day to individuals or group of individuals who are not admitted as inpatients.

Care is delivered according to accepted medical practice for the condition of the person.

Physician

A **health professional** trained and licensed to practice and prescribe medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy. Under some plans, a **physician** can also be a **primary care provider (PCP)**.

Precertification, precertify

Pre-approval that you or your **provider** receives from us before you receive certain **covered services**. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage.

Prescription

This is an instruction written by a **physician** or other **provider** that authorizes a patient to receive a service, supply, medicine or treatment.

Primary care provider (PCP)

A **provider** who:

- The directory lists as a **PCP**
- Is selected by you from the list of **PCPs** in the directory
- Supervises, coordinates and provides initial care and basic medical services to you
- Initiates **referrals** for **specialist** care, if required by the plan, and maintains continuity of patient care
- Shows in our records as your **PCP**

A **PCP** can be any of the following **providers**:

- General practitioner
- Family **physician**
- Internist
- Nurse practitioner or any other advanced practice registered nurse
- Physician assistant
- Pediatrician
- OB, GYN, and OB/GYN
- Medical group, primary care office, or another **provider** allowed by the plan

Provider

A **physician**, pharmacist, **health professional**, person, or facility, licensed or certified by law to provide health care services to you, including the following:

- Chiropractor
 - Optometrist
 - Optician
 - Professional counselor
-

- Psychologist
- Clinical social worker
- Podiatrist
- Physical therapist
- Chiropracist
- Clinical nurse specialist
- Audiologist
- Speech pathologist
- Certified nurse midwife, nurse practitioner, or any other advanced practice registered nurse
- Marriage and family therapist
- Athletic trainer when services are performed in an office setting
- Licensed acupuncturist

If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare.

Psychiatric hospital

An institution licensed or certified as a **psychiatric hospital** by applicable laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse or **mental health disorders** (including **substance use disorders**).

Residential treatment facility

An institution specifically licensed by applicable laws to provide residential treatment programs for **mental health disorders, substance use disorders**, or both. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following:

For residential treatment programs treating **mental health disorders**:

- A **behavioral health provider** must be actively on duty 24 hours/day for 7 days/week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For residential treatment programs treating **substance use disorders**:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a **physician**
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For **detoxification** programs within a residential setting:

- An R.N. must be onsite 24 hours/day for 7 days/week within a residential setting
 - Residential care must be provided under the direct supervision of a **physician**
-

Retail pharmacy

A community pharmacy that dispenses outpatient **prescription** drugs.

Room and board

A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, we will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable laws to provide skilled nursing care.

Skilled nursing facilities also include:

- Rehabilitation **hospitals**
- Portions of a rehabilitation **hospital**
- A **hospital** designated for skilled or rehabilitation services

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- Custodial care
- Ambulatory care
- Part-time care

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty prescription drug

An FDA-approved **prescription** drug that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:

- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

Specialty pharmacy

A pharmacy that fills **prescriptions** for specialty drugs.

Stay

A full-time inpatient confinement for which a **room and board** charge is made.

Substance use disorder

The use of drugs, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association

Substance use disorder

A **substance use disorder**, addictive disorder, or both, as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association

Surgery, surgical procedure

The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution
- Otherwise physically changing body tissues and organs

Telemedicine

A consultation between you and a **physician, specialist, behavioral health provider, or telemedicine provider** who is performing a clinical medical or behavioral health service by means of electronic communication, including remote patient monitoring services.

Remote patient monitoring services means the delivery of home health services using telecommunications technology, including:

- Monitoring clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data
- Medication adherence monitoring
- Interactive video conference with or without digital image upload

Terminal illness

A medical prognosis that you are not likely to live more than 12 months.

Walk-in clinic

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near or within a:

- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
 - Emergency room
 - **Hospital**
 - Outpatient department of a **hospital**
 - **Physician's** office
 - Urgent care facility
-

Aetna Life Insurance Company

Schedule of benefits

Active Officers Comprehensive Dental Insurance Plan

If this is an ERISA plan, you have certain rights under this plan. If the **policyholder** is a church group or a government group this may not apply. Please contact the **policyholder** for additional information.

Prepared for:

Policyholder:	Booz Allen Hamilton
Policyholder number:	
Schedule of benefits:	1A
Group policy effective date:	January 1, 2022
Plan name:	Active Officers Comprehensive Dental Plan
Plan effective date:	January 1, 2021
Plan issue date:	January 29, 2026
Plan revision effective date:	January 1, 2026

Underwritten by Aetna Life Insurance Company in the Commonwealth of Virginia



Schedule of benefits

This schedule of benefits lists the **eligible dental services, deductibles, coinsurance**, maximums, and any limits that apply to the services you get under this plan.

How to read your schedule of benefits

- The **deductibles** and **coinsurance** listed in the schedule of benefits below reflects the **deductibles** and **coinsurance** amounts under your plan.
- You must pay any **deductibles** and your part of the **coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- You must pay the full amount of any dental care services you get that is not a **covered benefit** or that exceed your **Calendar Year maximum** and **lifetime maximum**.
- This plan also has limits for some **covered benefits**. For example, these could be visit limits. See later in this schedule of benefits for more information about limits.

Important note:

All **covered benefits** are subject to a **Calendar Year deductible** and **coinsurance** unless otherwise noted in the schedule of benefits below.

How to contact us for help

We are here to answer your questions:

- Register and log onto our self-service website available 24/7 at <https://www.aetna.com/>
- Call us at 1-877-238-6200

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company's group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

General coverage provisions

This section explains the:

- Maximums

Calendar Year maximum

The most the plan will pay for **eligible dental services** incurred by any one covered person in a **Calendar Year** is called the **Calendar Year maximum**.

Specific dental care lifetime maximum

This is the most that this plan will pay for specific dental care treatment expenses incurred by any one covered person during their lifetime for **eligible dental services**.

Any expenses applied to satisfy a specific dental care **lifetime maximum** will not be applied to satisfy any **lifetime maximum**.

Your financial responsibility and determination of benefits provisions

Your financial responsibility for the cost of services is based on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment that occurs in more than one **Calendar Year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet-certificate.

Plan features

Coinsurance

The **coinsurance** listed below reflects the plan **coinsurance** percentage. This is the **coinsurance** amount that the plan pays. You are responsible for paying any remaining **coinsurance**.

Expenses	Coinsurance
Type A expenses	100%
Type B expenses	100%
Type C expenses	100%

Calendar Year maximum

Maximums	Amounts
Calendar Year maximum	\$1,500
Includes TMJ expenses	
Does not apply to oral surgery	

Specific dental care lifetime maximum

Eligible dental services	Maximum amounts
Temporomandibular joint dysfunction/disorder (TMJ)	\$2,000

Eligible dental services

Type A Expenses

- Oral exams once every 150 days
- Prophylaxis (limited to 2 per year)
- Topical application of sodium or stannous fluoride for persons under 19 years of age not to exceed one application every 150 days
- Sealants for permanent bicuspids and molars for persons under age 16 not to exceed one application in any 36 months
- Application of hydroxyapatite regeneration medicament - per tooth (1 application every 3 years)
- X-rays for diagnosis (Also other X-rays not to exceed one full mouth series in a 3-year period and one set of bitewings every 150 days)
- First installation of a space maintainer to replace any baby tooth which is lost prematurely
- Periodontal maintenance 4 per Calendar Year following active therapy

Type B Expenses

- Extractions (Non-Surgical)
 - Coronal Remnants (deciduous tooth)
 - Removal of erupted tooth or exposed root
- Fillings
- Removal of an indirect restoration on a natural tooth
- Repair or recementing of crowns, inlays, bridgework, or dentures
- General anesthetics given in connection with covered dental services
- Treatment of diseased periodontal structures
 - -Scaling and root planing
 - -Full mouth debridement
 - Clinical crown lengthening, hard tissue
- Endodontic treatment (This includes root canal therapy and Retreatment)
 - Anterior
 - Bicuspid
 - Molar
- Emergency palliative treatment
- First 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, subject to the *Replacement Rule*.
- Relining of dentures

Type C Expenses

- 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 (This includes inlays and crowns as abutments)
- Replacement of an existing removable denture or fixed bridgework by new fixed bridgework, or the adding of teeth to existing fixed bridgework, subject to the *Replacement Rule*.

Type D Expenses

- Non-surgical Temporomandibular joint dysfunction/disorder (TMJ)

Type E Expenses

- **Oral Surgery Expense**
 - Apicoectomy
 - Retrograde filling
 - Guided tissue regeneration
 - Injection of antibiotic drugs
- Coronectomy
- Osseous Surgery
- Gingival Flap
- Soft tissue graft

Important note:

The following apply:

- Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only:
 - As treatment for decay or acute traumatic **injury**.
 - When teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.
- There is an extra charge for **eligible dental services** that use high noble metals (ex. gold or titanium).
- General anesthesia and sedation are **covered benefits** when part of a covered surgical procedure.

Additional eligible dental services

We will provide additional **eligible dental services** if you have at least one of the following conditions:

- Pregnancy
- Coronary artery disease/cardiovascular disease
- Cerebrovascular disease
- Diabetes

The additional **eligible dental services** are:

- Prophylaxis (cleaning) (one additional per **Calendar Year**)
- Scaling and root planing, (4 or more teeth), per quadrant
- Scaling and root planing (limited to 1 to 3 teeth), per quadrant
- Full mouth debridement
- Periodontal maintenance

Payment of benefits

We will waive the **Calendar Year deductible** and **coinsurance** for the additional **eligible dental services** above.

The plan **coinsurance** applied to the additional **eligible dental services** will be:

Expense	Coinsurance
Additional eligible dental services	100%

Certificate of coverage

Prepared for:

Policyholder: Booz Allen Hamilton
Policyholder number:
Plan name: Open Choice - Retired Officers Plan
Booklet-certificate: 4
Group policy effective date: January 1, 2019
Plan effective date: January 1, 2022
Plan issue date: February 6, 2026
Plan revision effective date: January 1, 2026

Underwritten by Aetna Life Insurance Company



This certificate of coverage is made part of the group policy

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Schedule of benefits Issued with your certificate of coverage



Welcome

At Aetna®, your health goals lead the way, so we're joining you to put them first. We believe that whatever you decide to do for your health, you can do it with the right support. And no matter where you are on this personal journey, it's our job to enable you to feel the joy of achieving your best health.

Welcome to Aetna.

Introduction

This is your certificate of coverage or "certificate." It describes your **covered services** – what they are and how to get them. It also describes how we manage the plan, according to our policies, federal and state laws and regulations. The schedule of benefits tells you how we share expenses for **covered services** and explains any limits. Along with the group policy, they describe your Aetna plan. Each may have riders or amendments attached to them. These change or add to the document. This certificate takes the place of any others sent to you before.

It's really important that you read the entire certificate and your schedule of benefits.

If your coverage under any part of this plan replaces coverage under another plan, your coverage for benefits provided under the other coverage may reduce benefits paid by this plan. See the *Coordination of benefits - Effect of prior plan coverage* section.

We are regulated in Virginia by both the State Corporation Commission Bureau of Insurance under Title 38.2 of the Code of Virginia and the Virginia Department of Health under Title 32.1 of the Code of Virginia.

If you need help or more information, see the *Contact us* section below.

How we use words

When we use:

- "You" and "your", we mean you and any covered dependents (if your plan allows dependent coverage)
- "Us," "we," and "our", we mean Aetna Life Insurance Company (Aetna)
- Words that are in bold, these are defined in the *Glossary* section

Contact us – important information regarding your insurance

If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions about your plan, you can contact us by:

- Calling the toll-free number on your ID card
- Writing us at 151 Farmington Ave, Hartford, CT, 06156
- Visiting <https://www.aetna.com> to register and access your member website

Your member website is available 24/7. With your member website, you can:

- See your coverage, benefits and costs
- Print an ID card and various forms
- Find a **provider**, research **providers**, care and treatment options
- View and manage claims
- Find information on health and wellness

If you have been unable to contact or obtain satisfaction from us or the agent, you can contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
(804) 371-9741, local
(800) 552-7945, in-state toll-free number
(877) 310-6560, national toll-free number

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting us, the agent or the BOI, have your policy number available.

Your ID card

Show your ID card each time you get **covered services** from a **provider**. Only members on your plan can use your ID card. We will mail you your ID card. If you haven't received it before you need **covered services**, or if you lose it, you can print a temporary one using your member website.

Wellness and other rewards

You may be eligible to earn rewards for completing certain activities that improve your health, coverage, and experience with us. We may encourage you to access certain health services or categories of healthcare **providers**, participate in programs, including but not limited to financial wellness programs; utilize tools, improve your health metrics or continue participation as an Aetna member through incentives. Talk with your **provider** about these and see if they are right for you. We may provide incentives based on your participation and outcomes such as:

- Modifications to **copayment, deductible** or **coinsurance** amounts
- Contributions to a health savings account
- Merchandise
- Coupons
- Gift cards or debit cards
- Any combination of the above

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third-party service providers”. These third-party service providers may pay us so that they can offer you their services.

Third-party service providers are independent contractors. The third-party service provider is responsible for the goods or services they deliver. We are not responsible; but we have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third-party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

Coverage and exclusions

Providing covered services

Your plan provides **covered services**. These are:

- Described in this section
- Not listed as an exclusion in this section or the *General plan exclusions* section
- Not beyond any limits in the schedule of benefits
- **Medically necessary**. See the *How your plan works – Medical necessity and, precertification requirements* section and the *Glossary* for more information.
- Services that are not prohibited by law. See *Services not permitted by law in the General plan exclusions* section for more information.

For **covered services** under the outpatient **prescription** drug plan:

- You need a **prescription** from the prescribing **provider**
- You need to show your ID card to the **network pharmacy** when you get a **prescription** filled

This plan provides insurance coverage for many kinds of **covered services**, such as a doctor's care and **hospital stays**, but some services aren't covered at all or are limited. For other services, the plan pays more of the expense. For example:

- **Physician** care generally is covered but **physician** care for cosmetic **surgery** is an exclusion and not covered, except where described in *Coverage and exclusions* under the *Reconstructive breast surgery and supplies* and *Reconstructive surgery and supplies* sections.
- Home health care is generally covered but may only be covered up to a set number of visits per year. This is a limitation.
- Your **provider** may recommend services that considered **experimental, investigational, or unproven** services. But an **experimental, investigational, or unproven** service is not covered and is also an exclusion, unless it is recognized as part of an approved clinical trial when you have cancer or a **terminal illness**. See *Clinical trials* in the list of services below.
- Preventive services. Usually the plan pays more, and you pay less. Preventive services are designed to help keep you healthy, supporting you in achieving your best health. To find out what these services are, see the *Preventive care* section in the list of services below. To find out how much you will pay for these services, see *Preventive care* in your schedule of benefits.

Some services require **precertification** from us. For more information see the *How your plan works – Medical necessity and, precertification requirements* section.

The **covered services** and exclusions below appear alphabetically to make it easier to find what you're looking for. If a service isn't listed here as a **covered service** or is listed as not covered under a specific service, it still may be covered. If you have questions, ask your **provider** or contact us. You can find out about limitations for **covered services** in the schedule of benefits.

Abortion

Covered services include services provided and supplies used in connection with an abortion.

Acupuncture

Covered services include manual or electro acupuncture.

The following are not **covered services**:

- Acupressure
-

Ambulance services

An ambulance is a vehicle staffed by medical personnel and equipped to transport an ill or injured person.

Emergency

Covered services include emergency transport to a **hospital** by a licensed ambulance:

- To the first **hospital** to provide **emergency services**
- From one **hospital** to another if the first **hospital** can't provide the **emergency services** you need
- When your condition is unstable and requires medical supervision and rapid transport

Non-emergency

Covered services also include **precertified** transportation to a **hospital** by a licensed ambulance:

- From a **hospital** to your home or to another facility if an ambulance is the only safe way to transport you
- From your home to a **hospital** if an ambulance is the only safe way to transport you; 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 treatment

The following are not **covered services**:

- Ambulance services for routine transportation to receive outpatient or inpatient services

Applied behavior analysis

Covered services include applied behavior analysis for a diagnosis of autism spectrum disorder. Applied behavior analysis means the design, implementation and evaluation of environmental changes by applying interventions using behavioral stimuli and consequences that:

- Systematically change behavior
- Are responsible for observable improvements in behavior, including the use of:
 - Direct observation
 - Measurement
 - Functional analysis of the relationship between environment and behavior

Autism spectrum disorder

Autism spectrum disorder means any pervasive developmental disorder or autism spectrum disorder, as defined in the most recent edition or the most recent edition at the time of diagnosis of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) of the American Psychiatric Association. It includes:

- Autistic disorder
- Asperger's syndrome
- Rett's syndrome
- Childhood disintegrative disorder
- Pervasive developmental disorder not otherwise specified

Covered services include services and supplies provided by a **physician** or **behavioral health provider** for:

- The diagnosis and treatment of autism spectrum disorder
- Physical, occupational, and speech therapy associated with the diagnosis of autism spectrum disorder

We will cover treatment ordered by a **physician** or **behavioral health provider** as part of a treatment plan they develop:

- Following a complete evaluation or re-evaluation
 - In accordance with the most recent clinical report or recommendation on one of the following:
-

- American Academy of Pediatrics
- American Academy of Child and Adolescent Psychiatry.

The care within a treatment plan includes:

- Applied behavior analysis
- Behavioral health treatment
- Pharmacy care
- Psychiatric care
- Psychological care
- Therapeutic care

Medically necessary as used here means in accordance with the generally accepted standards of mental disorder or condition care and clinically appropriate in terms of type, frequency, site, and duration, based on evidence and reasonably expected to do any of the following:

- Prevent the onset of an illness, condition, injury or disability;
- Reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability; or
- Assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individual of the same age.

Behavioral health

Mental health treatment

Covered services include the treatment of **mental health disorders** provided by a **hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider** including:

- Inpatient **room and board** at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies related to your condition that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or residential treatment facility**, including:
 - Office visits to a **physician or behavioral health provider** such as a psychiatrist, psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
 - Individual, group, and family therapies for the treatment of **mental health disorders**
 - Other outpatient mental health treatment such as:
 - Mobile crisis response services when experiencing an acute mental health crisis. Mobile crisis response services in this section means services delivered to provide for rapid response to, assessment of, and early intervention when experiencing an acute mental health crisis that are deployed at the location of the individual who is experiencing an acute mental health crisis.
 - Short-term residential program or crisis receiving center providing behavioral crisis intervention and stabilization for observation and assessment of an acute mental health crisis to determine whether admission to an inpatient or outpatient setting is necessary.
 - Residential crisis stabilization unit in this section means a short-term residential program providing support and stabilization when experiencing an acute mental health crisis.
 - Crisis receiving center means a community-based facility licensed by the Department of Behavioral Health and Developmental Services to provide short term assessment, observation, and crisis stabilization services.

- **Partial hospitalization** treatment provided in a facility or program for mental health treatment provided under the direction of a **physician**
- Intensive outpatient program provided in a facility or program for mental health treatment provided under the direction of a **physician**
- Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
 - You are homebound
 - Your **physician** orders them
 - The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
- Electro-convulsive therapy (ECT)
- Transcranial magnetic stimulation (TMS)
- Psychological testing
- Neuropsychological testing
- Observation
- Peer counseling support by a peer support specialist (including telemedicine consultation)

Substance use disorders treatment

Covered services include the treatment of **substance use disorders** provided by a **hospital, psychiatric hospital, residential treatment facility, physician, or behavioral health provider** as follows:

- Inpatient **room and board**, at the **semi-private room rate** (your plan will cover the extra expense of a private room when appropriate because of your medical condition), and other services and supplies that are provided during your **stay** in a **hospital, psychiatric hospital, or residential treatment facility**.
- Outpatient treatment received while not confined as an inpatient in a **hospital, psychiatric hospital, or residential treatment facility**, including:
 - Office visits to a **physician** or **behavioral health provider** such as a psychologist, social worker, or licensed professional counselor (includes **telemedicine** consultation)
 - Individual, group, and family therapies for the treatment of **substance use disorders**
 - Other outpatient **substance use disorders** treatment such as:
 - Mobile crisis response services when experiencing an acute mental health crisis. Mobile crisis response services in this section means services delivered to provide for rapid response to, assessment of, and early intervention when experiencing an acute mental health crisis that are deployed at the location of the individual who is experiencing an acute mental health crisis.
 - Short-term residential program or crisis receiving center providing behavioral crisis intervention and stabilization for observation and assessment of an acute mental health crisis to determine whether admission to an inpatient or outpatient setting is necessary.
 - Residential crisis stabilization unit in this section means a short-term residential program providing support and stabilization when experiencing an acute mental health crisis.
 - Crisis receiving center means a community-based facility licensed by the Department of Behavioral Health and Developmental Services to provide short term assessment, observation, and crisis stabilization services.
 - **Partial hospitalization** treatment provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
 - Intensive outpatient program provided in a facility or program for treatment of **substance use disorders** provided under the direction of a **physician**
 - Skilled behavioral health services provided in the home, but only when all of the following criteria are met:
 - You are homebound

- Your **physician** orders them
- The services take the place of a **stay** in a **hospital** or a **residential treatment facility**, or you are unable to receive the same services outside your home
- Ambulatory or outpatient **detoxification** which includes outpatient services that monitor withdrawal from alcohol or other substances, including administration of medications
- Observation
- Peer counseling support by a peer support specialist (including **telemedicine** consultation)

Behavioral health important note:

A peer support specialist serves as a role model, mentor, coach, and advocate. A peer support specialist must be supervised by a **behavioral health provider**.

Clinical trials

Routine patient costs

Covered services include routine patient costs you have from a **provider** in connection with participation in an approved clinical trial as a qualified individual for cancer or other life-threatening disease or condition.

“Routine patient cost” means the cost of a health care service incurred as a result of treatment being provided to the covered person for purposes of a clinical trial.

“Life threatening condition” means any disease or condition from which death is likely unless the course of disease or condition is interrupted.

“Qualified individual” means a covered person who is eligible to participate in an approved clinical trial according to the trial protocol, with respect to treatment of cancer or other life-threatening disease or condition, and the referring health care professional has concluded that the individual’s participation in such trial is appropriate to treat the disease or condition, or the individual’s participation is based on medical and scientific information.

The following are not **covered services**:

- Services and supplies related to data collection and record-keeping needed only for the clinical trial
- Services and supplies provided by the trial sponsor for free
- Services that are clearly inconsistent with widely accepted and established standards of care for a particular diagnosis
- The experimental intervention itself (except Category B investigational devices and promising experimental or investigational interventions for **terminal illnesses** in certain clinical trials in accordance with our policies)

Experimental or investigational therapies

Covered services include drugs, devices, treatments, or procedures from a **provider** under an “approved clinical trial” only when you have cancer or other life-threatening disease or condition. All of the following conditions must be met:

- Standard therapies have not been effective or are not appropriate
- We determine you may benefit from the treatment

An approved clinical trial is a phase I, phase II, phase III or phase IV clinical trial conducted to prevent, detect, or treat cancer or other life-threatening disease or condition. It must meet all of these requirements:

- The clinical trial is a federally funded or approved trial

- The clinical trial is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration (FDA), or is a drug that is exempt from having an investigational new drug application

Dental anesthesia

Covered services include anesthesia and hospitalization or outpatient facility charges for dental care if:

- Your **provider** determines that you require general anesthesia and admission to a **hospital** or outpatient surgery center to effectively and safely provide the underlying dental care; and
- You are severely disabled; or
- You have a medical need for general anesthesia; or
- You are under 7 years of age.

For purposes of this review, a determination of **medical necessity** includes but is not limited to a consideration of whether your age, physical condition or mental condition requires the utilization of general anesthesia and the admission to a **hospital** or outpatient surgery center to safely provide the underlying dental care.

Diabetic services, supplies, equipment, and self-care programs

Covered services include:

- Services
 - Foot care to minimize the risk of infection
- Supplies
 - Injection devices including syringes, needles and pens
 - Test strips - blood glucose, ketone and urine
 - Blood glucose calibration liquid
 - Lancet devices and kits
 - Alcohol swabs
- Equipment
 - External insulin pumps and pump supplies
 - Blood glucose monitors without special features, unless required due to blindness
- Prescribed self-care programs with a health care **provider** certified in diabetes self-care training, including medical nutrition therapy

Durable medical equipment (DME)

Covered services are DME and the accessories needed to operate it when:

- Made to withstand prolonged use
- Mainly used in the treatment of illness or injury
- Suited for use in the home
- Not normally used by people who do not have an illness or injury
- Not for altering air quality or temperature
- Not for exercise or training

Your plan only covers the same type of DME that Medicare covers. But there are some DME items Medicare covers that your plan does not.

Covered services include the expense of renting or buying DME and accessories you need to operate the item from a DME supplier. If you purchase DME, that purchase is only covered if you need it for long-term use.

Covered services also include:

- One item of DME for the same or similar purpose
 - Repairing DME due to normal wear and tear
-

- A new DME item you need because your physical condition has changed
- Buying a new DME item to replace one that was damaged due to normal wear, if it would be cheaper than repairing it or renting a similar item

The following are not **covered services**:

- Communication aid
- Elevator
- Maintenance and repairs that result from misuse or abuse
- Massage table
- Message device (personal voice recorder)
- Over bed table
- Portable whirlpool pump
- Sauna bath
- Telephone alert system
- Vision aid
- Whirlpool

Emergency services

When you experience an **emergency medical condition**, you should go to the nearest emergency room. You can also dial 911 or your local emergency response service for medical and ambulance help.

Covered services include only outpatient services to evaluate and stabilize an **emergency medical condition** in a **hospital** emergency room or free-standing emergency department, including:

- Diagnostic x-ray
- Lab services
- Medical supplies
- Advanced diagnostic imaging, such as MRIs and CAT scans

Emergency services for behavioral health conditions may be obtained from a facility and staff credentialed to provide behavioral health crisis services. These services include the following when they are within the capabilities of the staff and facilities available at the behavioral health crisis **provider**:

- A behavioral health assessment, including ancillary services routinely available to evaluate an **emergency medical condition**, and
- Further examination and treatment as are required so that your condition does not deteriorate

You can get **emergency services** from network **providers** or **out-of-network providers**.

Your coverage for **emergency services** will continue until the following conditions are met:

- You are evaluated and your condition is stabilized
- Post-stabilization: Your attending **physician** determines that you are medically able to travel or be transported, by non-medical or non-emergency transportation, to another **provider** or facility located within a reasonable travel distance, taking into account your medical condition

If your **physician** decides you need to stay in the **hospital** (emergency admission) or receive follow-up care, these are not **emergency services**. Different benefits and requirements apply. See the *How your plan works – Medical necessity and precertification requirements* section and the *Coverage and exclusions* section that fits your situation (for example, *Hospital care* or *Physician services*). You can also contact us or your network **physician** or **primary care physician (PCP)**.

Non-emergency services

See the schedule of benefits for this information.

Gender affirming treatment

Covered services include certain services and supplies for gender affirming treatment.

Medically necessary transition-related services can include:

- Outpatient psychotherapy and mental health services for gender dysphoria and associated comorbid psychiatric diagnoses
- Continuous hormone replacement therapy
- Outpatient laboratory testing to monitor continuous hormone therapy
- Gender reassignment surgeries

Important note:

Visit <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html> for detailed information about this benefit, including eligibility and **medical necessity** requirements. You can also call the toll-free number on your ID card.

Habilitation therapy services

Habilitation therapy services are services needed to keep, learn or improve your skills and functioning for daily living (e.g., therapy for a child who isn't walking or talking at the expected age). The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a:

- Licensed or certified physical, occupational or speech therapist
- **Hospital, skilled nursing facility** or hospice facility
- **Home health care agency**
- **Physician**

Outpatient physical, occupational, and speech therapies

Covered services include:

- Physical therapy if it is expected to develop any impaired function
- Occupational therapy if it is expected to develop any impaired function
- Speech therapy if it is expected to develop speech function that resulted from delayed development (Speech function is the ability to express thoughts, speak words and form sentences.)

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Early intervention services

Early intervention services are available to children from birth to age 3. They are services that help a child develop, learn or keep skills to function age appropriately within their home or normal everyday settings and shall include services that enhance functional ability without effecting a cure. To receive services, your child must be certified by the Department of Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Education Act.

Covered services include:

- Speech and language therapy
 - Occupational therapy
 - Physical therapy
 - Assistive technology services and devices
-

Hearing aids for minors

Hearing aid means:

- Any wearable, non-disposable instrument or device designed or offered to aid or make up for impaired hearing
- Parts, attachments, or accessories, including earmolds, initial batteries, and other necessary equipment, maintenance, and adaptation training

Covered services for children 18 years of age or younger include services and equipment recommended by an otolaryngologist and provided by the following:

- A **physician** certified as an otolaryngologist, otologist or licensed hearing aid **provider**
- An audiologist who:
 - Is legally qualified in audiology
 - Holds a certificate of Clinical Competence in Audiology from the American Speech and Hearing Association in the absence of any licensing requirements
- Hearing aid installed in accordance with a **prescription** written
- Any other related services necessary to access, select, and adjust or fit a hearing aid

The following are not **covered services**:

- Replacement of a hearing aid that is lost, stolen, or damaged through neglect
- Batteries after the initial is provided or cords
- A hearing aid that does not meet the specifications prescribed for correction of hearing loss

Hearing exams

Covered services include hearing exams for evaluation and treatment of illness, injury or hearing loss when performed by a hearing **specialist**.

The following are not **covered services**:

- Hearing exams given during a **stay** in a **hospital** or other facility, except those provided to newborns as part of the overall **hospital stay**

Hemophilia and congenital bleeding disorders

Covered services for home treatment of routine bleeding episodes associated with hemophilia and other congenital disorders include:

- Blood infusion equipment, including but not limited to, syringes and needles
- Blood products, including but not limited to, Factor VII, Factor VIII, Factor IX and cryoprecipitate
- Training to provide infusion therapy at home

The home treatment must be supervised by a state-approved hemophilia treatment center.

Home health care

Covered services include home health care provided by a **home health care agency** in the home, but only when all of the following criteria are met:

- You are homebound
 - Your **physician** orders them
 - The services take the place of a **stay** in a **hospital** or a **skilled nursing facility**, or you are unable to receive the same services outside your home
 - The services are a part of a home health care plan
-

- The services are skilled nursing services, home health aide services or medical social services, or are short-term speech, physical or occupational therapy
- Home health aide services are provided under the supervision of a registered nurse
- Medical social services are provided by or supervised by a **physician** or social worker

Skilled nursing services are services provided by a registered nurse or licensed practical nurse within the scope of their license.

If you are discharged from a **hospital** or **skilled nursing facility** after a **stay**, the intermittent requirement may be waived to allow coverage for continuous skilled nursing services. See the schedule of benefits for more information on the intermittent requirement.

Short-term physical, speech, and occupational therapy provided in the home are subject to the same conditions and limitations imposed on therapy provided outside the home. See *Rehabilitation services* and *Habilitation therapy services* in this section and the schedule of benefits.

The following are not **covered services**:

- Custodial care
- Services provided outside of the home (such as in conjunction with school, vacation, work, or recreational activities)
- Transportation

Hospice care

Covered services include inpatient, outpatient, and home hospice care when given as part of a hospice care program. The types of hospice care services that are eligible for coverage include:

- **Room and board**
- Services and supplies furnished to you on an inpatient, outpatient, or home basis
- Services by a hospice care agency or hospice care provided in a **hospital**
- Psychological, psychosocial and dietary counseling
- Pain management and symptom control
- Bereavement counseling
- Respite and palliative care

Hospice care services provided by the **providers** below will be covered, even if the **providers** are not an employee of the hospice care agency responsible for your care:

- A **physician** for consultation or case management
- A physical or occupational therapist
- A **home health care agency** for:
 - Physical and occupational therapy
 - Medical supplies
 - Outpatient **prescription** drugs
 - Psychological and psychosocial counseling
 - Dietary counseling

The following are not **covered services**:

- Funeral arrangements
 - Pastoral counseling
 - Financial or legal counseling including estate planning and the drafting of a will
-

- Homemaker services, caretaker services, or any other services not solely related to your care, which may include:
 - Sitter or companion services for you or other family members
 - Transportation
 - Maintenance of the house

Hospital care

Covered services include inpatient and outpatient **hospital** care. This includes:

- Semi-private **room and board** (your plan will cover the extra expense of a private room when appropriate because of your medical condition)
- Services and supplies provided by the outpatient department of a **hospital**, including the facility charge
- Services of **physicians** employed by the **hospital**
- Administration of blood and blood products
- Services and supplies for a hysterectomy, for a minimum stay of not less than:
 - 23 hours following a laparoscopy-assisted vaginal hysterectomy
 - 48 hours following a vaginal hysterectomy
 A shorter inpatient stay will be allowed if the attending **provider** and you determine that a shorter length of stay is appropriate.

The following are not **covered services**:

- All services and supplies provided in:
 - Rest homes
 - Any place considered a person’s main residence or providing mainly custodial or rest care
 - Health resorts
 - Spas
 - Schools or camps

Infertility services

Basic infertility

Covered services include seeing a **provider**:

- To diagnose and evaluate the underlying medical cause of infertility.
- To do **surgery** to treat the underlying medical cause of infertility. Examples are endometriosis **surgery** or, for men, varicocele **surgery**.
- For artificial insemination, which includes intrauterine (IUI)/intracervical (ICI) insemination.

See the *Coverage and exclusions-Prescription drugs – outpatient* section for information on coverage of infertility **prescription** drugs.

Advanced reproductive technology (ART)

Advanced reproductive technology, also called “assisted reproductive technology”, is a more advanced type of infertility treatment.

Covered services include the following services provided by an ART **specialist**

- Ovulation induction cycle(s) using medication to stimulate the ovaries. This may include the use of ultrasound and lab tests.
- In vitro fertilization (IVF).
- Zygote intrafallopian transfer (ZIFT).
- Gamete intrafallopian transfer (GIFT).
- Cryopreserved (frozen) embryo transfers (FET).
- Charges associated with your care when you receive a donor egg or embryo in a donor IVF cycle. These

- services include culture and fertilization of the egg from the donor and transfer of the embryo into you.
- Charges associated with your care when using a gestational carrier including egg retrieval and culture and fertilization of your eggs that will be transferred into a gestational carrier. Services for the gestational carrier, including transfer of the embryo into the carrier, are not covered. (See exclusions, below.)

ART **covered services** may include either dollar or cycle limits. Your schedule of benefits will tell you which limits apply to your plan.

For plans with ovulation induction cycle limits, an ovulation induction cycle is defined as an attempt at ovulation induction while on medication to stimulate the ovaries with or without artificial insemination.

For plans with ART cycle limits, an ART “cycle” is defined as:

ART service	Procedure	Cycle count
IVF	One complete fresh cycle with transfer (egg retrieval, fertilization, and transfer of embryo)	One full cycle
IVF	One fresh cycle with attempted egg aspiration (with or without egg retrieval) but without transfer of embryo	One half cycle
IVF	Fertilization of egg and transfer of embryo	One half cycle
IVF	One cryopreserved (frozen) embryo transfer	One half cycle
GIFT	One complete cycle	One full cycle
ZIFT	One complete cycle	One full cycle

Aetna’s National Infertility Unit

Our National Infertility Unit (NIU) is here to help you. It is staffed by a dedicated team of registered nurses and infertility coordinators. They can help you with determining eligibility for benefits and **precertification**. They can also give you information about our infertility Institutes of Excellence™(IOE) facilities. You can call the NIU at 1-800-575-5999.

Your **network provider** will request approval from us in advance for your infertility services. If your **provider** is not a **network provider**, you are responsible to request approval from us in advance.

Fertility preservation

Fertility preservation involves the retrieval of mature eggs/sperm with or without the creation of embryos that are frozen for future use.

Covered services for fertility preservation are provided when:

- You are believed to be fertile
- You have planned medical services that are proven to result in infertility such as:
 - Chemotherapy or radiation therapy that is established in medical literature to result in infertility
 - Other gonadotoxic therapies
 - Removing the uterus
 - Removing both ovaries or testicles
- The eggs that will be retrieved for use are likely to result in a pregnancy by meeting the FSH level and ovarian responsiveness criteria outlined in Aetna’s infertility clinical policy

Premature ovarian insufficiency

If your infertility has been diagnosed as premature ovarian insufficiency (POI), as described in our clinical policy bulletin, you are eligible for ART services using donor eggs/embryos through age 45 regardless of FSH level.

Infertility services exclusions:

The following are not **covered services**:

- Cryopreservation (freezing) and storage of eggs, embryos, sperm, or reproductive tissue.
- Thawing of cryopreserved (frozen) eggs, sperm, or reproductive tissue.
- The donor's care in a donor egg cycle. This includes, but is not limited to, screening fees, lab test fees and charges associated with donor care as part of donor egg retrievals or transfers.
- A gestational carrier's care, including transfer of the embryo to the carrier. A gestational carrier is a woman who has a fertilized egg from another woman placed in her uterus and who carries the resulting pregnancy on behalf of another person.
- Infertility **medication** not injected by your **provider**, including but not limited to menotropins, hCG, and GnRH agonists. See the *Coverage and exclusions-Prescription drugs – outpatient* section for information on coverage of infertility **prescription** drugs for your plan.
- All charges associated with or in support of surrogacy arrangements for you or the surrogate. A surrogate is a female carrying her own genetically related child with the intention of the child being raised by someone else, including the biological father.
- Home ovulation prediction kits or home pregnancy tests.
- The purchase of donor embryos, donor eggs or donor sperm.
- Obtaining sperm from a person not covered under this plan.
- Infertility treatment when a successful pregnancy could have been obtained through less costly treatment.
- Infertility treatment when either partner has had voluntary sterilization **surgery**, with or without surgical reversal, regardless of post reversal results. This includes tubal ligation, hysterectomy and vasectomy only if obtained as a form of voluntary sterilization.
- Infertility treatment when infertility is due to a natural physiologic process such as age related ovarian insufficiency (e.g., perimenopause, menopause) as measured by an unmedicated FSH level at or above 19 on cycle day two or three of your menstrual period or other abnormal testing results as outlined in Aetna's infertility clinical policy.
- Treatment for dependent children, except for fertility preservation as described above.

Jaw joint disorder treatment

Covered services include the diagnosis, surgical and non-surgical treatment of **jaw joint disorder** by a **provider**, including:

- The jaw joint itself, such as temporomandibular joint dysfunction (TMJ) syndrome
- The relationship between the jaw joint and related muscle and nerves, such as myofascial pain dysfunction (MPD)

Lymphedema

Covered services include the diagnosis, evaluation and treatment of lymphedema. Your plan will cover:

- Equipment
- Supplies
- Complex decongestive therapy
- Self-management training and education by a licensed **health professional**

Maternity and related newborn care

Covered services include pregnancy (prenatal) care, care after delivery and obstetrical services. After your child is born, **covered services** include:

- No less than 48 hours of inpatient care in a **hospital** after a vaginal delivery
 - No less than 96 hours of inpatient care in a **hospital** after a cesarean delivery
-

- 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 home visits after delivery by a health care **provider** according to the guidelines recommended by the American Academy of Pediatrics or the American College of Obstetricians and Gynecologists. **Covered services** also include services and supplies needed for circumcision by a **provider**.

The following are not **covered services**:

- Any services and supplies related to births that take place in the home or in any other place not licensed to perform deliveries

Nutritional support

Covered services include formula and enteral nutrition products for the treatment of an inherited metabolic disorder.

An inherited metabolic disorder is an inherited enzymatic disorder caused by single gene defects involved in the metabolism of amino, organic, or fatty acids.

Covered services include:

- Formula and enteral nutrition products that:
 - Are liquid or solid formulas and enteral nutrition products for the partial or exclusive feeding by means of oral intake or enteral feeding by tube
 - A **physician** or other **health professional** that is qualified for the management of an inherited metabolic disorder has issued a written notice stating that the formula or enteral nutrition product is **medically necessary**
 - Are a critical source of nutrition as certified by the **physician** by diagnosis, but do not need to be your primary source of nutrition
 - Are proven effective as your treatment regimen
 - Are used under medical supervision which may include a home setting
- Medical equipment, supplies, and services that are required to administer the covered formula or enteral nutrition products

The following are not **covered services**:

Any other food item, including:

- Infant formulas
- Nutritional supplements
- Vitamins
- Medical foods
- Other nutritional items

Obesity surgery and services

Obesity **surgery** is a type of procedure performed on people who are **morbidly obese** for the purpose of losing weight. Your **physician** will determine whether you qualify for obesity **surgery**.

Covered services include:

- An initial medical history and physical exam
 - Diagnostic tests given or ordered during the first exam
 - Outpatient **prescription** drugs included under the *Prescription drugs - outpatient* section
 - An obesity **surgical procedure**, such as gastric bypass, or other method as recognized by the National
-

Institutes of Health as effective for the long-term reversal of **morbid obesity**

- A multi-stage procedure when planned and approved by us
- Adjustments after an approved lap band procedure, including approved adjustments in an office or outpatient setting

The following are not **covered services**:

- Weight management treatment
- Drugs intended to decrease or increase body weight, control weight or treat obesity except as described in the certificate.
- Preventive care services for obesity screening and weight management interventions, regardless of whether there are other related conditions. This includes:
 - Drugs, stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food supplements, appetite suppressants and other medications
 - Hypnosis, or other forms of therapy
- Exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement

Oral and maxillofacial treatment (mouth, jaws and teeth)

Covered services include the following when provided by a **physician**, dentist and **hospital**:

- Cutting out:
 - Cysts, tumors, or other diseased tissues
- Cutting into gums and tissues of the mouth:
 - Only when not associated with the removal, replacement or repair of teeth

Outpatient surgery

Covered services include services provided and supplies used in connection with outpatient **surgery** performed in a **surgery** center or a **hospital's** outpatient department.

Important note:

Some **surgeries** can be done safely in a **physician's** office. For those **surgeries**, your plan will pay only for **physician, PCP** services and not for a separate fee for facilities.

The following are not **covered services**:

- A **stay** in a **hospital** (see *Hospital care* in this section)
- Services of another **physician** for the administration of a local anesthetic

Physician services

Covered services include services by your **physician** to treat an illness or injury. You can get services:

- At the **physician's** office
- In your home
- In a **hospital**
- From any other inpatient or outpatient facility
- By way of **telemedicine**

Important note:

For behavioral health services, all in-person, **covered services** with a **behavioral health provider** are also **covered services** if you use **telemedicine** instead.

Other services and supplies that your **physician** may provide:

- Allergy testing and allergy injections
- Radiological supplies, services, and tests
- Immunizations that are not covered as preventive care

Prescription drugs - outpatient

Read this section carefully. This plan does not cover all **prescription** drugs and some coverage may be limited. This doesn't mean you can't get **prescription** drugs that aren't covered; you can, but you have to pay for them yourself. For more information about **prescription** drug benefits, including limits, see the schedule of benefits.

Important note:

A pharmacy may refuse to fill or refill a **prescription** when, in the professional judgement of the pharmacist, it should not be filled or refilled.

Your plan provides standard safety checks to encourage safe and appropriate use of medications. These checks are intended to avoid adverse events and align with the medication's U.S. Food and Drug Administration (FDA) approved prescribing information and current published clinical guidelines and treatment standards. These checks are routinely updated as new medications come to market and as guidelines and standards are updated.

Covered services are based on the drugs in the **drug guide**. We exclude **prescription** drugs listed on the formulary exclusions list unless we approve a medical exception. The formulary exclusions list is a list of **prescription** drugs not covered under the plan. This list is subject to change. If it is **medically necessary** for you to use a **prescription** drug that is not on this **drug guide**, you or your **provider** must request a medical exception. See the *Requesting a medical exception* section or just contact us.

Your **provider** can give you a **prescription** in different ways including:

- A written **prescription** that you take to a network pharmacy
- Calling or e-mailing a **prescription** to a network pharmacy
- Submitting the **prescription** to a network pharmacy electronically

The pharmacy may substitute a **generic prescription drug** for a **brand-name prescription drug**. Your cost share may be less if you use a **generic drug** when it is available.

Any **prescription** drug made to work beyond one month shall require the **copayment** amount that equals the expected duration of the medication.

Prescription drug synchronization

If you are prescribed multiple maintenance medications, including **specialty prescription drugs**, and would like to have them each dispensed on the same fill date for your convenience, your **network pharmacy** may be able to coordinate that for you, provided that:

- Your pharmacy or **provider** tells us that the synchronization of the dates is in your best interest
- You request or agree to the synchronization

We will apply a prorated daily cost share rate, to a partial fill of a maintenance drug, if needed, to synchronize your **prescription** drugs. We will not perform this proration more often than annually.

How to access network pharmacies

A **network pharmacy** will submit your claim. You will pay your cost share to the pharmacy. You can find a **network pharmacy** either online or by phone. See the *Contact us* section for how. You may go to any of our network pharmacies. A **network pharmacy** also includes an out-of-network pharmacy or its intermediary that has agreed in writing to accept payment at the same rate as a **network pharmacy**.

Pharmacy types

Retail pharmacy

A **retail pharmacy** may be used for up to a 90 day supply of a **prescription** drug.

Mail order pharmacy

The drugs available through mail order are maintenance drugs that you take on a regular basis for a chronic or long-term medical condition. A **mail order pharmacy** may be used for up to a 90 day supply of a **prescription** drug.

Prescriptions can be filled at a network **mail order pharmacy**.

Specialty pharmacy

A **specialty pharmacy** may be used for up to a 30 day supply of a **specialty prescription drug**. You can view the list of **specialty prescription drugs**. See the *Contact us* section for how.

Specialty prescription drug fills may be filled only at pharmacies that have agreed to accept our reimbursement terms for **specialty prescription drugs**. Pharmacies that have accepted our reimbursement terms are listed on our online **provider** directory at www.aetna.com/formulary. You can also call the toll-free number on your ID card to request a printed directory.

All **specialty prescription drug** fills including the first fill must be filled at a network **specialty pharmacy** or an out-of-network **specialty pharmacy** or its intermediary that has agreed in writing to accept payment at the same rate as a network **specialty pharmacy**, unless it is an urgent situation.

Prescription drugs covered by this plan are subject to misuse, waste, or abuse utilization review by us, your **provider**, and/or your **network pharmacy**. The outcome of this review may include:

- Limiting coverage of a drug to one prescribing **provider** or one **network pharmacy**
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

How to access out-of-network pharmacies

You can directly access an out-of-network pharmacy to get covered outpatient **prescription** drugs.

When you use an out-of-network pharmacy, you pay your in-network **copayment** or **coinsurance** then you pay any remaining **deductible** and then you pay your out-of-network **coinsurance**. If you use an out-of-network pharmacy to obtain outpatient **prescription** drugs, you are subject to a higher out-of-pocket expense and are responsible for:

- Paying your in-network outpatient **prescription** drug cost share
- Paying any applicable out-of-network outpatient **prescription** drug **deductible**
- Your out-of-network **coinsurance**
- Any charges over the **allowable amount**
- Submitting your own claims

Other covered services

Abortion drugs

Covered services include **prescription** drugs used for elective termination of pregnancy.

Anti-cancer drugs taken by mouth

Covered services include any drug prescribed for cancer treatment, including chemotherapy drugs. The drug must be recognized for treating cancer in standard reference materials or medical literature even if it isn't approved by the FDA for this treatment.

Contraceptives (birth control)

For females who are able to reproduce, **covered services** include any drugs and devices that the FDA has approved to prevent pregnancy. You will need a **prescription** from your **provider** and must fill it at a **network pharmacy**. At least one form of each FDA-approved contraception method is a **covered service**. You can access a list of covered drugs and devices. See the *Contact us* section for how.

We also cover over-the-counter (OTC) and **generic prescription drugs** and devices for each method of birth control approved by the FDA at no cost to you. If a generic drug or device is not available for a certain method, we will cover the **brand-name prescription drug** or device at no cost share.

Preventive contraceptives important note:

You may qualify for a medical exception if your **provider** determines that the contraceptives covered as preventive **covered services** under the plan are not medically appropriate for you. Your **provider** may request a medical exception and submit it to us for review. If the exception is approved, the **brand-name prescription drug** contraceptive will be covered at 100%.

Diabetic supplies

Covered services include but are not limited to the following:

- Alcohol swabs
- Blood glucose calibration liquid
- Diabetic syringes, needles and pens
- Continuous glucose monitors
- Insulin infusion disposable pumps
- Lancet devices and kits
- Test strips for blood glucose, ketones, urine

See the *Diabetic services, supplies, equipment, and self-care programs* provision for medical **covered services**.

Immunizations

Covered services include preventive immunizations as required by the ACA when given by a **network pharmacy**. You can find a participating **network pharmacy** by contacting us. Check with the pharmacy before you go to make sure the vaccine you need is in stock. Not all pharmacies carry all vaccines.

Infertility drugs

Covered services include oral and injectable ovulation induction **prescription** drugs.

Obesity drugs

Covered services include **prescription** drugs used only for the purpose of weight loss. These are sometimes called anti-obesity agents.

Off-label use

FDA approved **prescription** drugs may be covered when the off-label use of the drug has not been approved by the FDA for your condition. Eligibility for coverage is subject to the following:

- The drug has been approved by the FDA for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.
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- The drug is prescribed for the treatment of cancer and it is recognized as safe and effective for treatment of that specific type of cancer in any of the standard reference compendium even if the drug is not approved by the FDA for a particular indication.
- The drug is approved by the FDA for use in the treatment of cancer pain and the dosage is in excess of the recommended dosage for a patient with intractable cancer pain.

Over-the-counter (OTC) drugs

Covered services include certain OTC medications when you have a **prescription** from your **provider**. You can see a list of covered OTC drugs by logging on to your member website.

Risk reducing breast cancer prescription drugs

Covered services include **prescription** drugs used to treat people who are at:

- Increased risk for breast cancer
- Low risk for medication side effects

Sexual enhancement or dysfunction prescription drugs

Covered services include **prescription** drugs for the treatment of sexual dysfunction or enhancement. For the most up-to-date information on covered **prescription** drugs and doses, contact us.

Tobacco cessation prescription drugs

Covered services include FDA-approved **prescription** drugs, OTC drugs, and OTC aids to help stop the use of tobacco products, including nicotine replacement therapy. A **provider** must prescribe all OTC aids.

A tobacco product is something that contains tobacco or nicotine. Examples of this are:

- Candy-like products with tobacco as an ingredient
- Cigarettes
- Cigars
- Smoking tobacco
- Smokeless tobacco
- Snuff

Nicotine replacement therapy is a **prescription** drug or aid that:

- Delivers nicotine to a person who is trying to stop using tobacco products
- Is prescribed by a **provider**

Prescription drug exclusions:

The following are not **covered services**:

- Allergy sera and extracts given by injection
 - Any services related to providing, injecting or application of a drug
 - Compounded **prescriptions** containing bulk chemicals not approved by the FDA including compounded bioidentical hormones
 - Cosmetic drugs including medication and preparations used for cosmetic purposes
 - Devices, products and appliances unless listed as a **covered service**
 - Dietary supplements including medical foods
 - Drugs or medications
 - Administered or entirely consumed at the time and place they are prescribed or provided
 - Which do not require a **prescription** by law, even if a **prescription** is written, unless we have approved a medical exception
 - That are therapeutically the same or an alternative to a covered **prescription** drug, unless we approve a medical exception
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- Not approved by the FDA or not proven safe or effective
 - Provided under your medical plan while inpatient at a healthcare facility
 - That include vitamins and minerals unless recommended by the United States Preventive Services Task Force (USPSTF)
 - That are used 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 alter the shape or appearance of a sex organ unless listed as a **covered service**
 - That are used for the purpose of weight gain or loss including but not limited to stimulants, preparations, foods or diet supplements, dietary regimens and supplements, food or food supplements, non-**prescription** appetite suppressants or other medications except as described in the certificate
 - That are drugs or growth hormones used to stimulate growth and treat idiopathic short stature unless there is evidence that the member meets one or more clinical criteria detailed in our **precertification** and clinical policies
 - Duplicative drug therapy; for example, two antihistamines for the same condition
 - Genetic care including:
 - Any treatment, device, drug, service or supply to alter the body's genes, genetic makeup or the expression of the body's genes unless listed as a **covered service**
 - Immunizations related to travel or work
 - Immunization or immunological agents except as specifically stated in the schedule of benefits or the certificate
 - Implantable drugs and associated devices except as specifically stated in the schedule of benefits or the certificate
 - Injectables including:
 - Any charges for the administration or injection of **prescription** drugs
 - Needles and syringes except for those used for insulin administration
 - Any drug which, due to its characteristics as determined by us, must typically be administered or supervised by a qualified **provider** or licensed certified **health professional** in an outpatient setting with the exception of Depo Provera and other injectable drugs for contraception
 - Off-label drug use except as described in the *Prescription drugs – outpatient, Off-label use* section
 - **Prescription** drugs:
 - That are ordered by a dentist or prescribed by an oral surgeon in relation to the removal of teeth or **prescription** drugs for the treatment of a dental condition
 - That are considered oral dental preparations and fluoride rinses except pediatric fluoride tablets or drops as specified on the plan's **drug guide**
 - That are used for the purpose of improving visual acuity or field of vision
 - That are being used or abused in a manner that is determined to be furthering an addiction to a habit-forming substance, or drugs obtained for use by anyone other than the member as identified on the ID card
 - Replacement of lost or stolen **prescriptions**
 - Test agents except diabetic test agents
 - We reserve the right to exclude:
 - A manufacturer's product when the same or similar drug (one with the same active ingredient or same therapeutic effect), supply or equipment is on the plan's **drug guide**
 - Any dosage or form of a drug when the same drug is available in a different dosage or form on the plan's **drug guide**
-

Preventive care

Preventive **covered services** are designed to help keep you healthy, supporting you in achieving your best health through early detection. If you need further services or testing such as diagnostic testing, you may pay more as these services aren't preventive. If a **covered service** isn't listed here under preventive care, it still may be covered under other **covered services** in this section. For more information, see your schedule of benefits.

The following agencies set forth the preventive care guidelines in this section:

- Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC)
- United States Preventive Services Task Force (USPSTF)
- Health Resources and Services Administration
- American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents

These recommendations and guidelines may be updated periodically. When updated, they will apply to this plan. The updates are effective on the first day of the year, one year after the updated recommendation or guideline is issued.

For frequencies and limits, contact your **physician** or us. This information is also available at <https://www.healthcare.gov/>

Important note:

Gender-specific preventive care benefits include **covered services** described regardless of the sex you were assigned at birth, your gender identity, or your recorded gender.

Counseling services

Covered services include preventive screening and counseling by your **health professional** for:

- Alcohol or drug misuse
 - Preventive counseling and risk factor reduction intervention
 - Structured assessment
- Genetic risk for breast and ovarian cancer
- Obesity and healthy diet
 - Preventive counseling and risk factor reduction intervention
 - Nutritional counseling
 - Healthy diet counseling provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease
- Sexually transmitted infection
- Tobacco cessation
 - Preventive counseling to help stop using tobacco products
 - Treatment visits
 - Class visits

Family planning services – female contraceptives

Covered services include family planning services as follows:

- Contraceptive devices (including any related services or supplies) when they are prescribed, provided, administered, or removed by a **health professional**.
 - Voluntary sterilization including charges billed separately by the [**provider**] for female voluntary sterilization procedures and related services and supplies. This also could include tubal ligation and sterilization implants.
-

The following are not preventive **covered services**:

- Services provided as a direct result of complications resulting from a voluntary sterilization procedure and related follow-up care
- Any contraceptive methods that are only “reviewed” by the FDA and not “approved” by the FDA
- Male contraceptive methods, sterilization procedures or devices, except for male condoms prescribed by a **health professional**

Immunizations

Covered services include preventive immunizations for infectious diseases.

The following are not preventive **covered services**:

- Immunizations that are not considered preventive care, such as those required due to your employment or travel

Routine cancer screenings

Covered services include the following routine cancer screenings:

- Colonoscopies including pre-procedure **specialist** consultation, anesthesia, removal of polyps during a screening procedure, and a pathology exam on any removed polyp, as recommended by the American College of Gastroenterology in association with the American Cancer Society
- Digital rectal exams (DRE)
- Double contrast barium enemas (DCBE)
- Fecal occult blood tests (FOBT), as recommended by the American College of Gastroenterology in association with the American Cancer Society
- Follow-up colonoscopies after a positive noninvasive stool-based (FOBT) screening test or direct visualization test
- Lung cancer screenings
- Mammograms
 - One mammogram if you are 35-39
 - One mammogram every 2 years if you are age 40-49
 - One mammogram per year if you are age 50 or older
- Prostate specific antigen (PSA) tests per year if you are either:
 - Younger than age 50 but considered to be high risk
 - Age 50 or older
- Sigmoidoscopies, as recommended by the American College of Gastroenterology in association with the American Cancer Society
- Radiologic imaging in appropriate circumstances for colorectal cancer screening, as recommended by the American College of Gastroenterology in association with the American Cancer Society

Routine physical exams

A routine preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Evidence-based items that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force.
 - Services as recommended in the American Academy of Pediatrics/Bright Futures/Health Resources and Services Administration guidelines for children and adolescents.
 - Screenings and counseling services as provided for in the comprehensive guidelines recommended by the Health Resources and Services Administration. These services may include but are not limited to:
 - Screening and counseling services on topics such as:
 - Interpersonal and domestic violence
-

- Sexually transmitted diseases
- Human immune deficiency virus (HIV) infections
- High risk human papillomavirus (HPV) DNA testing for women

Covered services include:

- Office visit to a **physician**
- Hearing screening
- Vision screening
- Radiological services, lab and other tests
- For covered newborns, an initial **hospital** checkup

Well woman preventive visits

A routine well woman preventive exam is a medical exam given for a reason other than to diagnose or treat a suspected or identified illness or injury and also includes:

- Office visit to a **physician, PCP, OB, GYN** or **OB/GYN** for services including an annual cervical cancer screening (Pap smear) and testing using any FDA approved gynecologic cytology screening technologies
- Preventive care breast cancer (BRCA) gene blood testing
- Screening for diabetes after pregnancy for women with a history of diabetes during pregnancy
- Screening for urinary incontinence

Private duty nursing - outpatient

Covered services include private duty nursing care provided by an R.N. or L.P.N. when:

- You are homebound
- Your **physician** orders services as part of a written treatment plan
- Services take the place of a **hospital** or **skilled nursing facility stay**
- Your condition is serious, unstable, and requires continuous skilled 1-on-1 nursing care
- Periodic skilled nursing visits are not adequate

The following are not **covered services**:

- Inpatient private duty nursing care
- Care provided outside the home
- Maintenance or custodial care
- Care for your convenience or the convenience of the family caregiver

Prosthetic device

A prosthetic device is a device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of illness, injury or congenital defects.

Covered services include the initial provision and subsequent replacement of a prosthetic device that your **physician** orders and administers.

Coverage includes:

- Any myoelectric, biomechanical, or microprocessor-controlled prosthetic device that peer-reviewed medical literature has determined to be medically appropriate on the basis of the clinical assessment of your rehabilitation potential
 - Instruction and other services (such as components, fittings, attachment or insertion) so you can properly use the device
 - Repairing or replacing the original device you outgrow or that is no longer appropriate because your physical condition changed
 - Replacements required by ordinary wear and tear or damage
-

Component means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

If you receive a prosthetic device as part of another **covered service**, it will not be covered under this benefit.

The following are not **covered services**:

- Orthopedic shoes and therapeutic shoes, unless the orthopedic shoe is an integral part of a covered leg brace
- Trusses, corsets, and other support items
- Repair and replacement due to loss, misuse, abuse or theft

Reconstructive breast surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** reconstructs the breast where a necessary mastectomy was performed, such as an implant and areolar reconstruction. It also includes:
 - **Surgery** on a healthy breast to make it symmetrical with the reconstructed breast
 - Treatment of physical complications of all stages of the mastectomy, including lymphedema
 - Prostheses

Unless you and your [**physician**] decide that a shorter time period for inpatient care is appropriate, **covered services** for reconstructive breast surgery include:

- 48 hours of inpatient care following a mastectomy
- 24 hours of inpatient care after a lymph node dissection for treatment of breast cancer

Reconstructive surgery and supplies

Covered services include all stages of reconstructive **surgery** by your **provider** and related supplies provided in an inpatient or outpatient setting only in the following circumstances:

- Your **surgery** is to implant or attach a covered prosthetic device.
- Your **surgery** corrects a birth defect, including but not limited to cleft lip and cleft palate or ectodermal dysplasia. The **surgery** will be covered if:
 - The defect results in facial disfigurement or functional impairment of a body part, and
 - The purpose of the **surgery** is to improve function
- Your **surgery** is needed because treatment of your illness resulted in facial disfigurement or functional impairment of a body part, and your **surgery** will improve function.

Accidental injury to natural teeth

Covered services also include the procedures or **surgery** to sound natural teeth, injured due to an accident and performed as soon as medically possible, when:

- The teeth were stable, functional and free from decay or disease at the time of the injury
- The **surgery** or procedure returns the injured teeth to how they functioned before the accident

These accident-related dental services are limited to:

- The first placement of a permanent crown or cap to repair a broken tooth
 - The first placement of dentures or bridgework to replace lost teeth
 - Orthodontic therapy to pre-position teeth
-

Short-term cardiac and pulmonary rehabilitation services

Cardiac rehabilitation

Covered services include cardiac rehabilitation services you receive at a **hospital, skilled nursing facility** or **physician's office**, but only if those services are part of a treatment plan determined by your risk level and ordered by your **physician**.

Pulmonary rehabilitation

Covered services include pulmonary rehabilitation services as part of your inpatient **hospital stay** if they are part of a treatment plan ordered by your **physician**. A course of outpatient pulmonary rehabilitation may also be covered if it is performed at a **hospital, skilled nursing facility, or physician's office** and is part of a treatment plan ordered by your **physician**.

Short-term rehabilitation services

Short-term rehabilitation services are services needed to restore or develop your skills and functioning for daily living. The services must follow a specific treatment plan, ordered by your **physician**. The services have to be performed by a:

- Licensed or certified physical, occupational, or speech therapist
- **Hospital, skilled nursing facility, or hospice facility**
- **Home health care agency**
- **Physician**

Covered services include:

- Spinal manipulation to correct a muscular or skeletal problem. Your **provider** must establish or approve a treatment plan that details the treatment and specifies frequency and duration.

Cognitive rehabilitation, physical, occupational, and speech therapy

Covered services include:

- Physical therapy, but only if it is expected to significantly improve or restore physical functions lost as a result of an acute illness, injury, or **surgical procedure**
- Occupational therapy, but only if it is expected to do one of the following:
 - Significantly improve, develop, or restore physical functions you lost as a result of an acute illness, injury, or **surgical procedure**
 - Help you relearn skills so you can significantly improve your ability to perform the activities of daily living on your own
- Speech therapy, but only if it is expected to do one of the following:
 - Significantly improve or restore lost speech function or correct a speech impairment resulting from an acute illness, injury, or **surgical procedure**
 - Improve delays in speech function development caused by a birth defect
(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 rehabilitation associated with physical rehabilitation, but only when:
 - Your cognitive deficits are caused by neurologic impairment due to trauma, stroke, or encephalopathy
 - The therapy is coordinated with us as part of a treatment plan intended to restore previous cognitive function

Short-term physical, speech and occupational therapy services provided in an outpatient setting are subject to the same conditions and limitations for outpatient short-term rehabilitation services. See the *Short-term rehabilitation services* section in the schedule of benefits.

The following are not **covered services**:

- Services provided in an educational or training setting or to teach sign language
- Vocational rehabilitation or employment counseling

Skilled nursing facility

Covered services include inpatient **skilled nursing facility** care. This includes:

- **Room and board**, up to the **semi-private room rate**
- Services and supplies provided during a **stay** in a **skilled nursing facility**

Specialty prescription drugs

Covered services include **specialty prescription drugs** when they are:

- Purchased by your **provider**
- Injected or infused by your **provider** in an outpatient setting such as:
 - A freestanding outpatient facility
 - The outpatient department of a **hospital**
 - A **physician** in the office
 - A home care **provider** in your home

Certain injected and infused medications may be covered under the outpatient **prescription drug** benefit. Contact us to determine if coverage is under this **specialty prescription drug** or the outpatient **prescription drug** benefit.

Telemedicine

Covered services include **telemedicine** consultations when provided by a **physician, specialist, behavioral health provider** or other **telemedicine provider** acting within the scope of their license.

Covered services for **telemedicine** consultations are available from a number of different kinds of **providers** under your plan. Log in to your member website at <https://www.aetna.com/> to review our **telemedicine provider** listing and contact us to get more information about your options, including specific cost sharing amounts.

The following are not **covered services**:

- Telephone calls
- **Telemedicine** kiosks

Tests, images and labs - outpatient

Diagnostic complex imaging services

Covered services include:

- Computed tomography (CT) scans, including for preoperative testing
- Magnetic resonance imaging (MRI) including magnetic resonance spectroscopy (MRS), magnetic resonance venography (MRV) and magnetic resonance angiogram (MRA)
- Nuclear medicine imaging including positron emission tomography (PET) scans
- Other imaging service where the billed charge exceeds \$500

Complex imaging for preoperative testing is covered under this benefit.

Diagnostic lab work

Covered services include:

- Lab
- Pathology
- Other tests

These are covered only when you get them from a licensed radiology **provider** or lab.

Diagnostic x-ray and other radiological services

Covered services include x-rays, scans and other services (but not complex imaging) only when you get them from a licensed radiology **provider**. See *Diagnostic complex imaging services* above for more information.

Therapies – chemotherapy, GCIT, infusion, radiation

Chemotherapy

Covered services for chemotherapy depend on where treatment is received. In most cases, chemotherapy is covered as outpatient care. However, your **hospital** benefit covers the initial dose of chemotherapy after a cancer diagnosis during a **hospital stay**.

Gene-based, cellular and other innovative therapies (GCIT)

Covered services include GCIT provided by a **physician, hospital** or other **provider**.

Key Terms

Here are some key terms we use in this section. These will help you better understand GCIT.

Gene

A gene is a unit of heredity which is transferred from a parent to child and is thought to determine some feature of the child.

Molecular

Molecular means relating to or consisting of molecules. A molecule is a group of atoms bonded together, making the smallest vital unit of a chemical compound that can take part in a chemical reaction.

Therapeutic

Therapeutic means a treatment, therapy, or drug meant to have a good effect on the body or mind, adding to a sense of well-being.

GCIT are defined as any services that are:

- Gene-based
- Cellular and innovative therapeutics

The services have a basis in genetic/molecular medicine and are not covered under the Institutes of Excellence™ (IOE) programs. We call these "GCIT services."

GCIT **covered services** include:

- Cellular immunotherapies.
- Genetically modified viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for treatment of certain conditions.
- All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
 - Luxturna® (Voretigene neparvovec)
 - Zolgensma® (Onasemnogene abeparvovec-xioi)
 - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
 - Antisense. An example is Spinraza (Nusinersen).
 - siRNA.
 - mRNA.
 - microRNA therapies.

Facilities/providers for gene-based, cellular and other innovative therapies

We designate facilities to provide GCIT services or procedures. GCIT **physicians, hospitals** and other **providers** are GCIT-designated facilities/**providers** for Aetna and CVS Health.

Important note:

You must get GCIT **covered services** from a GCIT-designated facility/**provider**. If there are no GCIT-designated facilities/**providers** assigned in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your GCIT services at the facility/**provider** we designate, they will not be **covered services**.

Infusion therapy

Infusion therapy is the intravenous (IV) administration of prescribed medications or solutions.

Covered services include infusion therapy you receive in an outpatient setting including but not limited to:

- A freestanding outpatient facility
- The outpatient department of a **hospital**
- A **physician's** office
- Your home from a home care **provider**

You can access the list of preferred infusion locations by contacting us.

When Infusion therapy services and supplies are provided in your home, they will not count toward any applicable home health care maximums.

Certain infused medications may be covered under the outpatient **prescription** drug benefit. You can access the list of **specialty prescription drugs** by contacting us.

Radiation therapy

Covered services include the following radiology services provided by a **health professional**:

- Accelerated particles
 - Gamma ray
 - Mesons
 - Neutrons
 - Radioactive isotopes
-

- Radiological services
- Radium

Transplant services

Covered services include transplant services provided by a **physician** and **hospital**.

This includes the following transplant types:

- Solid organ
- Hematopoietic stem cell
- Bone marrow
- CAR-T and T Cell receptor therapy for FDA-approved treatments
- Thymus tissue for FDA-approved treatments

Network of transplant facilities

We designate facilities to provide specific services or procedures. They are listed as IOE facilities in your **provider** directory.

The amount you will pay for covered transplant services depends on where you get the care. Your cost share will be lower when you get transplant services from the facility we designate to perform the transplant you need. Transplant services received from an IOE facility are subject to the network **copayment, coinsurance, deductible, maximum out-of-pocket** and limits, unless stated differently in this certificate and schedule of benefits. You may also get transplant services at a non-IOE facility, but your cost share will be higher. Transplant services received from a non-IOE facility are subject to the out-of-network **copayment, coinsurance, deductible, maximum out-of-pocket**, and limits, unless stated differently in this certificate and schedule of benefits.

Important note:

If there are no IOE facilities assigned to perform your transplant type in your network, it's important that you contact us so we can help you determine if there are other facilities that may meet your needs. If you don't get your transplant services at the facility we designate, your cost share will be higher.

Many pre and post-transplant medical services, even routine ones, are related to and may affect the success of your transplant. If your transplant care is being coordinated by the National Medical Excellence® (NME) program, all medical services must be managed through NME so that you receive the highest level of benefits at the appropriate facility. This is true even if the **covered service** is not directly related to your transplant.

The following are not **covered services**:

- Services and supplies furnished to a donor when the recipient is not a covered person
 - Harvesting and storage of organs, without intending to use them for immediate transplantation for your existing illness
 - Harvesting and/or storage of bone marrow, hematopoietic stem cells, or other blood cells without intending to use them for transplantation within 12 months from harvesting, for an existing illness
-

Urgent care services

Covered services include services and supplies to treat an urgent condition at an urgent care center. An urgent condition is an illness or injury that requires prompt medical attention but is not a life-threatening **emergency medical condition**. An urgent care center is a facility licensed as a freestanding medical facility to treat urgent conditions.

If you need care for an urgent condition, you should first seek care through your **physician, PCP**. If your **physician** is not reasonably available, you may access urgent care from an urgent care center.

The following are not **covered services**:

- Non-urgent care in an urgent care center

Virtual primary care (VPC)

VPC provides coverage for eligible in-network **covered services** for persons 18 years of age or older. **Covered services** include basic medical and preventive health care services when provided by a Virtual Primary Care (VPC) **telemedicine provider**.

A VPC **telemedicine provider** is a **provider** who is contracted with us to provide you with VPC **covered services** by **telemedicine**. This **provider** can also be your **PCP**.

Covered services include:

- Preventive care
 - Preventive care screening and counseling
 - Preventive care biometric review and analysis:
 - If you will perform self-assessments, when you schedule your first VPC consultation, you'll get tools to do so at no cost to you
 - Your results will be reviewed with your VPC **telemedicine provider**
- Basic medical services
 - General primary care consultations
 - Consultations for non-emergency illness or injury, including **prescriptions**, when needed
 - **Prescription** drug coordination to encourage safe and appropriate use of medications
 - Follow-up care and coordination with **network providers**

Your VPC **telemedicine provider** can help you access **network providers** and **specialists** for **covered services** ordered during your virtual consultation, including:

- Diagnostic lab tests
- Preventive care immunizations
- In-person preventive care
- In-person biometric screenings such as cholesterol and blood sugar testing

Your regular cost share will apply for services not provided by a VPC **telemedicine provider** and for any **prescription** drugs you may need. See the schedule of benefits.

The following are not **covered services**:

- VPC **telemedicine** consultations received from a **provider** who is not a VPC **telemedicine provider**.
-

Vision care

Covered services include:

- Routine vision exam provided by an ophthalmologist or optometrist including refraction and glaucoma testing

The following are not **covered services**:

- Office visits to an ophthalmologist, optometrist or optician related to the fitting of **prescription** contact lenses
- Eyeglass frames, non-**prescription** lenses and non-**prescription** contact lenses that are for cosmetic purposes

Walk-in clinic

Covered services include, but are not limited to, health care services provided through a **walk-in clinic** for:

- Scheduled and unscheduled visits for illnesses and injuries that are not **emergency medical conditions**
 - Preventive care immunizations administered within the scope of the clinic's license
 - Individual screening and counseling services that will help you:
 - With obesity or healthy diet
 - To stop using tobacco products
-

General plan exclusions

The following are not **covered services** under your plan:

Blood and blood products

Blood, blood products, and related services which are supplied to your **provider** free of charge

This exception does not apply:

- If services are **medically necessary** and you incur a charge for the expense
- For treatment of hemophilia and congenital bleeding disorders

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, except where described in the *Coverage and exclusions* section

Cost share waived

Any cost for a service when any **out-of-network provider** waives all or part of your **copayment, coinsurance, deductible**, or any other amount

Court-ordered services and supplies

This includes court-ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are a **covered service** under your plan

Custodial care

Services and supplies meant to help you with activities of daily living or other personal needs.

Examples of these are:

- Routine patient care such as changing dressings, periodic turning and positioning in bed
- Administering oral medications
- Care of 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 bladder catheter, including emptying or 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 walking, grooming, bathing, dressing, getting in or out of bed, going to the bathroom, eating, or preparing foods
- Any other services that a person without medical or paramedical training could be trained to perform
- For behavioral health (mental health treatment and **substance use disorder** treatment):
 - Services provided when you have reached the greatest level of function expected with the current level of care
 - Services given mainly to:
 - Provide a place free from conditions that could make your physical or mental state worse

Dental services

The following are not **covered services**:

- Services normally covered under a dental plan
-

- Dental implants except when part of an approved treatment plan for a **covered service** described in the *Coverage and exclusions - Reconstructive surgery and supplies* section

Educational services

Examples of these are:

- Any service or supply for education, training or retraining services or testing, except as described in the *Coverage and exclusions* section. This includes:
 - Special education
 - Remedial education
 - Wilderness treatment programs (whether or not the program is part of a **residential treatment facility** or otherwise licensed institution)
 - Job training
 - Job hardening programs
- Educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

Examinations

Any health or dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, and examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, sporting event, or to join in a sport or other recreational activity.

Experimental, investigational, or unproven

Experimental, investigational, or unproven drugs, devices, treatments or procedures unless otherwise covered under clinical trials

Foot care

Routine services and supplies for the following:

- Routine pedicure services, such as routine cutting of nails, when there is no illness or injury in the nails
- Supplies (including orthopedic shoes), ankle braces, guards, protectors, creams, ointments and other equipment, devices and supplies
- Treatment of calluses, bunions, toenails, hammertoes or fallen arches
- Treatment of weak feet, chronic foot pain or conditions caused by routine activities, such as walking, running, working, or wearing shoes

Foot orthotic devices

Foot orthotics or other devices to support the feet, such as arch supports and shoe inserts, unless **medically necessary** or required for the treatment of or to prevent complications of diabetes

Gene-based, cellular and other innovative therapies (GCIT)

The following are not **covered services** unless you receive prior written approval from us:

- GCIT services received at a facility or with a **provider** that is not a GCIT-designated facility/**provider**
- All associated services when GCIT services are not covered. Examples include:
 - Infusion
 - Lab
 - Radiology
 - Anesthesia
 - Nursing services

See the *How your plan works – Medical necessity and precertification requirements* section

Growth/height care

- A treatment, device, drug, service or supply to increase or decrease height or alter the rate of growth
- **Surgical procedures**, devices and growth hormones to stimulate growth

Maintenance care

Care made up of services and supplies that maintain, rather than improve, a level of physical or mental function, except for habilitation therapy services and services for the treatment of autism spectrum disorder

Medical supplies – outpatient disposable

Any outpatient disposable supply or device. Examples of these include:

- Sheaths
- Bags
- Elastic garments
- Support hose
- Bandages
- Bedpans
- Home test kits not related to diabetic testing
- Splints
- Neck braces
- Compresses
- Other devices not intended for reuse by another patient

Missed appointments

Any cost resulting from a canceled or missed appointment

Other non-covered services

- Services you have no legal obligation to pay
- Services that would not otherwise be charged if you did not have the coverage under the plan
- Stay in a facility for treatment for dementia and amnesia

Other primary payer

Payment for a portion of the charges that Medicare or another party is responsible for as the primary payer

Personal care, comfort or convenience items

Any service or supply primarily for your convenience and personal comfort or that of a third party

Prescription or non-prescription drugs and medicines - outpatient

- Outpatient **prescription** or non-**prescription** drugs and medicines provided by the policyholder or through a third party vendor contract with the policyholder
- **Specialty prescription drugs** except as stated in the *Coverage and exclusions* section

Routine exams and preventive services and supplies

Routine physical exams, routine eye exams, routine dental exams, routine hearing exams and other preventive services and supplies, except as specifically provided in the *Coverage and exclusions* section

Services not permitted by law

Some laws restrict the range of health care services a **provider** may perform under certain circumstances or in a particular state. When this happens, the services are not covered by the plan.

Services provided by a family member

Services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law, or any household member

Services, supplies and drugs received outside of the United States

Non-emergency medical services, outpatient **prescription** drugs or supplies received outside of the United States. They are not covered even if they are covered in the United States under this certificate.

Sexual dysfunction and enhancement

Any treatment, **prescription** drug, or supply to treat sexual dysfunction, enhance sexual performance or increase sexual desire, including:

- **Surgery, prescription** drugs, implants, devices or preparations to correct or enhance erectile function, enhance sensitivity or alter the shape of a sex organ
- Sex therapy, sex counseling, marriage counseling, or other counseling or advisory services

Strength and performance

Services, devices and supplies such as drugs or preparations designed primarily to enhance your strength, physical condition, endurance or physical performance

Therapies and tests

- Full body CT scans, unless **medically necessary**
- Hair analysis
- Hypnosis and hypnotherapy
- Massage therapy, except when used for physical therapy treatment
- Sensory or hearing and sound integration therapy

Tobacco cessation

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, medications, nicotine patches and gum.

This also includes:

- Counseling, except as specifically provided in the *Coverage and exclusions* section
 - Hypnosis and other therapies
 - Medications, except as specifically provided in the *Coverage and exclusions* section
 - Nicotine patches
 - Gum
-

Treatment in a federal, state, or governmental entity

Any care in a **hospital** or other facility owned or operated by any federal, state or other governmental entity unless coverage is required by applicable laws

Voluntary sterilization

- Reversal of voluntary sterilization procedures, including related follow-up care

Wilderness treatment programs

See *Educational services* in this section

Work related illness or injuries

Coverage available to you under workers' compensation or a similar program under local, state or federal law for any illness or injury related to employment or self-employment

Important note:

A source of coverage or reimbursement is considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law. If you submit proof that you are not covered for a particular illness or injury under such law, then that illness or injury will be considered "non-occupational" regardless of cause.

How your plan works

How your medical plan works while you are covered in-network

Your in-network coverage helps you get and pay for a lot of, but not all, health care services.

Your cost share is lower when you use a **network provider**.

Providers

Our **provider** network is there to give you the care you need. The easiest way to find **providers** and see important information about them is by logging in to your member website. There you'll find our online **provider** directory. See the *Contact us* section for more information.

You may choose a **PCP** to oversee your care. Your **PCP** will provide routine care and send you to other **providers** when you need specialized care. You don't have to get care through your **PCP**. You may go directly to **network providers**.

For more information about the network and the role of your **PCP**, see the *Who provides the care* section.

How your medical plan works while you are covered out-of-network

With your out-of-network coverage:

- You can get care from **providers** who are not part of the Aetna network
- You may have to pay the full cost for your care, and then submit a claim to be reimbursed
- You are responsible to get any required **precertification**
- Your cost share will be higher

Who provides the care

Network providers

We have contracted with **providers** to provide **covered services** to you. These **providers** make up the network for your plan.

To get network benefits, you must use **network providers**. There are some exceptions:

- **Emergency services** – see the description of **emergency services** in the *Coverage and exclusions* section.
- Non-emergency surgical or ancillary services provided by an **out-of-network provider** at a **network** facility.
- **Out-of-network** air ambulance services.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

You may select a **network provider** from the online directory through your member website.

You will not have to submit claims for services received from **network providers**. Your **network provider** will take care of that for you. And we will pay the **network provider** directly for what the plan owes.

Your PCP

We encourage you to get **covered services** through a **PCP**. They will provide you with primary care.

How you choose your PCP

You can choose a **PCP** from the list of **PCPs** in our directory. Each covered family member is encouraged to select a **PCP**. You may each choose a different **PCP**. You should select a **PCP** for your covered dependent if they are a minor or cannot choose a **PCP** on their own.

What your PCP will do for you

Your **PCP** will coordinate your medical care or may provide treatment. They may send you to other **network providers**.

Changing your PCP

You may change your **PCP** at any time by contacting us.

Out-of-network providers

You can also get care from **out-of-network providers**. When you use an **out-of-network provider**, your cost share is higher. You are responsible for:

- Your out-of-network **deductible**
- Your out-of-network **coinsurance**
- Any charges over the **allowable amount**
- Submitting your own claims and getting any required **precertification**

Keeping a provider you go to now (continuity of care)

You may have to find a new **provider** when:

- You join the plan and the **provider** you have now is not in the network
- You are already an Aetna member and your **provider** stops being in our network

When you have an existing **provider**-patient relationship with the **provider**, you can keep going to your current **provider**. This is called continuity of care. An existing **provider**-patient relationship means the **provider** or **provider** group has provided you with health care services or admitted or discharged you in the previous 12 months.

If this situation applies to you, contact us for details.

If the **provider** didn't leave the network for cause, you'll be able to receive transitional care from your **provider**:

- For a period of at least 90 days from when we notified you of their network status
- For a period of up to 180 days from when we notified you of their network status, if medically determined to have a life-threatening condition

Important note:

If you have been medically confirmed to be pregnant at the time of the **provider's** termination, transitional care will be through the postpartum period.

If you have been admitted and receiving treatment in an inpatient facility, treatment will continue until you are discharged.

If you are terminally ill, the transitional period is the remainder of your life for care directly related to treatment of the terminal illness.

You will not be responsible for an amount that exceeds the cost share that would have applied had your **provider** remained in the network.

Medical necessity and precertification requirements

Your plan pays for its share of the expense for **covered services** only if the general requirements are met. They are:

- The service is **medically necessary**
-

- For in-network benefits, you get the service from a **network provider**
- You or your **provider precertifies** the service when required. **Precertification** includes determining that services are not more costly than an alternative service or sequence of services or site of service 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.

Medically necessary, medical necessity

The **medical necessity** requirements are in the *Glossary* section, where we define “**medically necessary, medical necessity.**” That is where we also explain what our medical directors or a **physician** they assign consider when determining if a service is **medically necessary**.

Important note:
We cover **medically necessary, sex-specific covered services** regardless of identified gender.

Precertification

You need pre-approval from us for some **covered services**. Pre-approval is also called **precertification**.

In-network

Your network **physician** is responsible for obtaining any necessary **precertification** before you get the care. **Network providers** cannot bill you if they fail to ask us for **precertification**. But if your **physician** requests **precertification** and we deny it, and you still choose to get the care, you will have to pay for it yourself.

Out-of-network

When you go to an **out-of-network provider**, you are responsible to get any required **precertification** from us. If you don’t **precertify**:

- Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details.
- You will be responsible for the unpaid bills.
- Your additional out-of-pocket expenses will not count toward your **deductible** or **maximum out-of-pocket limit**, if you have any.

Timeframes for **precertification** are listed below. For **emergency services**, **precertification** is not required, but you should still notify us as shown. That includes an emergency interhospital transfer for a life-threatening condition for a newborn and for the mother to accompany the newborn.

To obtain **precertification**, contact us. You, your **physician** or the facility must call us within these timelines:

Type of care	Timeframe
Non-emergency admission	Call at least 14 days before the date you are scheduled to be admitted
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted
Urgent admission	Call before you are scheduled to be admitted
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment or procedure is scheduled

An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an illness, the diagnosis of an illness, or injury.

We will tell you and your **physician** in writing of the **precertification** decision, where required by state law. An approval is valid for 180 days as long as you remain enrolled in the plan.

For an inpatient **stay** in a facility, we will tell you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that you stay longer, the extra days will need to be **precertified**. You, your **physician**, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your **physician** in writing of an approval or denial of the extra days.

If you or your **provider** request **precertification** and we don't approve coverage, we will tell you why and explain how you or your **provider** may request review of our decision. See the *Complaints, claim decisions and appeal procedures* section.

Types of services that require precertification

Precertification is required for inpatient **stays** and certain outpatient services and supplies.

Precertification is required for the following types of services and supplies:

Inpatient -

- Gender affirming treatment
- Gene-based, cellular and other innovative therapies (GCIT)
- Obesity (bariatric) **surgery**
- **Stays** in a hospice facility
- **Stays** in a **hospital**
- **Stays** in a rehabilitation facility
- **Stays** in a **residential treatment facility** for treatment of **mental health disorders** and **substance use disorders**
- **Stays** in a **skilled nursing facility**

Contact us to get a complete list of the services that require **precertification**. The list may change from time to time.

Sometimes you or your **provider** may want us to review a service that doesn't require **precertification** before you get care. This is called a predetermination, and it is different from **precertification**. Predetermination means that you or your **provider** requests the pre-service clinical review of a service that does not require **precertification**.

Our clinical policy bulletins explain our policy for specific services and supplies. We use these bulletins and other resources to help determine medical necessity under our plans. You can find the bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>

For certain drugs covered under your medical plan or **prescription** drug plan, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**.

Step therapy is a type of **precertification** where you must try one or more prerequisite drugs before a step therapy drug is covered. A 'prerequisite' is something that is required before something else. Prerequisite drugs are FDA-approved, may cost less and treat the same condition. If you don't try the prerequisite drugs first, the step therapy drug may not be covered.

Contact us or go online to get the most up-to-date **precertification** requirements and list of step therapy drugs.

Requesting a medical exception

Sometimes you or your **provider** may ask for a medical exception to get coverage for drugs that are not covered or for **brand name** or **specialty drugs** or for which coverage was denied through **precertification** or **step therapy**. You, someone who represents you or your **provider** can contact us. You will need to provide us with clinical documentation. For directions on how you can submit a request for a review:

- Call the toll-free number on your ID card
- Go online at <https://www.aetna.com>
- Submit the request in writing to:
CVS Health
ATTN: Aetna PA
1300 E Campbell Road
Richardson, TX 75081

You, someone who represents you, or your **provider** may seek a quicker medical exception when the situation is urgent. It's an urgent situation when you have a health condition that may seriously affect your life, health, or ability to get back maximum function. It can also be when you are going through a current course of treatment using a non-covered drug.

After we receive your step therapy exception request, we will tell you and your **provider** of our coverage decision within 72 hours (including hours on weekends) or within 24 hours (including hours on weekends) if the situation is urgent.

We will grant your step therapy exception request if we determine that your request has met any of the following conditions:

- The prerequisite drug is contraindicated
- The prerequisite drug would be ineffective based on your known clinical characteristics and the drug regimen's known characteristics
- You have tried the prerequisite drug under this plan or a previous plan, and the drug was discontinued due to its ineffectiveness, reduced effect, or an adverse event
- You are currently receiving a good result on a drug recommended by your **provider** for your condition while under this plan or the plan immediately earlier

You may obtain coverage without additional cost sharing beyond that which is required of formulary **prescription** drugs for a non-formulary drug if:

- We determine, after consultation with the prescribing **provider**, that the formulary drugs are inappropriate for your condition; or
- You have been taking or using the non-formulary **prescription** drug for at least six months prior to its exclusion from the formulary; and
- The prescribing **provider** determines that either the formulary drugs are inappropriate therapy for your condition, or that changing drug therapy presents a significant health risk.

We will act upon your request within one business day of receipt.

If we deny your request for a medical exception, including a step-therapy exception request, you will have the right to request an external review by an independent review organization (IRO). If our coverage decision is one that allows you to ask for an external review, we will say that in the notice of adverse benefit determination we send you. That notice will also describe the external review process.

If the medical exception is approved by us or the IRO, the exception will apply for the entire time of the prescription, or in the case of an expedited exception, for the entire time you have an urgent situation. The cost share will be applied the same as for a drug listed in the drug guide.

What the plan pays and what you pay

Who pays for your **covered services** – this plan, both of us, or just you? That depends.

The general rule

The schedule of benefits lists what you pay for each type of **covered service**. In general, this is how your benefit works:

- You pay the **deductible**, when it applies.
- Then the plan and you share the expense. Your share is called a **copayment** or **coinsurance**.
- Then the plan pays the entire expense after you reach your **maximum out-of-pocket limit**.

When we say “expense” in this general rule, we mean the **negotiated charge** for a **network provider**, and **allowable amount** for an **out-of-network provider**.

Negotiated charge

For health coverage:

This is the amount a **network provider** has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid).

We may enter into arrangements with **network providers** or others related to:

- The coordination of care for members
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing
- Accountable care arrangements

These arrangements will not change the **negotiated charge** under this plan.

For prescription drug services:

When you get a **prescription** drug, we have agreed to this amount for the **prescription** or paid this amount to the network pharmacy or third party vendor that provided it. The **negotiated charge** may include a rebate, additional service or risk charges and administrative fees. It may include additional amounts paid to or received from third parties under price guarantees.

Allowable amount

This is the amount of an **out-of-network provider’s** charge that is eligible for coverage. You are responsible for all charges above this amount. The **allowable amount** depends on the geographic area where you get the service or supply.

Allowable amount doesn’t apply to involuntary services. These are services or supplies that are:

- Provided at a network facility by an **out-of-network provider**
- Not available from a **network provider**
- An **emergency service**

We will calculate your cost share for involuntary services in the same way as we would if you received the services from a **network provider**. See the *Surprise bill* section for more information on some of these services.

The table below shows the method for calculating the **allowable amount** for specific services or supplies:

Service or supply:	Allowable amount is based on:
Professional services and other services or supplies not mentioned below	Reasonable amount rate
Services of hospitals and other facilities	Reasonable amount rate
Prescription drugs	110% of average wholesale price (AWP)

Important note:

See *Special terms used* below, for a description of what the **allowable amount** is based on.

If the **provider** bills less than the amount calculated using a method above, the **allowable amount** is what the **provider** bills.

If your ID card displays the National Advantage Program (NAP) logo, your cost share may be lower when you get care from a NAP **provider**. These are **out-of-network providers** and third party vendors who have contracts with us but are not **network providers**. When you get care from a NAP **provider**, your out-of-network cost share applies. Contact us or the policyholder for more information.

Special terms used:

- Average wholesale price (AWP) is the current average wholesale price of a **prescription** drug as listed in the Facts & Comparisons®, Medi-Span daily price updates or any other similar publication we choose to use.
- Geographic area is normally based using the first three digits of a zip code. If we believe we need more data for a particular service or supply, we may base rates on a wider geographic area such as the entire state.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees without taking into account adjustments for specific **provider** performance. We update our system with revised rates within 180 days of receiving them from CMS. If Medicare doesn't have a rate, we use one or more of the items below to determine the rate for a service or supply:
 - The method CMS uses to set Medicare rates
 - How much other **providers** charge or accept as payment
 - How much work it takes to perform a service
 - Other things as needed to decide what rate is reasonable

We may make the following exceptions:

- For inpatient services, our rate may exclude amounts CMS allows for operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME) programs
- Our rate may exclude other payments that CMS may make directly to **hospitals** or other **providers** and backdated adjustments
- For anesthesia, our rate may be at least 100% of the rate CMS establishes
- For lab, our rate may be 75% of the rate CMS establishes
- For DME, our rate may be 75% of the rate CMS establishes
- For medications that are paid as a medical benefit instead of a pharmacy benefit, our rate may be 100% of the rates CMS establishes

When the **allowable amount** is based on a percentage of the Medicare allowed rate, it is not affected by adjustments or incentives given to **providers** under Medicare programs.

Reasonable amount rate means your plan has established a rate amount as follows:

Service or supply:	Reasonable amount rate is:
Professional services	The percentile value reported in a database prepared by FAIR Health
Inpatient and outpatient hospital charges	200% of Medicare allowed rate

Service or supply:	Reasonable amount rate is:
Inpatient and outpatient charges that are not from a hospital	200% of Medicare allowed rate

Our reimbursement policies

We have the right to apply our reimbursement policies to all out-of-network services including involuntary services. This may affect the **allowable amount**. When we do this, we consider:

- The length and difficulty of a service
- Whether additional expenses are needed, when multiple procedures are billed at the same time
- Whether an assistant surgeon is needed
- If follow up care is included
- Whether other conditions change or make a service unique
- Whether any of the services described by a claim line are part of or related to the primary service provided, when a charge includes more than one claim line
- The educational level, licensure or length of training of the **provider**

We base our reimbursement policies on our review of:

- CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and aren't appropriate
- Generally accepted standards of medical and dental practice
- The views of **physicians** and dentists practicing in relevant clinical areas

We use commercial software to administer some of these policies. Policies may differ for professional services and facility services.

These reimbursement policies will comply with Virginia state law.

Get the most from your benefits:

We have online tools to help you decide whether to get care and if so, where. Log in to your member website. The website contains additional information that can help you determine the cost of a service or supply.

Balance billing protection for out-of-network services

You are protected from balance billing by an **out-of-network provider** for certain services.

Surprise bill

There may be times when you receive **emergency services** and treatment to stabilize or services after stabilization from an **out-of-network provider**, even when you try to stay in the network for your **covered services**. You may get a bill at the out-of-network rate that you didn't expect. This is called a surprise bill.

An **out-of-network provider** can't balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirement, such as **deductibles**, **copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider** and ancillary services initiated from your **emergency services**
- Non-emergency surgical or ancillary services provided by an **out-of-network provider** at an in-network facility
- Out-of-network air ambulance services

Surgical or ancillary services mean any professional services including:

- Items and services related to emergency medicine

- Surgery
- Anesthesiology
- Hospitalist services
- Laboratory services
- Neonatology
- Pathology
- Radiology
- Services provided by an **out-of-network provider** because there was no **network provider** available to perform the service

A facility in this section means an institution providing health care related services, or a health care setting. This includes the following:

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory, and imaging centers
- Rehabilitation facilities
- Other therapeutic health settings

A surprise bill claim is paid based on the median contracted rate for all plans offered by us in the same insurance market for the same or similar item or service that is all of the following:

- A commercially reasonable amount
- Provided by a **provider** in the same or similar specialty or facility of the same or similar facility type
- Provided in the geographic region in which the item or service is furnished

The median contracted rate is subject to additional adjustments as specified in federal regulations.

Any cost share paid with respect to the items and services will apply toward your in-network **deductible** and **maximum out-of-pocket limit** if you have one.

You may request external review if you want to know if the federal surprise bill law applies to your situation.

If you are billed an amount that exceeds your payment responsibility stated on your explanation of benefits or you believe you've been wrongly billed, you can call the federal agencies responsible for enforcing the federal balance billing protection law at: 1-800-985-3059 and/or file a complaint with the State Corporation Commission's Virginia Bureau of Insurance at <https://scc.virginia.gov/pages/File-Complaint-Consumers> or call 1-877-310-6560.

If you receive a surprise bill or have any questions about what a surprise bill is, contact us.

Paying for covered services – the general requirements

There are several general requirements for the plan to pay any part of the expense for a **covered service**. For in-network coverage, they are:

- The service is **medically necessary**
- You get your care from a **network provider**
- You or your **provider precertifies** the service when required

For out-of-network coverage:

- The service is **medically necessary**
- You get your care from an **out-of-network provider**
- You or your **provider precertifies** the service when required

For outpatient **prescription** drugs, your costs are based on:

- The type of **prescription** you're prescribed
- Where you fill the **prescription**

The plan may make some **brand-name prescription drugs** available to you at the **generic prescription drug** cost share.

Generally, your plan and you share the cost for **covered services** when you meet the general requirements. But sometimes your plan will pay the entire expense, and sometimes you will. For details, see your schedule of benefits and the information below.

You pay the entire expense when:

- You get services or supplies that are not **medically necessary**.
- Your plan requires **precertification**, your **physician** requests it, we deny it and you get the services without **precertification**.
- You get care and the **provider** waives all or part of your cost share.

In all these cases, the **provider** may require you to pay the entire charge. Any amount you pay will not count towards your **deductible** or your **maximum out-of-pocket limit**.

Where your schedule of benefits fits in

The schedule of benefits shows any out-of-pocket costs you are responsible for when you receive **covered services** and any benefit limitations that apply to your plan. It also shows any **maximum out-of-pocket limits** that apply.

Limitations include things like maximum age, visits, days, hours, and admissions. Out-of-pocket costs include things like **deductibles**, **copayments** and **coinsurance**.

Keep in mind that you are responsible for paying your part of the cost sharing. You are also responsible for costs not covered under this plan.

Coordination of benefits

Some people have health coverage under more than one health plan. If you do, we will work with your other plan to decide how much each plan pays. This is called coordination of benefits (COB).

Key Terms

Here are some key terms we use in this section. These will help you understand this COB section.

Allowable expense means a health care expense that any of your health plans cover.

In this section when we talk about “plan” through which you may have other coverage for health care expenses we mean:

- Group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, employer organization plans, or employee benefit organization plans
- Medicare or other government benefits
- Any group health insurance contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

How COB works

- When this is your primary plan, we pay your medical claims first as if there is no other coverage.
- When this is your secondary plan:
 - We pay benefits after the primary plan and coordinate our payment based on any amount the primary plan paid.
 - Total payments from this plan and your other coverage will never add up to more than 100% of the allowable expenses.
 - Each family member has a separate benefit reserve for each year. The benefit reserve balance is:
 - The amount that the secondary plan saved due to COB
 - Used to cover any unpaid allowable expenses
 - Erased at the end of the year

Determining who pays

The basic rules are listed below. Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary. Contact us if you have questions or want more information. A plan that does not contain a COB provision is always the primary plan.

COB rule	Primary Plan	Secondary plan
Non-dependent or dependent	Plan covering you as an employee, retired employee or subscriber (not as a dependent)	Plan covering you as a dependent
Child – parents married or living together	Plan of parent whose birthday (month and day) is earlier in the year (Birthday rule)	Plan of parent whose birthday is later in the year
Child – parents separated, divorced, or not living together	<ul style="list-style-type: none"> • Plan of parent responsible for health coverage in court order • Birthday rule applies if both parents are responsible or have joint custody in court order • Custodial parent’s plan if there is no court order 	<ul style="list-style-type: none"> • Plan of other parent • Birthday rule applies (later in the year) • Non-custodial parent’s plan
Child – covered by individuals who are not parents (i.e. stepparent or grandparent)	Same rule as parent	Same rule as parent

COB rule	Primary Plan	Secondary plan
Active or inactive employee	Plan covering you as an active employee (or dependent of an active employee)	Plan covering you as a laid off or retired employee (or dependent of a former employee)
Consolidated Omnibus Budget Reconciliation Act (COBRA) or state continuation	Plan covering you as an employee or retiree (or dependent of an employee or retiree)	COBRA or state continuation coverage
Longer or shorter length of coverage	Plan that has covered you longer	Plan that has covered you for a shorter period of time
Other rules do not apply	Plans share expenses equally	Plans share expenses equally

How COB works with Medicare

If your other coverage is under Medicare, federal laws explain whether Medicare will pay first or second. COB with Medicare will always follow federal requirements. Contact us if you have any questions about this.

When you are eligible for Medicare, we coordinate the benefits we pay with the benefits that Medicare pays. If you are eligible due to age but not covered, and Medicare would be your primary payer, we may still pay as if you are covered by Medicare and coordinate with the benefits Medicare would have paid. Sometimes, this plan pays benefits before Medicare pays. Sometimes, this plan pays benefits after Medicare or after an amount that Medicare would have paid if you had been covered.

You are eligible for Medicare if you are covered under it. You are also eligible for Medicare even if you are not covered or if you refused it, dropped it, or didn't make a request for it.

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. Your current and prior plan must be offered through the same policyholder.

Other health coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

Our rights

We have the right to:

- Release or obtain any information we need for COB purposes, including information we need to recover any payments from your other health plans
- Reimburse another health plan that paid a benefit we should have paid
- Recover any excess payment from a person or another health plan, if we paid more than we should have paid

Benefit payments and claims

A claim is a request for payment that you or your health care **provider** submits to us when you want or get **covered services**. There are different types of claims. You or your **provider** may contact us at various times, to make a claim, to request approval, or payment, for your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit.

It is important that you carefully read the previous sections within *How your plan works*. When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. The amount of time we have

to tell you about our decision on a claim depends on the type of claim.

Claim type and timeframes

Urgent care claim

An urgent claim is one for which the doctor treating you decides a delay in getting medical care could put your life or health at risk. Or a delay might put your ability to regain maximum function at risk. It could also be a situation in which you need care to avoid severe pain. We will make a decision within 72 hours. We will make a decision within 24 hours for appeals that related to a **prescription** to alleviate cancer pain.

If you are pregnant, an urgent claim also includes a situation that can cause serious risk to the health of your unborn baby.

Pre-service claim

A pre-service claim is a claim that involves services you have not yet received and which we will pay for only if we **precertify** them. We will make a decision within 15 days.

Post-service claim

A post-service claim is a claim that involves health care services you have already received. We will make a decision within 30 days.

Concurrent care claim extension

A concurrent care claim extension occurs when you need us to approve more services than we already have approved. Examples are extending a **hospital stay** or adding a number of visits to a **provider**. You must let us know you need this extension 24 hours before the original approval ends. We will have a decision within 24 hours for an urgent request. You may receive the decision for a non-urgent request within 15 days.

Concurrent care claim reduction or termination

A concurrent care claim reduction or termination occur when we decide to reduce or stop payment for an already approved course of treatment. We will notify you of such a determination. You will have enough time to file an appeal. Your coverage for the service or supply will continue until you receive a final appeal decision from us or an independent review organization if the situation is eligible for external review.

During this continuation period, you are still responsible for your share of the costs, such as **copayments**, **coinsurance** and **deductibles** that apply to the service or supply. If we uphold our decision at the final internal appeal, you will be responsible for all of the expenses for the service or supply received during the continuation period.

Filing a claim

This section will give you instruction on filing a claim that is not subject to surprise bill protection. All surprise bill claims will be paid in 30 days. See *Surprise bill* provision.

When you see a **network provider**, that office will usually send us a detailed bill for your services. If you see an **out-of-network provider**, you may receive the bill (proof of loss) directly. This bill forms the basis of your post-service claim. If you receive the bill directly, you or your **provider** must send us the bill within 15 months of the date you received services, unless you are legally unable to notify us. You must send it to us with a claim form. Please see the *Claim forms* section for more information. You should always keep your own record of the date, **providers** and cost of your services.

The benefit payment determination is made based on many things, such as your **deductible** or **coinsurance**, the **medical necessity** of the service you received, when or where you receive the services, or even what other insurance you may have. We may need to ask you or your **provider** for some more information to make a final

decision. You can always contact us directly to see how much you can expect to pay for any service.

We will pay the claim within 30 days from when we receive all the information necessary. In no event will benefits be paid later than 60 days after we receive the proof of loss. Sometimes we may pay only some of the claim. Sometimes we may deny payment entirely.

We will give you our decision in writing. You may not agree with our decision. There are several ways to have us review the decisions. Please see the *Complaints, claim decisions, and appeal procedures* section for that information.

Claim forms

You are required to submit a claim form to us in writing. Claim forms will be furnished by us within 15 days of notification of the claim. If we fail to provide a claim form within 15 days of notification of a claim, proof of loss will be met by giving us a written statement of the nature and extent of the loss within the time limit in the *Proof of loss* section.

Notice of claim

You must give us written notice of claim within 20 days after you have incurred expenses for **covered services**. If you don't notify us within that time and can show that it was not reasonably possible to do so, we won't void or reduce your claim. But you must send us notice as soon as reasonably possible.

Proof of loss

You should give us written proof of loss no later than 90 days after you have incurred expenses for **covered services**. We won't void or reduce your claim if it was not reasonably possible to send us proof of loss within the required time. But you must send us the proof as soon as reasonably possible. Proof of loss may not be given later than 1 year after the time proof is otherwise required, except if you are legally unable to notify us.

Complaints, claim decisions and appeal procedures

The difference between a complaint and an appeal

Complaint

You may not be happy about a **provider** or an operational issue, and you may want to complain. You can contact us at any time. This is a complaint. Your complaint should include a description of the issue. You should include copies of any records or documents you think are important. We will review the information and give you a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

Appeal

When we make a decision to deny services or reduce the amount of money we pay on your care or out-of-pocket expense, it is an adverse benefit determination. You can ask us to re-review that determination. This is an appeal. You can start an appeal process by contacting us.

Claim decisions and appeal procedures

Your **provider** may contact us at various times to make a claim, or to request approval for payment based on your benefits. This can be before you receive your benefit, while you are receiving benefits and after you have received the benefit. You may not agree with our decision. As we said in *Benefit payments and claims* in the *How your plan works* section, we pay many claims at the full rate, except for your share of the costs. But sometimes we pay only some of the claim. Sometimes we deny payment entirely.

Any time we deny even part of the claim, it is an “adverse benefit determination” or “adverse decision.” For any adverse decision, you will receive an explanation of benefits in writing. You can ask us to review an adverse benefit determination. This is the internal appeal process. If you still don’t agree, you can also appeal that decision. There are times you may skip the two levels of internal appeal. But in most situations, you must complete both levels before you can take any other actions, such as an independent review.

Appeal of an adverse benefit determination

Urgent care or pre-service claim appeal

If your claim is an urgent claim or a pre-service claim, your **provider** may appeal for you without having to fill out an appeal form. We will give you an answer within 36 hours for an urgent appeal and within 15 calendar days for a pre-service appeal. A concurrent claim appeal will be addressed according to what type of service and claim it involves. We will give you an answer within 72 hours of receipt of your concurrent claim appeal.

Any other claim appeal

You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination, or by contacting us. You need to include:

- Your name
- The plan sponsor’s name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

We will assign your appeal to someone who was not involved in making the original decision. You will receive a decision within 30 calendar days for a post-service claim.

If you are still not satisfied with the answer, you may make a second internal appeal. You must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Another person may submit an appeal for you, including a **provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **provider**). You should fill out an authorized representative form telling us you are allowing someone to appeal for you. You can get this form on your member website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

At your last available level of appeal, we will give you any new or additional information we may find and use to review your claim. There is no cost to you. We will give you the information before we give you our decision. This decision is called the final adverse benefit determination. You can respond to the information before we tell you what our final decision is.

Prescription drug exception request

See the *Medical necessity, referral, and precertification requirements* section for information on requesting and gaining access to clinically appropriate **prescription drugs** that are not covered under this policy.

Exhaustion of appeal process

In most situations, you must complete the two levels of appeal with us before you can take these other actions:

- Appeal through an external review process
- Pursue arbitration, litigation or other type of administrative proceeding

Sometimes you do not have to complete the two levels of appeal before you may take other actions. These situations are:

- You have an urgent claim or claim that involves ongoing treatment, or a claim that involves treatment of cancer. You can have your claim reviewed internally and through the external review process at the same time.
- We did not follow all of the claim determination and appeal requirements of Virginia. But you will not be able to proceed directly to external review if:
 - The rule violation was minor and not likely to influence a decision or harm you
 - The violation was for a good cause or beyond our control
 - The violation was part of an ongoing, good faith exchange between you and us; or
 - You filed an appeal and did not receive a written decision within 30 days unless you requested or agreed to a delay.

The Virginia Bureau of Insurance is also available to help you at any time during the appeal process. You are not required to complete the appeal process with us before you contact them. See the *Managed Care Ombudsman* section below for additional information.

External review

External review is a review done by people in an organization outside of Aetna. This is called an independent review organization (IRO).

You have a right to external review only if all the following conditions are met:

- You have received an adverse benefit determination
- Our claim decision involved medical judgement
- We decided the service or supply is not **medically necessary**, not appropriate, or we decided the service or supply is **experimental, investigational, or proven**
- You have exhausted the internal appeal process (in most cases)

If our claim decision is one for which you can seek external review, we will say that in the notice of adverse benefit determination or final adverse benefit determination we send you. That notice also will describe the external review process. It will include a copy of the request for external review form at the final adverse determination level.

You must submit the request for external review form:

- To the Virginia Bureau of Insurance
- Within 120 calendar days of the date you received the decision from us
- With a copy of the notice from us, along with any other important information that supports your request

You will pay the postage and/or delivery fees for any information that you send and want reviewed by the IRO. We will pay for information we send to the IRO plus the cost of the review.

The Virginia Bureau of Insurance will contact the IRO that will conduct the review of your claim.

The IRO will:

- Assign the appeal to one or more independent clinical reviewers that have proper expertise to do the review
- Consider appropriate credible information that you sent
- Follow our contractual documents and your plan of benefits
- Send notification of the decision within 45 calendar days of the date we receive your request form and all the necessary information

We will stand by the decision that the IRO makes.

How long will it take to get an IRO decision?

We will give you the IRO decision not more than 45 calendar days after we receive your notice of external review form with all the information you need to send in.

Sometimes you can get a faster external review decision. Your **provider** must submit a request for external review form to the Virginia Bureau of Insurance.

There are two scenarios when you may be able to get a faster external review:

For initial adverse benefit determinations

- Your treatment is for cancer or your **provider** tells the Virginia Bureau of Insurance a delay in receiving health care services for your medical condition would:
 - Jeopardize your life, health or ability to regain maximum function

- Be much less effective if not started right away (in the case of **experimental or investigational** treatment)

For final adverse determinations

Your treatment is for cancer or your **provider** tells the Virginia Bureau of Insurance a delay in receiving health care services for your medical condition would:

- Jeopardize your life, health or ability to regain maximum function
- Be much less effective if not started right away (in the case of **experimental or investigational** treatment), or
- The final adverse determination concerns an admission, availability of care, continued **stay** or health care service for which you received **emergency services**, but have not been discharged from a facility

If your situation qualifies for this faster review, you will receive a decision within 72 hours of the IRO's receipt of the request.

Managed Care Ombudsman

If you have any questions regarding an appeal which have not been satisfactorily addressed by us, you may contact the Office of the Managed Care Ombudsman for assistance.

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218-1157

Toll-free: (877) 310-6560
Richmond Metropolitan Area: (804) 371-9741
Email: ombudsman@scc.virginia.gov

Virginia Department of Health, Office of Licensure and Certification

Your or your **provider** can contact the Office of Licensure and Certification to file a complaint regarding quality of care, choice and accessibility of **providers**, or network adequacy. The contact information is shown below:

Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Richmond, VA 23233-1463

Toll-free: (800) 955-1819
Richmond Metropolitan Area: (804) 367-2104
E-mail: OLC-Complaints@vdh.virginia.gov
Fax: (804) 527-4503

Utilization review

Prescription drugs covered under this plan are subject to misuse, waste or abuse utilization review by us, your **provider** or your network pharmacy. The outcome of the review may include:

- Limiting coverage of a drug to one prescribing **provider** or one network pharmacy
- Quantity, dosage or day supply limits
- Requiring a partial fill or denial of coverage

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you in pursuing a complaint or appeal.

Eligibility, starting and stopping coverage

Eligibility

Who is eligible

The policyholder decides and tells us who is eligible for health coverage.

When you can join the plan

You must live or work in the service area to enroll in this plan.

You can enroll:

- At the end of any waiting period the policyholder requires
- Once each year during the annual enrollment period
- At other special times during the year (see the *Special times you can join the plan* section below)

You can enroll eligible family members (these are your “dependents”) at this time too.

If you don’t enroll when you first qualify for benefits, you may have to wait until the next annual enrollment period to join.

Who can be a dependent on this plan

You can enroll the following family members:

- Your legal spouse
- Your domestic partner who meets policyholder rules and requirements under state law
- Dependent children – yours or your spouse’s or partner’s
 - Dependent children must be:
 - Under 26 years of age
 - Dependent children include:
 - Natural children
 - Stepchildren
 - Adopted children including those placed with you for adoption
 - Foster children
 - Children you are responsible for under a qualified medical support order or court order
 - Grandchildren in your legal custody

Adding new dependents

You can add new dependents during the year. These include any dependents described in the *Who can be a dependent on this plan* section above.

Coverage begins on the date of the event for new dependents that join your plan for the following reasons:

- Birth
- Adoption or placement for adoption
- Marriage or domestic partnership
- Legal guardianship
- Court or administrative order

We must receive a completed enrollment form not more than 31 days after the event date.

Special times you can join the plan

You can enroll in these situations:

- You didn't enroll before because you had other coverage and that coverage has ended
-

- Your COBRA coverage has ended
- A court orders that you cover a dependent on your health plan
- When your dependent moves outside the service area for your employee plan

We must receive the completed enrollment information within 31 days of the date when coverage ends.

You can also enroll in these situations:

- You or your dependent lose your eligibility for enrollment in Medicaid or an S-CHIP plan
- You are now eligible for state premium assistance under Medicaid or S-CHIP which will pay your premium contribution under this plan

We must receive the completed enrollment information within 60 days of the date when coverage ends.

Notification of change in status

Tell us of any changes that may affect your benefits. Please contact us as soon as possible when you have a:

- Change of address
- Dependent status change
- Dependent who enrolls in Medicare or any other health plan

Starting coverage

Your coverage under this plan has a start and an end. You must start coverage after you complete the eligibility and enrollment process. You can ask your policyholder to confirm your effective date.

Stopping coverage

Your coverage typically ends when you leave your job; but it can happen for other reasons. Ending coverage doesn't always mean you lose coverage with us. There will be circumstances that will still allow you to continue coverage. See the *Special coverage options after your coverage ends* section.

We will send you notice if your coverage is ending. This notice will tell you the date that your coverage ends.

When will your coverage end

Your coverage under this plan will end if:

- This plan is no longer available
- You ask to end coverage
- The policyholder asks to end coverage
- You are no longer eligible for coverage
- Your work ends
- You stop making required contributions, if any apply
- We end your coverage as described under the *Why would we end your coverage* section.
- You start coverage under another medical plan offered by your employer

When dependent coverage ends

Dependent coverage will end if:

- A dependent is no longer eligible for coverage.
- You stop making premium contributions, if any apply.
- Your coverage ends for any of the reasons listed above except:
 - You enroll under a group Medicare plan we offer. However, dependent coverage will end if your coverage ends under the Medicare plan.
- The date this plan no longer allows coverage for domestic partners.

- The date the domestic partnership ends.
 - You will need to complete a Declaration of Termination of Domestic Partnership.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your coverage ends* section for more information.

Why would we end your coverage?

We may end your coverage if you act in a way that affects our business operations. We will give you 30 days notice in writing if we end your coverage for any of these reasons.

We will give you a 31 day advance notice if we end your coverage if you commit fraud or you intentionally misrepresented yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on rescissions.

On the date your coverage ends, we will refund to your employer any prepayment for periods after the date your coverage ended.

Special coverage options after your coverage ends

When coverage may continue under the plan

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have. Contact the policyholder to see what options apply to you.

In some cases, premium payment is required for coverage to continue. Your coverage will continue under the plan as long as the policyholder and we have agreed to do so. It is the policyholder responsibility to let us know when your work ends. If the policyholder and we agree in writing, we will extend the limits.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The federal COBRA law usually applies to employers of group sizes of 20 or more and gives employees and most of their covered dependents the right to keep their health coverage for 18, 29 or 36 months after a qualifying event. The qualifying event is something that happens that results in you losing your coverage.

The qualifying events are:

- Your active employment ends for reasons other than gross misconduct
- Your working hours are reduced
- You divorce or legally separate and are no longer responsible for dependent coverage
- You become entitled to benefits under Medicare
- Your covered dependent children no longer qualify as dependents under the plan
- You die
- You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy

Talk with your employer if you have questions about COBRA or to enroll.

Continuation of coverage

If your coverage ends under this plan, you can continue coverage for yourself and your covered dependents if:

- Your employer is not required to offer COBRA coverage
 - You are not eligible for Medicare
 - You are not eligible for any other replacement group coverage
 - You are not eligible for or have benefits available under another health care plan
 - You have had 3 months of continuous coverage prior to your termination
-

- Your employer did not end your employment because of gross misconduct, as determined by your employer and Virginia law

To continue coverage, you must:

- Apply through your employer's normal process
- Pay the required premium within 31 days of the written notice from your employer (but no later than 60 days following the date of the termination of your coverage)

Evidence of insurability is not required for you to continue coverage.

The premium will be the current premium rate for the policy. Your employer may charge an administrative fee of no more than 2.0% of the current rate.

You can continue your coverage for 12 months. Each premium must be paid on a monthly basis during the 12-month period.

Extension of coverage for other reasons

How you can extend coverage if you are totally disabled when coverage ends

Your coverage may be extended if you are totally disabled when coverage ends. You are "totally disabled" if you cannot work at your occupation or any other occupation for pay or profit.

Your covered dependent is "totally disabled" if they can't engage in most normal activities like a healthy person of the same age and gender.

You may extend coverage until the earliest of:

- When you or your dependent are no longer totally disabled
- When you become covered by another health benefits plan
- 12 months of coverage

How you can extend coverage for your disabled child beyond the plan age limits

You have the right to extend coverage for your dependent child beyond plan age limits, if the child is not able to be self-supporting because of intellectual or physical disability and depends mainly on you for support.

Proof of incapacity and dependency must be furnished to us within 31 days of the child's attainment of the specified age.

Subsequent proof may be required but not more frequently than annually after the 2-year period following the child's attainment of the specified age.

How you can extend coverage when getting inpatient care when coverage ends

Your coverage may be extended if you are getting inpatient care in a **hospital** or **skilled nursing facility** when coverage ends.

Benefits are extended for the condition that caused the **hospital** or **skilled nursing facility stay** or for complications from the condition. Benefits aren't extended for other medical conditions.

You can continue to get care for this condition until the earliest of:

- When you are discharged
 - When you no longer need inpatient care
 - When you become covered by another health benefits plan
 - 12 months of coverage
-

How you can extend coverage for hearing services and supplies when coverage ends

If you are not totally disabled when your coverage ends, coverage for hearing services and supplies may be extended for 30 days after your coverage ends:

- If the **prescription** for the hearing aid is written during the 30 days before your coverage ends
- If the hearing aid is ordered during the 30 days before your coverage ends

How you can extend coverage for your child in college on medical leave

You have the right to extend coverage for your dependent college student who takes a medically necessary leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins
- The date coverage would otherwise end

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious illness or injury
- Cause the dependent child to lose status as a full-time student under the plan
- Be certified by the treating **physician** as medically necessary due to serious illness or injury

The **physician** treating your child will be asked to keep us informed of any changes.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this certificate

We prepared this certificate according to ERISA and other federal and state laws that apply. You and we will interpret it according to these laws. Our interpretation of this certificate applies when we administer your coverage. But you have the right to appeal our decisions as described in the *Complaints, claim decisions and appeal procedures* section.

How we administer this plan

We administer this plan to comply with all applicable laws and regulations. We also apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. Even **network providers** are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the group policy. This document may have amendments and riders too. Under certain circumstances, we, the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive **precertification**, **prescription** quantity limits or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the policyholder or **provider**, can do this.

Physical examination

At our expense, we have the right to have a **physician** of our choice examine you. This will be done at reasonable times while a claim is pending.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim. Important things to keep are:

- Names of **physicians** and others who furnish services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional misrepresentation

Honest mistakes

You or the policyholder may make an honest mistake when you share facts with us. When we learn of the mistake, we may make a fair change in premium contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years from the date of the group policy.

Intentional misrepresentation

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Rescission of coverage
-

- Denial of benefits
- Recovery of amounts we already paid

You have special rights if we rescind your coverage:

- We will give you 30 days advance written notice of any rescission of coverage and the notice will:
 - Identify the alleged fraudulent act, practice, or omission or the intentional misrepresentation of material fact
 - Explain why the act, practice, or omission was fraud, an omission or an intentional misrepresentation of a material fact
 - advise you, or your authorized representative, of your right to an **Aetna** appeal
 - describe our internal appeal process, including any applicable time limits
 - provide the date the advance notice ends, and the day back to which coverage is lost
- We will refund all premiums you paid

See the *Complaints, claim decisions and appeal procedures* section for information on how to submit an appeal.

Some other money issues

Legal action

You cannot take any action until 60 days after we receive written proof of loss.

No legal action can be brought to recover payment under any benefit after 3 years from the date written proof of loss was required to be filed. See the *Proof of loss* section.

Assignment of benefits

When you see a **network provider**, they will usually bill us directly. When you see an **out-of-network provider**, we may choose to pay you or to pay the **provider** directly. If services are related to balance billing protection, we will always pay the **out-of-network provider** and not require an assignment of benefits. If we pay you, you are responsible for applying any payment to the claim from the **out-of-network provider**. Except for dental, oral surgery or ambulance services, to the extent allowed by law, we will not accept an assignment to an **out-of-network provider**.

Member cost share paid by a third party

We will apply amounts paid on your behalf toward your member cost share or maximum out-of-pocket limit.

Payment of benefits

All benefits are payable to you. Or we will pay your beneficiary designated by you. If any **covered services** are payable to either:

- Your estate, or
- A person who is a minor or otherwise not competent to give a valid release

We may pay up to \$5,000 to a person related to you by blood or marriage that we believe is fairly entitled to the benefits.

We may also pay all or any portion of the benefits to the provider who performed the services.

Financial sanctions exclusions

If coverage provided under this certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **covered services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Asset Control (OFAC). You can find out more by visiting <https://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Grace period

You have a grace period of 31 days after the due date to pay your contribution for coverage under the plan, except the first contribution. Your coverage will remain in force during the grace period. If you haven't paid your contribution by the end of the grace period, we will end your coverage at the end of the grace period.

Premium contribution

Your plan requires that the policyholder make premium contribution payments. After the expiration of the grace period, we will not pay for benefits if premium contributions are not made. Any decision to not pay benefits can be appealed.

Recovery of overpayments

We sometimes pay too much for **covered services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid, you or your **provider**, to return what we paid. If we don't do that, we have the right to reduce any future benefit payments by the amount we paid by mistake.

Your health information

We will protect your health information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just contact us.

When you accept coverage under this plan, you agree to let your **providers** share information with us. We need information about your physical and mental condition and care.

Effect of benefits under other plans**Health Maintenance Organization (HMO) plan**

If you are eligible for and enrolled in coverage under an HMO plan offered by the policyholder, you will not have coverage under this plan on the date that your HMO plan coverage starts. If you are pregnant when you change plans, you may be eligible for an extension of benefits. Contact us for more information.

Glossary

Allowable amount

See *How your plan works – What the plan pays and what you pay*.

Behavioral health provider

A **health professional** who is licensed or certified to provide **covered services** for mental health and **substance use disorders** in the state where the person practices.

Brand-name prescription drug

An FDA-approved drug marketed with a specific name or trademark name by the company that manufactures it; often the same company that developed and patents it.

Coinsurance

This is the percentage of **covered services** you pay after your **deductible**.

Copay, copayment

This is the dollar amount you pay for **covered services**. In most plans, you pay this after you meet your **deductible** limit. In **prescription** drug plans, it is the amount you pay for covered drugs.

Covered service

The benefits, subject to varying cost shares, covered under the plan. These are:

- Described in the *Providing covered services* section
- Not listed as an exclusion in the *Coverage and exclusions – Providing covered services* section or the *General plan exclusions* section
- Not beyond any limits in the schedule of benefits
- **Medically necessary**. See the *How your plan works – Medical necessity and precertification requirements* section and the *Glossary* for more information

Deductible

A **deductible** is the amount you pay out-of-pocket for **covered services** per year before we start to pay.

Detoxification

The process of getting alcohol or other drugs out of an addicted person's system and getting them physically stable.

Drug guide

A list of **prescription** and OTC drugs and devices established by us or an affiliate. It does not include all **prescription** and OTC drugs and devices. This list can be reviewed and changed by us or an affiliate. A copy is available at your request. Go to <https://www.aetna.com/individuals-families/find-a-medication.html>

Emergency medical condition

Regardless of the final diagnosis rendered to you, a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that:

- Needs immediate medical care
 - Leads a prudent layperson with average knowledge of health and medicine to reasonably believe that, without immediate medical care, it could result in:
-

- Danger to physical or mental health
- Danger of serious impairment to bodily function
- Serious dysfunction to any bodily part or organ, or
- In the case of a pregnant woman, danger to the health of an unborn baby

Emergency services

A medical screening examination, including ancillary services, given in a **hospital's** emergency room or an independent freestanding emergency department to evaluate an **emergency medical condition**. This includes any further medical examination evaluation of and treatment to stabilize the patient. **Emergency services** also include behavioral health assessments and routine ancillary services by a behavioral health crisis service provider to evaluate, treat, or prevent a patient's condition from deteriorating.

An independent freestanding emergency department means a health care facility that is geographically separate, distinct, and licensed separately from a **hospital** and provides **emergency services**.

Stabilize means providing treatment to assure the condition will not get worse as a result of, or during, the transfer of the individual from a facility. For a pregnant woman, stabilize also means that the woman has delivered, including the placenta.

Experimental, investigational, or unproven

A drug, device, procedure, supply, treatment, test, or technology is considered by us to be **experimental, investigational, or unproven** if any of the following apply:

- It hasn't been shown through well-conducted clinical trials or cohort studies published in peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which it's meant.
 - A well-conducted clinical trial means a randomized, controlled trial where the experimental intervention is compared to a control group receiving care according to best practice and study participants are randomly assigned to the experimental or control group.
 - A well-conducted cohort study means a prospective cohort study from more than one institution where the experimental intervention is compared to a group of subjects receiving care according to best practice and where the comparison group is well matched to the experimental intervention group.
- There isn't FDA approval or clearance to market it for the proposed use.
- A national medical society, dental society, or regulatory agency has written that it's **experimental, investigational, or unproven**, or mainly for research purposes.
- It's the subject of a Phase I, Phase II, or the experimental or research arm of a Phase III clinical trial. The FDA and Department of Health and Human Services define these.
- Written procedures or consent form used by a facility **provider** says it's **experimental, investigational, or unproven**.

Generic prescription drug

An FDA-approved drug with the same intended use as the brand-name product, that is considered to be as effective as the brand-name product. It offers the same:

- Dosage
 - Safety
 - Strength
 - Quality
 - Performance
-

Health professional

A person who is authorized by law to provide health care services to the public; for example, **physicians**, nurses and physical therapists.

Home health care agency

An agency authorized by law to provide home health services, such as skilled nursing and other therapeutic services.

Hospital

An institution licensed as a **hospital** by applicable law and accredited by The Joint Commission (TJC). This is a place that offers medical care. Patients can stay overnight for care. Or they can be treated and leave the same day. All **hospitals** must meet set standards of care. They can offer general or acute care. They can also offer service in one area, like rehabilitation.

Jaw joint disorder

This is:

- A temporomandibular joint (TMJ) dysfunction or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Mail order pharmacy

A pharmacy where **prescription** drugs are legally dispensed by mail or other carrier.

Maximum out-of-pocket limit

The **maximum out-of-pocket limit** is the most a covered person will pay per year in **copayments**, **coinsurance** and **deductible**, if any, for **covered services**.

Medically necessary, medical necessity

Health care services or supplies that prevent, evaluate, diagnose or treat an illness, injury, disease or its symptoms, and that are all of the following, as determined by us within our discretion:

- In accordance with “generally accepted standards of medical practice”
- Clinically appropriate, in terms of type, frequency, extent, duration, and considered effective for your illness, injury or disease
- Not primarily for your convenience, the convenience of your **physician**, or other health care **provider**

Generally accepted standards of medical practice mean:

- Standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community and
- Following the standards set forth in our clinical policies and applying clinical judgment

Important note:

We develop and maintain clinical policy bulletins that describe the generally accepted standards of medical practice, credible scientific evidence, and prevailing clinical guidelines that support our decisions regarding specific services. We use these bulletins and other resources to help guide individualized coverage decisions under our plans and to determine whether an intervention is **medically necessary, experimental, investigational, or unproven**. They are subject to change. You can find these bulletins and other information at <https://www.aetna.com/health-care-professionals/clinical-policy-bulletins.html>. You can also contact us. See the *Contact us* section for how.

Mental health disorder

A **mental health disorder** as defined in the most recent edition of *Diagnostic and Statistical Manual of Mental Disorders (DSM)* of the American Psychiatric Association.

Morbid obesity/ morbidly obese

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
- The body mass index (BMI) is:
 - Equal to or greater than 35 kilograms per meter squared with a comorbidity or coexisting condition such as:
 - High blood pressure
 - A heart or lung condition
 - Sleep apnea, or
 - Diabetes
 - 40 kilograms per meter squared and no other severe medical conditions are present

Negotiated charge

See *How your plan works – What the plan pays and what you pay.*

Network pharmacy

A **retail pharmacy, mail order pharmacy** or **specialty pharmacy** that has contracted with us, an affiliate or a third-party vendor, to provide outpatient **prescription** drugs to you. **Network pharmacy** also includes an out-of-network pharmacy that agrees to accept payment at our contracted network level rates as payment in full. The out-of-network pharmacy or its intermediary must notify us in writing, by fax or otherwise, of their agreement.

Network provider

A **provider** listed in the directory for your plan. A NAP **provider** listed in the NAP directory is not a **network provider**.

Other health care

Other health care coverage is care you get from an **out-of-network provider** when you could not reasonably get services and supplies from an in-network **provider**.

Out-of-network provider

A **provider** who is not a **network provider**.

Partial hospitalization treatment

Clinical treatment at a minimum of 4 or more continuous hours per treatment day for **medically necessary** services provided by a **behavioral health provider** with the appropriate license or credentials. Services are designed to address a **mental health disorder** or **substance use disorder** issue and may include:

- Group, individual or multi-family group psychotherapy
- Psycho-educational services
- Adjunctive services such as medication monitoring

Treatment includes intensive outpatient programs for the treatment of alcohol or other drug dependence which provide treatment over a period of 3 or more continuous hours per day to individuals or group of individuals who are not admitted as inpatients.

Care is delivered according to accepted medical practice for the condition of the person.

Physician

A **health professional** trained and licensed to practice and prescribe medicine under the laws of the state where they practice; specifically, doctors of medicine or osteopathy. Under some plans, a **physician** can also be a **primary care provider (PCP)**.

Precertification, precertify

Pre-approval that you or your **provider** receives from us before you receive certain **covered services**. This may include a determination by us as to whether the service is **medically necessary** and eligible for coverage.

Prescription

This is an instruction written by a **physician** or other **provider** that authorizes a patient to receive a service, supply, medicine or treatment.

Primary care provider (PCP)

A **provider** who:

- The directory lists as a **PCP**
- Is selected by you from the list of **PCPs** in the directory
- Supervises, coordinates and provides initial care and basic medical services to you
- Initiates **referrals** for **specialist** care, if required by the plan, and maintains continuity of patient care
- Shows in our records as your **PCP**

A **PCP** can be any of the following **providers**:

- General practitioner
- Family **physician**
- Internist
- Nurse practitioner or any other advanced practice registered nurse
- Physician assistant
- Pediatrician
- OB, GYN, and OB/GYN
- Medical group, primary care office, or another **provider** allowed by the plan

Provider

A **physician**, pharmacist, **health professional**, person, or facility, licensed or certified by law to provide health care services to you, including the following:

- Chiropractor
 - Optometrist
 - Optician
 - Professional counselor
-

- Psychologist
- Clinical social worker
- Podiatrist
- Physical therapist
- Chiropracist
- Clinical nurse specialist
- Audiologist
- Speech pathologist
- Certified nurse midwife, nurse practitioner, or any other advanced practice registered nurse
- Marriage and family therapist
- Athletic trainer when services are performed in an office setting
- Licensed acupuncturist

If state law does not specifically provide for licensure or certification, they must meet all Medicare approval standards even if they don't participate in Medicare.

Psychiatric hospital

An institution licensed or certified as a **psychiatric hospital** by applicable laws to provide a program for the diagnosis, evaluation, and treatment of alcoholism, drug abuse or **mental health disorders** (including **substance use disorders**).

Residential treatment facility

An institution specifically licensed by applicable laws to provide residential treatment programs for **mental health disorders, substance use disorders**, or both. It is credentialed by us or is accredited by one of the following agencies, commissions or committees for the services being provided:

- The Joint Commission (TJC)
- The Committee on Accreditation of Rehabilitation Facilities (CARF)
- The American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP)
- The Council on Accreditation (COA)

In addition to the above requirements, an institution must meet the following:

For residential treatment programs treating **mental health disorders**:

- A **behavioral health provider** must be actively on duty 24 hours/day for 7 days/week
- The patient must be treated by a psychiatrist at least once per week
- The medical director must be a psychiatrist
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For residential treatment programs treating **substance use disorders**:

- A **behavioral health provider** or an appropriately state certified professional (CADC, CAC, etc.) must be actively on duty during the day and evening therapeutic programming
- The medical director must be a **physician**
- It is not a wilderness treatment program (whether or not the program is part of a licensed **residential treatment facility** or otherwise licensed institution)

For **detoxification** programs within a residential setting:

- An R.N. must be onsite 24 hours/day for 7 days/week within a residential setting
 - Residential care must be provided under the direct supervision of a **physician**
-

Retail pharmacy

A community pharmacy that dispenses outpatient **prescription** drugs.

Room and board

A facility's charge for your overnight **stay** and other services and supplies expressed as a daily or weekly rate.

Semi-private room rate

An institution's **room and board** charge for most beds in rooms with 2 or more beds. If there are no such rooms, we will calculate the rate based on the rate most commonly charged by similar institutions in the same geographic area.

Skilled nursing facility

A facility specifically licensed as a **skilled nursing facility** by applicable laws to provide skilled nursing care.

Skilled nursing facilities also include:

- Rehabilitation **hospitals**
- Portions of a rehabilitation **hospital**
- A **hospital** designated for skilled or rehabilitation services

Skilled nursing facility does not include institutions that provide only:

- Minimal care
- Custodial care
- Ambulatory care
- Part-time care

Specialist

A **physician** who practices in any generally accepted medical or surgical sub-specialty.

Specialty prescription drug

An FDA-approved **prescription** drug that typically has a higher cost and requires special handling, special storage or monitoring. These drugs may be administered:

- Orally (mouth)
- Topically (skin)
- By inhalation (mouth or nose)
- By injection (needle)

Specialty pharmacy

A pharmacy that fills **prescriptions** for specialty drugs.

Stay

A full-time inpatient confinement for which a **room and board** charge is made.

Substance use disorder

The use of drugs, as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association

Substance use disorder

A **substance use disorder**, addictive disorder, or both, as defined in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) published by the American Psychiatric Association

Surgery, surgical procedure

The diagnosis and treatment of injury, deformity and disease by manual and instrumental means, such as:

- Cutting
- Abrading
- Suturing
- Destruction
- Ablation
- Removal
- Lasering
- Introduction of a catheter (e.g., heart or bladder catheterization) or scope (e.g., colonoscopy or other types of endoscopy)
- Correction of fracture
- Reduction of dislocation
- Application of plaster casts
- Injection into a joint
- Injection of sclerosing solution
- Otherwise physically changing body tissues and organs

Telemedicine

A consultation between you and a **physician, specialist, behavioral health provider, or telemedicine provider** who is performing a clinical medical or behavioral health service by means of electronic communication, including remote patient monitoring services.

Remote patient monitoring services means the delivery of home health services using telecommunications technology, including:

- Monitoring clinical patient data such as weight, blood pressure, pulse, pulse oximetry, blood glucose, and other condition-specific data
- Medication adherence monitoring
- Interactive video conference with or without digital image upload

Terminal illness

A medical prognosis that you are not likely to live more than 12 months.

Walk-in clinic

A health care facility that provides limited medical care on a scheduled and unscheduled basis. A **walk-in clinic** may be located in, near or within a:

- Drug store
- Pharmacy
- Retail store
- Supermarket

The following are not considered a **walk-in clinic**:

- Ambulatory surgical center
 - Emergency room
 - **Hospital**
 - Outpatient department of a **hospital**
 - **Physician's** office
 - Urgent care facility
-

Aetna Life Insurance Company

Booklet-certificate

Comprehensive dental insurance plan

Prepared for:

Policyholder: Booz Allen Hamilton

Policyholder number:

Booklet-certificate: 2

Group policy effective date: January 1, 2022

Plan name: Retired Officers Comprehensive Dental Plan

Plan effective date: January 1, 2026

Plan issue date: January 29, 2026

Plan revision effective date: January 1, 2026

Underwritten by Aetna Life Insurance Company

This booklet-certificate is made part of the **group policy**



Welcome

Thank you for choosing **Aetna**[®].

This is your booklet-certificate. It is one of three documents that together describe the benefits covered by your **Aetna** plan for dental coverage.

This booklet-certificate will tell you about your **covered benefits** – what they are and how you get them. If you become covered, this booklet-certificate becomes your certificate of coverage under the **group policy**, and it replaces all certificates describing similar coverage that we sent to you before. The second document is the schedule of benefits. It tells you how we share expenses for **eligible dental services** and tells you about limits – like when your plan covers only a certain number of visits.

The third document is the **group policy** between **Aetna Life Insurance Company** (“**Aetna**”) and the policyholder. Ask the policyholder if you have any questions about the **group policy**.

Sometimes, we may send you documents that are amendments, endorsements, attachments, inserts or riders. They change or add to the documents that they’re part of. When you receive these, they are considered part of your **Aetna** plan for coverage.

Where to next? Try the *Let’s get started!* section. *Let’s get started!* gives you a summary of how your plan works. The more you understand, the more you can get out of your plan.

Welcome to your **Aetna** plan.

We are regulated in Virginia by both the State Corporation Commission Bureau of Insurance under Title 38.2 of the Code of Virginia and the Virginia Department of Health under Title 32.1 of the Code of Virginia.

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Let's get started!

Here are some basics. First things first – some notes on how we use words. Then we explain how your plan works so you can get the most out of your coverage. But for all the details – and this is very important – you need to read this entire booklet-certificate and the schedule of benefits. And if you need help or more information, we tell you how to reach us.

Some notes on how we use words in the booklet-certificate and schedule of benefits

- When we say “you” and “your”, we mean you and any covered dependents
- When we say “us”, “we”, and “our”, we mean **Aetna**
- Some words appear in **bold** type and we define them in the *Glossary* section

Sometimes we use technical dental language that is familiar to **dental providers**.

What your plan does – providing covered benefits

Your plan provides **covered benefits**. These are **eligible dental services** for which your plan has the obligation to pay.

How your plan works – starting and stopping coverage

Your coverage under the plan has a start and an end. You start coverage after the eligibility and enrollment process is completed. To learn more see the *Who the plan covers* section.

You can lose coverage for many reasons. To learn more see the *When coverage ends* section.

Ending coverage under the plan doesn't necessarily mean you lose coverage with us. See the *Special coverage options after your plan coverage ends* section.

How your plan works while you are covered

Your coverage helps you get and pay for **eligible dental services**.

Important note:

See the schedule of benefits for any **deductibles, coinsurance**, and maximum age or visit limits that may apply.

Eligible dental services

Eligible dental services meet these requirements:

- They are listed in the *Eligible dental services* section in the schedule of benefits.
- They are not listed in these sections:
 - *What are your eligible dental services?*
 - *What rules and limits apply to dental care?*
 - *What your plan doesn't cover – exclusions*. We refer to this section as “Exclusions”.
- They are not beyond any limits in the *What rules and limits apply to dental care?* section and the schedule of benefits

Dental providers

You may choose any **dental provider** for the care you need. For more information about the role of your **dental provider**, see the *Who provides the care* section.

Paying for dental services– the general requirement

The general requirement for the plan to pay any part of the expense for an **eligible dental service** is that the **dental service** is **medically necessary**.

You will find details on **medical necessity** requirements in the *Medical necessity requirements* section.

Paying for eligible dental services– sharing the expense

Generally your plan and you will share the expense of your **eligible dental services** when you meet the general requirements for paying.

But sometimes your plan will pay the entire expense; and sometimes you will. For more information see the *What the plan pays and what you pay* section and see the schedule of benefits.

How to contact us for help – important information about your insurance

If you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, we are here to answer your questions. You can contact us by registering and logging onto our self-service website available 24/7 that requires registration and logon at <https://www.aetna.com/>.

In our website you can get reliable dental information, tools and resources. Online tools will make it easier for you to:

- Make informed decisions about your dental care
- View claims
- Research care and treatment options
- Access information on health and wellness

You can also contact us by:

- Calling **Aetna** at 1-877-238-6200
- Writing us at **Aetna Life Insurance Company**, 151 Farmington Ave, Hartford, CT 06156

If you have been unable to contact or obtain satisfaction from us or the agent, you can contact the Virginia State Corporation Commission's Bureau of Insurance at:

Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
(804) 371-9741, local
(800) 552-7945, in-state toll-free number
(877) 310-6560, national toll-free number

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting us, the agent or the BOI, have your policy number available.

Your ID card

You don't need to show an ID card. When visiting a **dentist**, just provide your:

- Name
- Date of birth
- ID card number or social security number

The dental office can use that information to verify your eligibility and benefits. Your ID number is located on your digital ID card which you can view or print by going to our self-service website. If you don't have internet access, call us. You can also access your ID card when you're on the go. To learn more, visit us at <https://www.aetna.com/>.

Who the plan covers

You will find information in this section about:

- Who is eligible
- When you can join the plan
- Who can be on your plan (who can be your dependent)
- Adding new dependents
- Special times you and your dependents can join the plan

Who is eligible

The policyholder decides and tells us who is eligible for dental care coverage.

When you can join the plan

As an employee you can enroll yourself and your dependents:

- Once each **Calendar Year** during the annual enrollment period
- At other special times during the year (see the *Special times you and your dependents can join the plan* section below)

If you don't enroll yourself and your dependents when you first qualify for dental benefits, you may have to wait until the next annual enrollment period to join.

Who can be on your plan (who can be your dependent)

You can enroll the following family members on your plan. (They are referred to in this booklet-certificate as your "dependents".)

- Your legal spouse
- Your domestic partner who meets any policyholder rules and requirements under state law
- Your dependent children – yours or your spouse's or partner's
 - Dependent children must be:
 - Under 26 years of age
 - Dependent children include:
 - Natural children
 - Stepchildren
 - Adopted children including those placed with you for adoption
 - Foster children
 - Children you are responsible for under a qualified medical support order or court order
 - Grandchildren in your legal custody

You may continue coverage for a disabled child past the age limit shown above. See the *Extension of coverage for other reasons* in the *Special coverage options after your plan coverage ends* section for more information.

Adding new dependents

You can add the following new dependents any time during the year:

- A spouse - If you marry, you can put your spouse on your plan.
 - We must receive your completed enrollment information not more than 31 days after the date of your marriage.
 - Ask the policyholder when benefits for your spouse will begin. It will be:
 - No later than the first day of the first calendar month after the date we receive your completed enrollment information
 - Within 31 days of the date of your marriage.
- A domestic partner - If you enter a domestic partnership, you can enroll your domestic partner on your dental plan.
 - We must receive your completed enrollment information not more than 31 days after the date you file a Declaration of Domestic Partnership, or not later than 31 days after you provide documentation required by the policyholder.
 - Ask the policyholder when benefits for your domestic partner will begin. It will be either on the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.
- A newborn child – Your newborn child is covered on your dental plan for the first 31 days after birth.
 - To keep your newborn covered, we must receive your completed enrollment information within 31 days of birth.
 - You must still enroll the child within 31 days of birth even when coverage does not require payment of an additional **premium** contribution for the covered dependent.
 - If you miss this deadline, your newborn will not have dental benefits after the first 31 days.
- An adopted child – A child that you, or that you and your spouse or domestic partner adopts is covered on your plan for the first 31 days from the date of the adoption or placement for adoption.
 - To keep your adopted child covered, we must receive your completed enrollment information within 31 days after the adoption.
 - If you miss this deadline, your adopted child will not have dental benefits after the first 31 days.
- A stepchild – You may put a child of your spouse or domestic partner on your plan.
 - You must complete your enrollment information and send it to us within 31 days after the date of your marriage or your Declaration of Domestic Partnership with your stepchild's parent.
 - Ask the policyholder when benefits for your stepchild will begin. It is either on the date of your marriage or the date your Declaration of Domestic Partnership is filed or the first day of the month following the date we receive your completed enrollment information.

Inform us of any changes

It is important that you inform us of any changes that might affect your benefit status. This will help us effectively deliver your benefits. Please contact us as soon as possible with changes such as:

- Change of address or phone number
- Change in marital status
- Change of covered dependent status
- A covered dependent who enrolls in any other dental plan

Special times you and your dependents can join the plan

You can enroll in these situations:

- When you did not enroll in this plan before because:
 - You were covered by another group dental plan, and now that other coverage has ended
 - You had COBRA, and now that coverage has ended
- You have added a dependent because of marriage, birth, adoption, placement for adoption or foster care. See the *Adding new dependents* section for more information
- When a court orders that you cover a current spouse, domestic partner, or a minor child on your dental plan

We must receive your completed enrollment information from you within 31 days of that date on which you no longer have the other coverage mentioned above.

Effective date of coverage

Your coverage will be in effect as of the date you become eligible for dental benefits.

Medical necessity requirements

The starting point for **covered benefits** under your plan is whether the services and supplies are **eligible dental services** and **medically necessary**. See the *Eligible dental services* and *Exclusions* sections plus the schedule of benefits.

This section addresses the **medical necessity** requirements.

Medically necessary/medical necessity

As we said in the *Let's get started!* section, **medical necessity** is a requirement for you to receive a **covered benefit** under this plan.

The **medical necessity** requirements are in the *Glossary* section, where we define "**medically necessary, medical necessity.**"

What are your eligible dental services?

The information in this section is the first step to understanding your plan's **eligible dental services**. If you have questions about this section, see the *How to contact us for help* section.

Your plan covers many kinds of dental care services and supplies. But some are not covered at all or are covered only up to a limit.

You can find out about exceptions and exclusions in the:

- *Dental provider services* benefit below
- *What rules and limits apply to dental care?* section
- *Exclusions* section

Your dental plan

We explain how your dental plan works in the *Let's get started!* section.

Schedule of benefits

Eligible dental services include dental services and supplies provided by a **dental provider**. Your schedule of benefits includes a detailed list of **eligible dental services** under your dental plan (including any maximums and limits that apply to them).

Dental provider services

You can get **eligible dental services**:

- At the **dental provider's** office
- By way of **teledentistry**

Important note:

Eligible dental services for **teledentistry** are paid based upon the cost share features that apply to the type of **eligible dental service** that you get. See your schedule of benefits for details.

The following are not **eligible dental services** under your plan except as described in the *What rules and limits apply to dental care?* section of this booklet-certificate, the schedule of benefits, or a rider or amendment issued to you for use with this booklet-certificate:

- Acupuncture, acupressure and acupuncture therapy
- Asynchronous dental treatment
- Crown, inlays and onlays, and veneers unless for one of the following:
 - It is treatment for decay or traumatic **injury** and teeth cannot be restored with a filling material
 - The tooth is an abutment to a covered partial denture or fixed bridge
- Dental implants, false teeth, prosthetic restoration of dental implants, plates, dentures, braces, mouth guards, and other devices to protect, replace or reposition teeth and removal of implants
- Dental services and supplies made with high noble metals (gold or titanium) except as covered in the schedule of benefits

- Dentures, crowns, inlays, onlays, bridges, or other prosthetic appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or correcting attrition, abrasion, or erosion
- General anesthesia and intravenous sedation, unless specifically covered and done in connection with another **eligible dental service**
- Instruction for diet, tobacco counseling and oral hygiene
- **Orthodontic treatment** except as covered in the schedule of benefits
- Prefabricated porcelain/ceramic crown – permanent tooth
- Services and supplies provided in connection with treatment or care that is not covered under the plan
- Replacement of a device or appliance that is lost, missing or stolen, and for the replacement of appliances that have been damaged due to abuse, misuse or neglect and for an extra set of dentures
- Replacement of teeth beyond the normal complement of 32
- Services and supplies provided where there is no evidence of pathology, dysfunction or disease, other than covered preventive services
- Space maintainers except when needed to preserve space resulting from the premature loss of deciduous teeth
- Surgical removal of impacted wisdom teeth when removed only for orthodontic reasons

Dental emergency services

Eligible dental services include **dental emergency services** provided for a **dental emergency**. The care provided must be a **covered benefit**.

If you have a **dental emergency**, you should consider using your **dental provider** who may be more familiar with your dental needs. However, you can get treatment from any **dentist**. If you need help in finding one, just call us.

What rules and limits apply to dental care?

Several rules apply to the dental benefits. Following these rules will help you use your plan to your advantage by avoiding expenses that are not covered by your plan.

Congenital defects treatment rule

For newly born children, dental benefits are provided for medically diagnosed congenital defects and birth abnormalities, including cleft lip, cleft palate or ectodermal dysplasia, to the same extent as other dental conditions.

Reimbursement policies

We reserve the right to apply our reimbursement policies to all services including involuntary services.. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of, or incidental to, the primary service provided
- The educational level, licensure or length of training of the **provider**

Aetna reimbursement policies are based on our review of:

- Generally accepted standards of dental practice
- The views of **providers** and **dentists** practicing in the relevant clinical areas

Replacement rule

Some **eligible dental services** are subject to your plan's replacement rule. The replacement rule applies to replacements of, or additions to existing:

- Crowns
- Inlays
- Onlays
- Veneers
- Complete dentures
- Removable partial dentures
- Fixed partial dentures (bridges)
- Other prosthetic services

These **eligible dental services** are covered only when you give us proof that:

- While you were covered by the plan:
 - You had a tooth (or teeth) extracted after the existing denture, bridge or other prosthetic item was installed.
 - As a result, you need to replace or add teeth to your denture, bridge or other prosthetic item and:
 - The tooth that was removed was not an abutment to a removable or fixed partial denture, bridge or other prosthetic item installed during the prior 5 years.
 - Your present denture is an immediate temporary one that replaced that tooth (or teeth). A permanent denture is needed and the temporary denture cannot be used as a permanent denture. Replacement must occur within 12 months from the date that the temporary denture was installed.
- The present item cannot be made serviceable, and is:
 - A crown installed at least 5 years before its replacement.
 - An inlay, onlay, veneer, complete denture, removable partial denture, fixed partial denture (bridge), or other prosthetic item installed at least 5 years before its replacement.

Tooth missing but not replaced rule

The first installation of complete dentures, removable partial dentures, fixed partial dentures (bridges), and other prosthetic services will be covered if:

- The dentures, bridges or other prosthetic items are needed to replace one or more natural teeth that were removed while you were covered by the plan. (The extraction of a third molar tooth does not qualify.)
- The tooth that was removed was not an abutment to a removable or fixed partial denture, bridge or prosthetic item installed during the prior 5 years.

Any such appliance, prosthetic item or fixed bridge must include the replacement of an extracted tooth or teeth.

What your plan doesn't cover - exclusions

We already told you about the many dental care services and supplies that are eligible for coverage under your plan in the *What are your eligible dental services?* section. In that section we also told you that some dental care services and supplies have exceptions and some are not covered at all (exclusions).

In this section we tell you about the exclusions that apply to your plan.

And just a reminder, you'll find benefit and coverage limitations in the schedule of benefits.

Exclusions

The following are not **eligible dental services** under your plan except as described in:

- The *What are your eligible dental services?* section
- The *What rules and limits apply to dental care?* section
- The schedule of benefits
- A rider or amendment issued to you for use with this booklet-certificate

Charges for services or supplies

- Provided for your personal comfort or convenience, or the convenience of any other person, including a **dental provider**
- Provided in connection with treatment or care that is not covered under the plan
- Cancelled or missed appointment charges or charges to complete claim forms
- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage, including:
 - Care in charitable institutions
 - Care for conditions related to current or previous military service
 - Care while in the custody of a governmental authority

Charges in excess of any benefit limits

- Any charges in excess of the benefit, dollar, visit, or frequency limits stated in the schedule of benefits.

Cosmetic services and plastic surgery (except to the extent coverage is specifically provided in the schedule of benefits)

- **Cosmetic** services and supplies including:
 - Plastic surgery
 - Reconstructive surgery
 - **Cosmetic** surgery
 - Personalization or characterization of dentures or other services and supplies which improve, alter or enhance appearance
 - Augmentation and vestibuloplasty and other services to protect, clean, whiten, bleach, alter the appearance of teeth whether or not for psychological or emotional reasons

Facings on molar crowns and pontics will always be considered **cosmetic**

Court-ordered services and supplies

- This includes those court ordered services and supplies, or those required as a condition of parole, probation, release or because of any legal proceeding, unless they are an **eligible dental service** under this plan.

Dental services and supplies

- Those covered under any other plan of group benefits provided by the policyholder

Examinations

Any dental examinations needed:

- Because a third party requires the exam. Examples include examinations to get or keep a job, or examinations required under a labor agreement or other contract.
- To buy insurance or to get or keep a license.
- To travel.
- To go to a school, camp, or sporting event, or to join in a sport or other recreational activity.

Experimental or investigational

- **Experimental or investigational** drugs, devices, treatments or procedures

Non-medically necessary services

- 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**.

Other primary payer

- Payment for a portion of the charge that another party is responsible for as the primary payer

Outpatient prescription drugs, and preventive care drugs and supplements

- Prescribed drugs, pre-medication or analgesia

Personal care, comfort or convenience items

- Any service or supply primarily for your convenience and personal comfort or that of a third party

Providers and other health professionals

- Treatment by other than a **dentist**. However, the plan will cover some services provided by a licensed dental hygienist under the supervision and guidance of a **dentist**. These are:
 - Scaling of teeth
 - Cleaning of teeth
 - Topical application of fluoride
- Charges submitted for services by an unlicensed **provider** or not within the scope of the **provider's** license.

Services provided by a family member

- Services provided by a spouse, domestic partner, parent, child, stepchild, brother, sister, in-law or any household member

Teledentistry

- Services given when you are not present at the same time as the **dental provider**
- Services including:
 - Telephone calls
 - **Teledentistry** kiosks
 - Electronic vital signs monitoring or exchanges

Work related illness or injuries

- Coverage available to you under workers' compensation or under a similar program under local, state or federal law for any **illness** or **injury** related to employment or self-employment.
- A source of coverage or reimbursement will be considered available to you even if you waived your right to payment from that source. You may also be covered under a workers' compensation law or similar law.
- If you submit proof that you are not covered for a particular **illness** or **injury** under such law, then that **illness** or **injury** will be considered "not work related" regardless of cause.

Who provides the care

Just as the starting point for coverage under your plan is whether the services and supplies are **eligible dental services**, the foundation for getting covered care is the **dental provider**. This section tells you about **dental providers**.

Providers

When you need dental care, you can go to any **dental provider** to provide **eligible dental services** to you.

You will have to pay for services at the time that they are provided. You will be required to pay the full charges and submit a claim for reimbursement to us. You are responsible for completing and submitting claim forms for reimbursement of **eligible dental services** that you paid directly to a **dental provider**.

What the plan pays and what you pay

Who pays for your **eligible dental services** – this plan, both you and this plan or just you? That depends. This section gives the general rule and explains these key terms:

- Your **deductible**
- Your **coinsurance**
- Your maximums

We also remind you that sometimes you will be responsible for paying the entire bill – for example, if you get care that is not an **eligible dental service**.

The general rule

When you get **eligible dental services**:

- You pay your **deductible**

And then

- The schedule of benefits lists how much you pay and your plan pays. The **coinsurance** percentage may vary by the type of expense.

And then

- You are responsible for any amounts above the **Calendar Year** and **lifetime maximums**.

See the *Glossary* section for what this term means.

Important note – when you pay all

You pay the entire expense for an **eligible dental service** when you get a dental care service or supply that is not **medically necessary**. See the *Medical necessity requirements* section.

The **dental provider** may require you to pay the entire charge. And any amount you pay will not count towards your **deductible** or towards your **Calendar Year** and **lifetime maximums**.

Special financial responsibility

You are responsible for the entire expense of:

- Cancelled or missed appointments

Neither you nor we are responsible for:

- Charges for which you have no legal obligation to pay
- Charges that would not be made if you did not have coverage

Where your schedule of benefits fits in

This section explains some of the terms you will find in your schedule of benefits.

How your deductible works

Your **deductible** is the amount you need to pay for **eligible dental services** per **Calendar Year** before your plan begins to pay for **eligible dental services**. Your schedule of benefits shows the **deductible** amounts for your plan.

How your coinsurance works

Your **coinsurance** is the amount you pay for **eligible dental services** after you have paid your **deductible**. The schedule of benefits shows the **coinsurance** this plan will pay for specific **eligible dental services**. You are responsible for paying any remaining **coinsurance**.

How your Calendar Year maximum works

This is the most that this plan will pay, after you have paid any applicable **deductible**, for charges that you incur for **eligible dental services** in a **Calendar Year**. You are responsible for any amounts above the maximum.

How your lifetime maximum works

This is the most the plan will pay, after you have paid your **deductible**, for charges that you incur for **eligible dental services** during your lifetime. You are responsible for any charges above this maximum.

Important note:

See the schedule of benefits for any **deductibles, coinsurance, maximum and maximum age, visit limits, and other limitations** that may apply.

When you disagree - claim decisions and appeals procedures

In the previous section, we explained how you and we share responsibility for paying for your **eligible dental services**.

When a claim comes in, we review it, make a decision and tell you how you and we will split the expense. We also explain what you can do if you think we got it wrong.

Claim procedures

You or your **dental provider** are required to send us a claim in writing. You can request a claim form from us. We will review that claim for payment to the **dental provider** or to you as appropriate.

The table below explains the claim procedures as follows:

Notice	Requirement	Deadline
<p>Submit a claim</p>	<ul style="list-style-type: none"> You should notify us in writing of a claim within 20 days after the loss and request a claim form from us. We won't void or reduce a claim if you failed to do so but did it as soon as reasonably possible The claim form will provide instructions on how to complete and where to send the forms 	<ul style="list-style-type: none"> We will furnish a claim form to you within 15 days of your request If the claim form is not sent on time, we will accept a written description that is the basis of the claim as your proof of loss. It must be sent to us within the time limits stated in the <i>Proof of loss</i> section and detail the nature and extent of the loss
<p>Proof of loss</p> <p>When you have received a service from an eligible dental provider, you will be charged.</p> <p>The information you receive for that service is your proof of loss.</p>	<ul style="list-style-type: none"> A completed claim form and any additional information required by us 	<ul style="list-style-type: none"> You must send us proof of loss within 90 days after the date of the loss We won't void or reduce your claim if you cannot send the proof of loss within the required timeframe but sent it as soon as reasonably possible Proof of loss may not be given later than 1 year after the time proof is otherwise required, except if you lack the legal capacity to do so

Benefit payment	<ul style="list-style-type: none"> • Written proof must be provided for all benefits • If we challenge any portion of a claim, the unchallenged portion of the claim will be paid within 60 days after the receipt of proof of loss. 	<ul style="list-style-type: none"> • Benefits will be paid as soon as the necessary proof to support the claim is received • In no event will benefits be paid later than the 60th day after we receive the proof of loss
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If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will not be voided or reduced if it is filed as soon as reasonably possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 27 months after the deadline.

Communicating our claim decisions

The amount of time that we have to tell you about our decision on a claim is shown below.

Post-service claim

A post service claim is a claim that involves dental care services you have already received.

Type of notice	Post-service claim
Initial decision by us	30 days
Extensions	15 days
If we request more information	30 days
Time you have to send us additional information	45 days

Adverse benefit determinations

But sometimes we pay only some of the claim. And sometimes we don't pay at all. Any time we don't pay even part of the claim, that is called an "adverse benefit determination" or "adverse decision".

If we make an adverse benefit determination, we will tell you in writing.

The difference between a complaint and an appeal

A complaint

You may not be happy about a **dental provider** or an operational issue, and you may want to complain. You can call or write us. Your complaint should include a description of the issue. You should include copies of any records or documents that you think are important. We will review the information and provide you with a written response within 30 calendar days of receiving the complaint. We will let you know if we need more information to make a decision.

An appeal

You can ask us to review an adverse benefit determination. This is called an appeal. You can appeal by calling us.

Appeals of adverse benefit determinations

You can appeal our adverse benefit determination. We will assign your appeal to someone who was not involved in making the original decision. You must file an appeal within 180 calendar days from the time you receive the notice of an adverse benefit determination.

You can appeal by sending a written appeal to the address on the notice of adverse benefit determination or by calling us. You need to include:

- Your name
- The policyholder's name
- A copy of the adverse benefit determination
- Your reasons for making the appeal
- Any other information you would like us to consider

Another person may submit an appeal for you, including a **dental provider**. That person is called an authorized representative. You need to tell us if you choose to have someone else appeal for you (even if it is your **dental provider**). You should fill out an authorized representative form telling us that you are allowing someone to appeal for you. You can get this form on our website or by contacting us. The form will tell you where to send it to us. You can use an authorized representative at any level of appeal.

You can appeal two times under this plan. If you appeal a second time you must present your appeal within 60 calendar days from the date you receive the notice of the first appeal decision.

Timeframes for deciding appeals

The amount of time that we have to tell you about our decision on an appeal claim depends on the type of claim. The chart below shows a timetable view of the different types of claims and how much time we have to tell you about our decision.

Type of notice	Post-service appeal
Initial decision by us	30 days
Extensions	15 days
If we request more information	30 days
Time you have to send us additional information	45 days

Exhaustion of appeals process

You must complete the appeal process with us before you can pursue arbitration, litigation or other type of administrative proceeding.

The Virginia Bureau of Insurance is also available to help you at any time during the appeal process. You are not required to complete the appeals process with us before you contact them. See the Managed Care Ombudsman provision for additional information.

Managed Care Ombudsman

If you have any questions regarding an **appeal** which have not been satisfactorily addressed by us, you may contact the Office of the Managed Care Ombudsman for assistance.

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218

Toll-free: (877) 310-6560
Richmond Metropolitan Area: (804) 371-9032
E-Mail: ombudsman@scc.virginia.gov

Virginia Department of Health, Office of Licensure and Certification

You or your **provider** can contact the Office of Licensure and Certification to file a complaint regarding quality of care, choice and accessibility of **providers**, or network adequacy. The contact information is shown below.

Virginia Department of Health
Office of Licensure and Certification
9960 Mayland Drive, Suite 401
Richmond, Virginia 23233-1463

Toll free: 1-800-955-1819
Richmond Metropolitan Area: (804) 367-2106
E-mail: OLC-Complaints@vdh.virginia.gov
Fax: (804) 527-4503

Recordkeeping

We will keep the records of all complaints and appeals for at least 10 years.

Fees and expenses

We do not pay any fees or expenses incurred by you when you submit a complaint or appeal.

Coordination of benefits

Some people have dental coverage under more than one plan. If you do, we will work together with your other plans to decide how much each plan pays. This is called coordination of benefits (COB).

Key terms

Here are some key terms we use in this section. These terms will help you understand this COB section.

Allowable expense means:

- A dental care expense that any of your dental plans cover to any degree. If the dental care service is not covered by any of the plans, it is not an allowable expense. For example, **cosmetic** surgery generally is not an allowable expense under this plan.

In this section we talk about other “plans” which are those plans where you may have other coverage for dental care expenses, such as:

- Group, blanket, or franchise health insurance policies issued by insurers, HMOs, or health care service contractors
- Labor-management trustee plans, labor organization plans, policyholder organization plans, or employee benefit organization plans
- Governmental benefits
- Any group health insurance contract that you can obtain or maintain only because of membership in or connection with a particular organization or group

Here’s how COB works

- The primary plan pays first. When this is the primary plan, we will pay your claims first as if the other plan does not exist.
- The secondary plan pays after the primary plan. When this is the secondary plan, we will pay benefits after the primary plan and will coordinate the payment based on any amount the primary plan paid.
- We will never pay an amount that, when combined with payments from your other coverage, add up to more than 100% of the allowable expenses.

Determining who pays

Reading from top to bottom the first rule that applies will determine which plan is primary and which is secondary.

A plan that does not contain a COB provision is always the primary plan.

If you are:	Primary plan	Secondary plan
Covered under the plan as an employee, retired employee or dependent	The plan covering you as an employee or retired employee	The plan covering you as a dependent You cannot be covered as an employee and dependent
COB rules for dependent children		
Child of: <ul style="list-style-type: none"> Parents who are married or living together 	The "birthday rule" applies. The plan of the parent whose birthday* (month and day only) falls earlier in the Calendar Year *Same birthdays--the plan that has covered a parent longer is primary	The plan of the parent born later in the year (month and day only)* *Same birthdays--the plan that has covered a parent longer is primary
Child of: <ul style="list-style-type: none"> Parents separated or divorced or not living together With court-order 	The plan of the parent whom the court said is responsible for dental coverage But if that parent has no coverage then their spouse's plan is primary.	The plan of the other parent. But if that parent has no coverage, then their spouse's plan is primary.
Child of: <ul style="list-style-type: none"> Parents separated or divorced or not living together – court-order states both parents are responsible for coverage or have joint custody 	Primary and secondary coverage is based on the birthday rule	
Child of: <ul style="list-style-type: none"> Parents separated or divorced or not living together and there is no court-order 	The order of benefit payments is: <ul style="list-style-type: none"> The plan of the custodial parent pays first The plan of the spouse of the custodial parent (if any) pays second The plan of the noncustodial parents pays next The plan of the spouse of the noncustodial parent (if any) pays last 	
Child covered by: <ul style="list-style-type: none"> Individual who is not a parent (i.e. stepparent or grandparent) 	Treat the person the same as a parent when making the order of benefits determination: See <i>Child of</i> content above	

Active or inactive employee	The plan covering you as an active employee (or as a dependent of an active employee) is primary to a plan covering you as a laid off or retired employee (or as a dependent of a former employee)	A plan that covers the person as a laid off or retired employee (or as a dependent of a former employee) is secondary to a plan that covers the person as an active employee (or as a dependent of an active employee)
COBRA or state continuation	The plan covering you as an employee or retiree or the dependent of an employee or retiree is primary to COBRA or state continuation coverage	COBRA or state continuation coverage is secondary to the plan that covers the person as an employee or retiree or the dependent of an employee or retiree
Longer or shorter length of coverage	If none of the above rules determine the order of payment, the plan that has covered the person longer is primary	
Other rules do not apply	If none of the above rules apply, the plans share expenses equally	

How are benefits paid?	
Primary plan	The primary plan pays your claims as if there is no other dental plan involved.
Secondary plan	<p>The secondary plan calculates payment as if the primary plan did not exist, and then applies that amount to any allowable expenses under the secondary plan that were not covered by the primary plan.</p> <p>The secondary plan will coordinate payments so the total payments do not exceed 100% of the total allowable expense</p>
Benefit reserve each family member has a separate benefit reserve for each Calendar Year	<p>The benefit reserve:</p> <ul style="list-style-type: none"> • Is made up of the amount that the secondary plan saved due to COB • Is used to cover any unpaid allowable expenses • Balance is erased at the end of each year

Other dental coverage updates – contact information

You should contact us if you have any changes to your other coverage. We want to be sure our records are accurate so your claims are processed correctly.

Right to receive and release needed information

We have the right to release or obtain any information we need for COB purposes. That includes information we need to recover any payments from your other dental plans.

Right to pay another carrier

Sometimes another plan pays something we would have paid under your plan. When that happens, we will pay your plan benefit to the other plan.

Right of recovery

If we pay more than we should have under the COB rules, we may recover the excess from:

- Any person we paid or for whom we paid
- Any other plan that is responsible under these COB rules

When coverage ends

Coverage can end for a number of reasons. This section tells you how and why coverage ends.

When will your coverage end?

Coverage under this plan will end if:

- This plan is no longer available
- You voluntarily stop your coverage
- The **group policy** ends
- You are no longer eligible for coverage
- Your employment ends
- You do not pay any required **premium** payment by the end of the grace period
- We end your coverage as described below
- You become covered under another dental plan offered by your policyholder

Your coverage will end on either the date your employment ends or the day before the first **premium** contribution due date that occurs after you stop active work.

When coverage may continue under the plan

Your coverage under this plan will continue if:

<p>Your employment ends because of illness, injury, sabbatical or other authorized leave as agreed to by the policyholder and us.</p>	<p>If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage may continue, until stopped by the policyholder, but not beyond 30 months from the start of your absence.
<p>Your employment ends because of a temporary lay-off, temporary leave of absence, sabbatical, or other authorized leave as agreed to by the policyholder and us.</p>	<p>If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage will stop on the date that your employment ends.
<p>Your employment ends because either:</p> <ul style="list-style-type: none"> Your job has been eliminated You have been placed on severance This plan allows former employees to continue their coverage 	<p>You may be able to continue coverage. See the <i>Special coverage options after your plan coverage ends</i> section.</p>
<p>Your employment ends because of a paid or unpaid medical leave of absence.</p>	<p>If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage may continue until stopped by the policyholder but not beyond 30 months from the start of the absence.
<p>Your employment ends because of a leave of absence that is not a medical leave of absence.</p>	<p>If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage may continue until stopped by the policyholder but not beyond 1 month from the start of the absence.
<p>Your employment ends because of a military leave of absence.</p>	<p>If premium payments are made for you, you may be able to continue coverage under the plan as long as the policyholder and we agree to do so and as described below:</p> <ul style="list-style-type: none"> Your coverage may continue until stopped by the policyholder but not beyond 24 months from the start of the absence.

Notification of when your employment ends

It is the policyholder's responsibility to let us know when your employment ends. The limits above may be extended only if we and the policyholder agree in writing to extend them.

When will coverage end for any dependents?

Coverage for your dependent will end if:

- Your dependent is no longer eligible for coverage
- The **group policy** ends
- You do not make the required **premium** contribution toward the cost of dependents' coverage
- Your coverage ends for any of the reasons listed above

In addition, coverage for your domestic partner will end on the earlier of:

- The date this plan no longer allows coverage for domestic partners.
- The date the domestic partnership ends. You should provide the policyholder a completed and signed Declaration of Termination of Domestic Partnership.

Your dependent's coverage will end on the earlier of the date the **group policy** terminates or as defined by the policyholder.

What happens to your dependents if you die?

Coverage for dependents may continue for some time after your death. See the *Special coverage options after your plan coverage ends* section for more information.

Why would we end your coverage?

We will give you 30 days advance written notice before we end your coverage because you commit fraud or intentionally misrepresent yourself when you applied for or obtained coverage. You can refer to the *General provisions – other things you should know* section for more information on loss of coverage.

On the date your coverage ends, we will refund to the policyholder any prepayments for periods after the date your coverage ended.

Special coverage options after your plan coverage ends

This section explains options you may have after your coverage ends under this plan. Your individual situation will determine what options you will have.

Consolidated Omnibus Budget Reconciliation Act (COBRA)

The federal COBRA law usually applies to employers of group sizes of 20 or more. It gives employees and most of their covered dependents the right to keep their dental coverage for 18, 29 or 36 months after a qualifying event. The qualifying event is something that happens that results in you losing your coverage.

The qualifying events are:

- Your active employment ends for reasons other than gross misconduct
- Your working hours are reduced
- You divorce or legally separate and are no longer responsible for dependent coverage
- You become entitled to benefits under Medicare
- Your covered dependent children no longer qualify as dependents under the plan
- You die
- You are a retiree eligible for retiree health coverage and your former employer files for bankruptcy

Talk with your employer if you have questions about COBRA or to enroll.

Continuation of coverage

If your coverage ends under this plan, you can continue coverage for you and your covered dependents if:

- Your employer is not required to offer COBRA coverage
- You are not eligible for Medicare
- You are not eligible for any other replacement group coverage
- You are not eligible for or have benefits available under another health care plan
- You have had 3 months of continuous coverage prior to your termination
- Your employer did not end your employment because of gross misconduct, as determined by your employer and Virginia law

To continue coverage you must:

- Apply through your employer's normal process and pay the required **premium** within 31 days of the written notice from your employer (but no later than 60 days period following the date of termination of your coverage)

Evidence of insurability is not required for you to continue coverage.

The **premium** will be the current **premium** rate for the policy. Your employer may charge an administrative fee of no more than 2.0% of the current rate.

You can continue your coverage for 12 months. Each **premium** must be paid on a monthly basis during the 12-month period.

Extension of coverage for other reasons

What exceptions are there for dental work when coverage ends?

Your dental coverage may end while you or your covered dependent are in the middle of treatment. The plan does not cover dental services that are given after your coverage terminates. There is an exception. The plan will cover the following services if they are ordered while you were covered by the plan, and installed within 30 days after your coverage ends:

- Inlays
- Onlays
- Crowns
- Removable bridges
- Cast or processed restorations
- Dentures
- Fixed partial dentures (bridges)
- Root canals

Ordered means:

- For a denture: The impressions from which the denture will be made were taken
- For a root canal: The pulp chamber was opened
- For any other item: The teeth which will serve as retainers or supports, or the teeth which are being restored:
 - Must have been fully prepared to receive the item
 - Impressions have been taken from which the item will be prepared

How can you extend coverage for your disabled child beyond the plan age limits?

You have the right to extend dental coverage for your dependent child beyond the plan age limits. If your disabled child:

- Is not able to be self-supporting because of intellectual or physical disability
- Depends mainly on you for support and maintenance

The right to coverage will continue only as long as a **physician** certifies that your child still is disabled.

We may ask you to send us proof of the disability within 31 days of the date coverage would have ended due to your child's attainment of the plan age limit. Before we extend coverage, we may ask that your child get a physical exam. We will pay for that exam.

We may ask you to send proof that your child is disabled after coverage is extended. We won't ask for this proof more than once a year after the 2 year period following your child's attainment of age limit. You must send it to us within 31 days of our request. If you don't, we can terminate coverage for your dependent child.

Your disabled child's coverage will end on the earlier of:

- The date the child is no longer disabled and dependent upon you for support
- As explained in the *When will coverage end for any dependents* section

How can you extend coverage for a child in college on medical leave?

You have the right to extend coverage for your dependent college student who takes a **medically necessary** leave of absence from school. The right to coverage will be extended until the earlier of:

- One year after the leave of absence begins
- The date coverage would otherwise end

To extend coverage the leave of absence must:

- Begin while the dependent child is suffering from a serious **illness or injury**
- Cause the dependent child to lose status as a full-time student under the plan
- Be certified by the treating **physician** as **medically necessary** due to a serious **illness or injury**

We must receive documentation or certification of the **medical necessity** for a leave of absence either:

- At least 30 days prior to the absence, if the medical reason for the absence and the absence are foreseeable
- 30 days after the start date of the medical leave of absence from school

The **physician** treating your child will be asked to keep us informed of any changes.

General provisions – other things you should know

Administrative provisions

How you and we will interpret this booklet-certificate

We prepared this booklet-certificate according to ERISA, and according to other federal and state laws that apply. You and we will interpret it according to these laws. Our interpretation of this booklet-certificate applies when we administer your coverage, so long as we use reasonable discretion. But you have the right to appeal our decisions as described in the *When you disagree - claim decisions and appeals procedures* section.

How we administer this plan

We apply policies and procedures we've developed to administer this plan.

Who's responsible to you

We are responsible to you for what our employees and other agents do.

We are not responsible for what is done by your **providers**. They are not our employees or agents.

Coverage and services

Your coverage can change

Your coverage is defined by the **group policy**. This document may have amendments and riders too. Under certain circumstances, we or the policyholder or the law may change your plan. When an emergency or epidemic is declared, we may modify or waive requirements under the plan or your cost share if you are affected. Only we may waive a requirement of your plan. No other person, including the policyholder or **provider**, can do this.

Financial sanctions exclusions

If coverage provided under this booklet-certificate violates or will violate any economic or trade sanctions, the coverage will be invalid immediately. For example, we cannot pay for **eligible dental services** if it violates a financial sanction regulation. This includes sanctions related to a person or a country under sanction by the United States, unless it is allowed under a written license from the Office of Foreign Assets Control (OFAC). You can find out more by visiting <http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx>.

Legal action

You cannot take any action until 60 days after we receive written proof of loss.

No legal action can be brought to recover payment under any benefit after 3 years from the date written proof of loss was required to be filed. See the *When you disagree - claim decisions and appeals procedures* section for more information.

Payment of benefits

All benefits are payable to you. Or we will pay your beneficiary designated by you. If any **covered benefits** are payable to either:

- Your estate, or
- A person who is a minor or otherwise not competent to give a valid release

we may pay up to \$5000 to a person related to you by blood or marriage that we believe is fairly entitled to the benefits.

We may also pay all or any portion of the benefits to the **provider** who performed the services.

Physical examinations and evaluations

At our expense, we have the right to have a **provider** of our choice examine you. This will be done as often as reasonably necessary while a claim for benefits is pending or under review.

Records of expenses

You should keep complete records of your expenses. They may be needed for a claim.

Things that would be important to keep are:

- Names of **dental providers, dentists** and other **providers** who provide services
- Dates expenses are incurred
- Copies of all bills and receipts

Honest mistakes and intentional misrepresentation

Honest mistakes

You or the policyholder may make an honest mistake when facts are shared with us. When we learn of the mistake, we may make a fair change in **premium** contribution or in your coverage. If we do, we will tell you what the mistake was. We won't make a change if the mistake happened more than 2 years from the date of the **group policy**.

Intentional misrepresentation

If we learn that you defrauded us or you intentionally misrepresented material facts, we can take actions that can have serious consequences for your coverage. These serious consequences include, but are not limited to:

- Loss of coverage, starting at the effective date of coverage, subject to the 2 year incontestability period. If we paid claims for your past coverage, we will want the money back.
- Loss of coverage going forward.
- Denial of benefits.
- Recovery of amounts we already paid.

Some other money issues

Assignment of benefits

When you see a **provider** they will usually bill us directly. We may choose to pay you or to pay the **provider** directly. If you have assigned benefits to a **provider**, we will pay them directly.

Recovery of overpayments

We sometimes pay too much for **eligible dental services** or pay for something that this plan doesn't cover. If we do, we can require the person we paid - you or your **provider** - to return what we paid. If we don't do that we have the right to reduce any future benefit payments by the amount we paid by mistake.

Premium contribution

This plan requires the policyholder to make **premium** contribution payments. If payments are made through a payroll deduction with the policyholder, the policyholder will forward your payment to us. We will not pay benefits under this booklet-certificate if **premium** contributions are not made. Any benefit payment denial is subject to our appeals procedure. See the *When you disagree - claim decisions and appeals procedures* section.

Payment of premiums

The first **premium** payment for this policy is due on or before your **effective date of coverage**. Your next **premium** payment will be due the 1st of each month ("**premium** due date"). Each **premium** payment is to be paid to us on or before the **premium** due date.

Your dental information

We will protect your dental information. We will only use or share it with others as needed for your care and treatment. We will also use and share it to help us process your **providers'** claims and manage your plan.

You can get a free copy of our Notice of Privacy Practices. Just call us. When you accept coverage under this plan, you agree to let your **providers** share your information with us.

Effect of prior plan coverage

If you are in a continuation period from a prior plan at the time you join this plan you may not receive the full benefit paid under this plan. Your current and prior plan must be offered through the same policyholder.

Glossary

Aetna®

Aetna Life Insurance Company, an affiliate, or a third party vendor under contract with **Aetna**.

Calendar year

A period of 12 months beginning on January 1st and ending on December 31st.

Calendar year maximum

This is the most this plan will pay for **eligible dental services** incurred by you during the **Calendar Year**.

Coinsurance

Coinsurance is the percentage of the bill that you and this plan have to pay for an **eligible dental service**. The schedule of benefits shows the percentage that this plan pays.

Cosmetic

Services, drugs or supplies that are primarily intended to alter, improve or enhance your appearance.

Covered benefits

Eligible dental services that meet the requirements for coverage under the terms of this plan.

Deductible

The amount you pay for **eligible dental services** per **Calendar Year** before your plan starts to pay.

Dental emergency

Any dental condition that:

- Occurs unexpectedly
- Requires immediate diagnosis and treatment in order to stabilize the condition
- Is characterized by symptoms such as severe pain and bleeding

Dental emergency services

Services and supplies given by a **dental provider** to treat a **dental emergency**.

Dental provider

Any individual legally qualified to provide dental services or supplies.

Dentist

A legally qualified **dentist** licensed to do the dental work he or she performs.

Effective date of coverage

The date your coverage begins under this booklet-certificate as noted in our records.

Eligible dental services

The benefits, subject to varying cost shares, covered in this plan. These are:

- Listed and described in the schedule of benefits.
- Not listed as an exception or exclusion in these sections:
 - *What are your eligible dental services?*
 - *What rules and limits apply to dental care?*
 - *Exclusions.*
- Not beyond any maximums and limitations in the *What rules and limits apply to dental care?* section and schedule of benefits.
- **Medically necessary.** See the *Medical necessity requirements* section and the *Glossary* for more information.

Experimental or investigational

A drug, device, procedure, or treatment that we find is **experimental** or **investigational** because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the **illness** or **injury** involved.
- The needed approval by the Food and Drug Administration (FDA) has not been given for marketing.
- A national medical or dental society or regulatory agency has stated in writing that it is **experimental or investigational** or suitable mainly for research purposes.
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services.
- Written protocols or a written consent form used by a facility **provider** state that it is **experimental or investigational**.
- It is provided or performed in a special setting for research purposes.

Group policy

The **group policy** consists of several documents taken together. These documents are:

- The attached group application and member enrollment forms
- The **group policy**
- The booklet-certificates
- The schedules of benefits
- Any amendments or riders to the **group policy**, the booklet-certificate, and the schedule of benefits

Health professional

A person who is licensed, certified or otherwise authorized by law to provide medical or dental care services to the public. For example, **providers** and dental assistants.

Illness

Poor health resulting from disease of the teeth or gums.

Injury or injuries

Physical damage done to the teeth or gums.

Lifetime maximum

This is the most this plan will pay for **eligible dental services** incurred by a covered person during their lifetime.

Medically necessary/medical necessity

Dental care services that we determine a **provider** using sensible clinical judgment would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an **illness, injury**, disease or its symptoms, and that we determine are:

- In accordance with generally accepted standards of dental practice
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's **illness, injury** or disease
- Not primarily for the convenience of the patient, **dentist**, or other health care **provider**
- Not more costly than an alternative service or sequence of services at least as likely to produce the same benefit or diagnostic results as to the diagnosis or treatment of that patient's **illness, injury** or disease

Generally accepted standards of dental practice means:

- Standards based on credible scientific evidence published in peer-reviewed dental literature and is generally recognized by the relevant dental community
- Consistent with the standards set forth in policy issues involving clinical judgment

Physician

A skilled **health professional** trained and licensed to practice medicine under the laws of the state where they practice, specifically, doctors of medicine or osteopathy.

Premium

The amount you or the policyholder are required to pay to **Aetna** to continue coverage.

Provider

A **dentist**, or other entity or person licensed, or certified under applicable state and federal law to provide dental care services to you.

Recognized charge

The amount of a **provider's** charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

Service or supply	
Eligible dental expenses	100% of the prevailing charge rate

Special terms used:

- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Involuntary services are **eligible dental services** that are **dental emergency services**.
- Prevailing charge rate is the percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. We update our systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, we have the right to substitute a different database that we believe is comparable.

Get the most value out of your benefits:

We have online tools to help you decide the type of care to get and where. Our self-service website offers tools to help you determine the cost of **eligible dental services**. See the *How to contact us for help* section for the website.

Teledentistry

A consultation between you and a **dental provider** who is performing a clinical dental service.

Services can be provided by:

- Two-way audiovisual teleconferencing
- Any other method permitted by state law

Temporomandibular joint dysfunction/disorder (TMJ)

This is:

- A **TMJ** or any similar disorder of the jaw joint
- A myofascial pain dysfunction (MPD) of the jaw
- Any similar disorder in the relationship between the jaw joint and the related muscles and nerves

Discount arrangements

We can offer you discounts on health care related goods or services. Sometimes, other companies provide these discounted goods and services. These companies are called “third party service providers”. These third party service providers may pay us so that they can offer you their services.

Third party service providers are independent contractors. The third party service provider is responsible for the goods or services they deliver. We are not responsible; but we have the right to change or end the arrangements at any time.

These discount arrangements are not insurance. We don't pay the third party service providers for the services they offer. You are responsible for paying for the discounted goods or services.

Wellness and other rewards

You may be eligible to earn rewards for completing certain activities that improve your health, coverage and experience with us. We may encourage you to access certain dental services or categories of **dental providers**, participate in programs, including but not limited to financial wellness programs, utilize tools, improve your health metrics or continue participation as an **Aetna** member through incentives. We may provide incentives based on your participation and outcomes such as:

- Modifications to **deductible**, maximum, **coinsurance** amounts
- Merchandise
- Coupons
- Gift cards or debit cards
- Any combination of the above



POLICY ENDORSEMENT

Group Policy No.:

Policyholder: Trustee of the MetLife Group Insurance Trust For Participating Employer: Booz Allen Hamilton Holding Corporation, Exhibit #102, CDF #

Effective Date: August 1, 2023

Metropolitan Life Insurance Company ("MetLife"), a stock company, issues this endorsement to change the following:

The disclosure shown below is to be added to the above referenced group policy:

Beneficiary and Bereavement Services are included with Group Variable Universal Life (GVUL) or Group Universal Life (GUL) for no additional premium. MetLife may arrange for some portion of these services to be provided to certificateholders and beneficiaries by a third-party provider.

This endorsement is to be attached to and made a part of the policy. This endorsement is subject to the terms and provisions of the policy.

END99

01/04/24
Endorsement #5



POLICY ENDORSEMENT

Group Policy No.:

Policyholder: Trustee of the MetLife Group Insurance Trust For Participating Employer: Booz Allen Hamilton Holding Corporation, Exhibit #102, CDF #

Effective Date: 01/01/21

Metropolitan Life Insurance Company ("MetLife"), a stock company, issues this endorsement to change the following:

Summary of Endorsement: A Digital Estate Planning benefit is added to the Employer Data Sheet in a new section titled "*Digital Estate Planning*" as described below.

Digital Estate Planning:	A Digital Estate Planning Platform is included with Group Variable Universal Life (GVUL)/Group Universal Life (GUL) Insurance at no additional cost. MetLife has arranged for this platform to be provided by a MetLife affiliate (the "Affiliate"). This platform will be made available to Employees and their Spouses through legalplans.com/estateplanning , and includes facilitation of the selection, completion, and execution of common estate planning documents.
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This endorsement is to be attached to and made a part of the policy. This endorsement is subject to the terms and provisions of the policy.



POLICY ENDORSEMENT

Group Policy No.:

Policyholder: Trustee of the MetLife Group Insurance Trust For Participating Employer: Booz Allen Hamilton Holding Corporation, Exhibit #102, CDF #

Effective Date: 01/01/18

Metropolitan Life Insurance Company ("MetLife"), a stock company, issues this endorsement to change the following:

To add the following to the Employer Data Sheet:

Employees who become insured under the Group Policy are eligible to receive non-insured grief counseling services at no additional premium. MetLife has arranged for these services to be provided to Employees through a third party service provider. MetLife is not responsible for providing or failing to provide these services nor is it liable for any negligence in the provision of such services by the third party service provider.

This endorsement is to be attached to and made a part of the policy. This endorsement is subject to the terms and provisions of the policy.

END99

04/19/18
Endorsement #3



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

POLICY ENDORSEMENT

Group Policy No.:

Policyholder: Trustee of the MetLife Group Insurance Trust For Participating Employer: Booz Allen Hamilton Holding Corporation, Exhibit #102, CDF #

Effective Date: 03/01/17

Metropolitan Life Insurance Company ("MetLife"), a stock company, issues this endorsement to change the following:

To add the following to the Employer Data Sheet:

- MetLife may from time to time add benefits or services to Participating Employer Plans.
- Funeral Services Discount Disclosure:
"Employees who become insured under the Group Policy are eligible to receive discounts of up to 10% off the service provider's standard price for certain funeral services including funeral, cremation and cemetery products and services provided by a third party national network of funeral and funeral planning providers while such insurance remains in effect. Employees who become insured will also have access to funeral planning resources including funeral planning tools and concierge services provided by the same national network of providers. MetLife has arranged for these services and discounts to be provided to Employees and their spouses and children and the parents, grandparents and great-grandparents of the Employees and their spouses for no additional premium. MetLife is not responsible for providing or failing to provide these services nor is it liable for any negligence in the provision of such services by the third party service provider.

The discounts and planning services are not available in all jurisdictions and are subject to regulatory approval."

This endorsement is to be attached to and made a part of the policy. This endorsement is subject to the terms and provisions of the policy.

END99

Funeral Svcs
02/07/17
Endorsement #2



Metropolitan Life Insurance Company
200 Park Avenue, New York, New York 10166

POLICY ENDORSEMENT

Group policy no.:

Policyholder: Trustee of the MetLife Group Insurance Trust

Effective date: January 1, 2016

Metropolitan Life Insurance Company ("MetLife"), a stock company, issues this endorsement to change the following:

For Participating Employer: **Booz Allen Hamilton Holding Corporation**
Exhibit #102
CDF #

Summary of Changes:

- 1) Supplemental coverage is added as described below.

The "**Supplemental Coverage Definition**", "**Supplemental Coverage Amount**", "**Maximum Coverage Amount**" and "**Simplified Issue Requirements**" and "**Effective Dates of Guaranteed Issue and Simplified Issue Coverage**" sections are deleted and replaced with the following.

Supplemental Coverage Definition:	Coverage in excess of the Basic coverage amount.
Supplemental Coverage Amount:	Class 1 and Class 2: Increments of \$50,000 to a combined maximum (Basic plus Supplemental) of \$3,000,000.
Maximum Coverage Amount:	\$3,000,000.
Simplified Issue Requirements:	Simplified Issue requires underwriting approval. No person shall be insured for Simplified Issue coverage until such person has provided the required Medical Evidence of Insurability (MEOI) and coverage has been approved in Writing by MetLife. MEOI requirements apply to any coverage in excess of the Guaranteed Issue Coverage Amounts described above. Minimum MEOI requirements include completion of an authorization form and a medical questionnaire. In some instances, MetLife may also require the completion of an additional medical questionnaire, ParaMed exam, and/or any other information as may necessary to evaluate insurability. Required tests and ParaMed exams conducted in the United States will be scheduled at the convenience of the applicant and paid for by MetLife.
Effective Dates of Guaranteed Issue and Simplified Issue Coverage	Initial Eligibles (Current Eligibles): Guaranteed Issue MetLife GVUL/GUL Basic coverage will be effective as of the Plan Effective Date. At the Participating Employer's request, Initial Eligibles who fail to actively enroll for the MetLife GVUL Basic coverage will be passively enrolled for such coverage. New Eligibles: Guaranteed Issue MetLife GVUL/GUL Basic coverage will be effective as of the first of the month of date of eligibility. At the

END99

Endorsement #1
02/03/16

	<p>Participating Employer's request, New Eligibles who fail to actively enroll for the MetLife GVUL Basic coverage will be passively enrolled for such coverage.</p> <p>New Hires: Guaranteed Issue Guaranteed Issue MetLife GVUL/GUL Basic coverage will be effective as of the first of the month of date of hire. At the Participating Employer's request, New Hires who fail to actively enroll for the MetLife GVUL Basic coverage will be passively enrolled for such coverage.</p> <p>All Categories: Supplemental coverage is available as Simplified Issue coverage. Simplified Issue coverage will be effective as of the first of the month following underwriter approval, unless the coverage is approved after MetLife has prepared the monthly bill for mailing to the employer, in which case the increase will be effective as of the first of the next following month to avoid retroactive payroll deductions.</p>
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This endorsement is to be attached to and made a part of the policy. This endorsement is subject to the terms and provisions of the policy.

EXHIBIT 102

PARTICIPATING EMPLOYER DATA

Participating Employer: Booz Allen Hamilton Holding Corporation
8283 Greensboro Drive
McLean, VA 22102

Plan Effective Date: October 1, 2014

Plan Anniversary Date: January 1, 2015 and each subsequent
January 1st

Rate Guarantee: Except as stated in the Group Policy, MetLife will not increase Plan Premium rates for the first thirty-seven months (October 1, 2014 through December 31, 2017).

Premium Due Date: Cumulative monthly Premium is due no later than the fifteenth of the month for the previous month's coverage. The first monthly premium will be payable on February 15, 2015. Subsequent premiums will be payable on the fifteenth day of each succeeding month. Failure to remit monthly premiums by the due date will reduce employees' cash value. Any unpaid cost of insurance premium due at termination of the GVUL or GUL contract may be collected from employees' GVUL or GUL certificate cash value.

Eligible Class or Classes of Employees

Eligibility Requirements: To be eligible for GVUL coverage, employees must meet the Actively at Work Requirements on the effective date of the coverage, and be a United States citizen or Permanent Resident Alien with a taxpayer identification number (social security number) working in United States locations.

To be eligible for GUL coverage, employees must meet the Actively at Work Requirements on the effective date of coverage in any other location and be approved by MetLife for such coverage.

There is one class of eligible employees. Class 1 consists of the CEO, Executive Vice Presidents and Senior Vice Presidents.

Actively at Work Requirements: Actively at Work Requirements: An employee must be in full-time Employment with the Participating Employer on the effective date of coverage, performing all the usual and customary duties of his or her job. They must be working at the Participating Employer's place of business; an alternate place approved by the Employer; or a place to which the Participating Employer's business requires travel.

Initial Eligibles Defined: Members of Class 1 who are eligible as of the **Plan Effective Date**.

New Eligibles Defined: Individuals who meet the Eligibility Requirements and become members of Class 1 subsequent to the **Plan Effective Date**.

New Hires Defined: Newly hired individuals who meet the Eligibility Requirements and become members of Class 1.

Date of Eligibility: The first day a member of an eligible class meets the Eligibility Requirements stated above.

EXHIBIT 102 (continued)

PARTICIPATING EMPLOYER DATA (continued)

Individual Effective Date

**Effective Dates of
Guaranteed Issue and
Simplified Issue Coverage**

For Initial Eligibles, Guaranteed Issue MetLife GVUL/GUL Basic coverage will be effective as of the **Plan Effective Date**. At the Participating Employer's request, Initial Eligibles who fail to actively enroll for the MetLife GVUL Basic coverage will be passively enrolled for such coverage.

For New Eligibles, Guaranteed Issue MetLife GVUL/GUL Basic coverage will be effective as of the first of the month of date of eligibility. At the Participating Employer's request, New Eligibles who fail to actively enroll for the MetLife GVUL Basic coverage will be passively enrolled for such coverage.

For New Hires, Guaranteed Issue Guaranteed Issue MetLife GVUL/GUL Basic coverage will be effective as of the first of the month of date of hire. At the Participating Employer's request, New Hires who fail to actively enroll for the MetLife GVUL Basic coverage will be passively enrolled for such coverage.

Employee Insurance Benefits

**Basic Coverage
Definition:**

The amount of life insurance coverage the Participating Employer has agreed to provide to eligible class members by paying them additional compensation to cover the cost.

**Supplemental Coverage
Definition:**

Coverage in excess of the **Basic Coverage Amount**.

Basic Coverage Amount:

\$2,000,000

**Supplemental Coverage
Amount:**

N/A

**Minimum Coverage
Amount:**

\$100,000

**Maximum Coverage
Amount:**

\$3,000,000

**Guaranteed Issue
Coverage Amounts**

For Initial Eligibles: The MetLife GVUL/GUL Basic coverage amount.

For New Eligibles: The MetLife GVUL/GUL Basic coverage amount.

For New Hires: The MetLife GVUL/GUL Basic coverage amount.

EXHIBIT 102 (continued)

PARTICIPATING EMPLOYER DATA (continued)

Guaranteed Issue Definition: Coverage issued without Medical Evidence of Insurability (MEOI), subject to the requirements set forth below:

- Guaranteed Issue Requirements:**
- MetLife must receive the enrollment form within 60 days of initial eligibility for any coverage which is not eligible for Passive Enrollment.
 - Participation requirements included in the MetLife GVUL Proposal Summary must be met.
 - Underwriting approval is required for all participants over the age of 70 unless replacing existing coverage.

Guaranteed Issue Basic coverage will not be withheld pending approval of any coverage applied for in excess of Guaranteed Issue amounts,

Simplified Issue Definition: Coverage in excess of Guaranteed Issue coverage.

Simplified Issue Requirements: Simplified Issue requires underwriting approval. No person shall be insured for Simplified Issue coverage until such person has provided the required Medical Evidence of Insurability (MEOI) and coverage has been approved in Writing by MetLife. MEOI requirements apply to any coverage in excess of the Guaranteed Issue Coverage Amounts described above. Minimum MEOI requirements include completion of an authorization form and a medical questionnaire. In some instances, MetLife may also require the completion of an additional medical questionnaire, ParaMed exam, and/or any other information as may necessary to evaluate insurability. Required tests and ParaMed exams will be scheduled at the convenience of the applicant. Parameds conducted in the United States will be paid for by MetLife.

Application Period: An employee who is eligible for Guaranteed Issue coverage other than Basic coverage must submit an enrollment form to MetLife no later than 60 days after the date of initial eligibility. If the employee fails to submit an application for such coverage within the specified Application Period, but subsequently applies for coverage, it will be deemed a Late Enrollment subject to Simplified Issue rules.

Late Enrollment: If an eligible employee actively declines life insurance when initially eligible, but later requests coverage, MEOI and underwriter approval will be required for all coverage amounts. Minimum MEOI requirements include completion of an authorization form and a medical questionnaire. In some instances, MetLife may also require the completion of an additional medical questionnaire, ParaMed exam and/or any other information necessary to evaluate insurability. Required tests and ParaMed exams will be scheduled at the convenience of the applicant. Parameds conducted in the United States will be paid for by MetLife.

Late Enrollment coverage will be effective as of the first of the month following underwriter approval, subject to the monthly underwriting cut-off dates. Enrollment forms approved by underwriting after this date will be effective as of the first of the next following month to avoid retroactive payroll deductions.

EXHIBIT 102 (continued)

PARTICIPATING EMPLOYER DATA (continued)

Employee Insurance Benefits (For Spouse/Domestic Partner, Dependent Children)

N/A

Additional Benefits

Accelerated Benefits Rider:	This rider is part of the certificate for all eligible employees.
Will Preparation Service Rider:	This rider is part of the certificate for all eligible employees who elect GVUL/GUL insurance.
Estate Resolution Services Rider:	This rider is part of the certificate for all eligible employees (services provided for both employee and spouse) who elect GVUL/GUL insurance.

Name/Address of Subsidiary, Affiliate, Division, Branch and Other Similar Entity	Effective Date Under the Plan
N/A	

Certificate Forms:

Certificate Number	1
Certificate Form	G.24300(2003) As amended by GCR08-1 – Employee GVUL Certificate
Applies To	All employees of Booz Allen Hamilton Holding Corporation
Effective Date	October 1, 2014
Certificate Number	2
Certificate Form	G.9704(2009) – Employee GUL certificate
Applies To	All employees of Booz Allen Hamilton Holding Corporation
Effective Date	October 1, 2014
Certificate Number	3
Certificate Form	G.24300-6 – Accelerated Death benefit rider
Applies To	All employees of Booz Allen Hamilton Holding Corporation
Effective Date	October 1, 2014
Certificate Number	4
Certificate Form	CR05-1 I/wil Will Prep Certificate Rider
Applies To	All employees of Booz Allen Hamilton Holding Corporation
Effective Date	October 1, 2014
Certificate Number	5
Certificate Form	GCR07-28 ERS Certificate Rider
Applies To	All employees of Booz Allen Hamilton Holding Corporation
Effective Date	October 1, 2014

**2023 EQUITY INCENTIVE PLAN OF
BOOZ ALLEN HAMILTON HOLDING CORPORATION
STOCK OPTION AGREEMENT**

GRANT NOTICE

Unless otherwise defined herein, the terms defined in the 2023 Equity Incentive Plan (the “Plan”) of Booz Allen Hamilton Holding Corporation (the “Company”) shall have the same defined meanings in this Stock Option Agreement, which includes the terms in this Grant Notice, including Exhibit A attached hereto (the “Grant Notice”) and Appendix A attached hereto, and any special terms and conditions set forth in Appendix B attached hereto with respect to your country of employment and/or residence (collectively, the “Agreement”). Capitalized terms used in this Grant Notice or in Appendix A without definition have the meanings given in the Plan.

You, #ParticipantName+C# (the “Optionee”), have been granted an option to purchase #QuantityGranted# Shares of Company Common Stock, and with an Option Price of #Grant Price# and on #GrantDate# (the “Grant Date”), in each case as set forth on the Fidelity NetBenefits system at www.netbenefits.com (the “Option”), subject to the terms and conditions of the Plan and this Agreement, including but not limited to the vesting schedule as set forth on Exhibit A to this Agreement, which shall be deemed part of and incorporated by reference into this Grant Notice, and the following terms:

Type of Option:	Non-Qualified Stock Option
Final Expiration Date:	Ten (10) years from the Grant Date

Your acceptance of the Option indicates your agreement and understanding that the Option is subject to the terms and conditions contained in the Agreement and the Plan. **ACCORDINGLY, PLEASE BE SURE TO READ THE PLAN AND THE AGREEMENT, EACH OF WHICH CONTAINS THE SPECIFIC TERMS AND CONDITIONS OF THIS OPTION. IN PARTICULAR, BY ACCEPTANCE OF THE OPTION, YOU AGREE TO THE TERMS AND CONDITIONS CONTAINED IN THE AGREEMENT RELATING TO ELECTRONIC DELIVERY OF ANY DOCUMENTS RELATED TO THE OPTION.**

APPENDIX A TO STOCK OPTION AGREEMENT

Article I. GRANT OF OPTION

Section 1.1 Grant of Option. The Company hereby grants to the Optionee, effective as of the Grant Date, the Option specified in the Grant Notice upon the terms and conditions set forth in the Plan and this Agreement (including the Grant Notice and any special terms and conditions applicable to the Optionee's country set forth in Appendix B to this Agreement). The Optionee hereby agrees that, except as required or permitted by Applicable Law, he or she will not disclose to any Person other than the Optionee's spouse and/or tax or financial advisor (if any) the grant of the Option or any of the terms or provisions hereof without prior approval from the Administrator.

Section 1.2 Option Subject to Plan. The Option granted hereunder is subject to the terms and provisions of the Plan, including, but not limited to, Article V, Article XI, Article XII, Article XIII and Article XIV thereof.

Section 1.3 Option Price. The Option Price of the Shares subject to the Option is equal to the Fair Market Value of a Share on the Grant Date, as determined by the Administrator in accordance with the provisions set forth in the Plan, and does not include any commission or other charges. The Option Price has been communicated to the Optionee in a communication accompanying the Grant Notice.

Article II. VESTING SCHEDULE; EXERCISABILITY

Section 2.1 Vesting and Exercisability of the Option.

(a) *Vesting.* Except as provided in this Section 2.1, the Option shall become vested and exercisable in the amount(s) and on the vesting date(s) set forth in Exhibit A (each, a "Vesting Date"), so long as the Optionee remains continuously in service as a Service Provider through such Vesting Date.

(b) *Discretionary Vesting.* The Administrator in its sole discretion may accelerate the vesting of any portion of the Option that does not otherwise vest pursuant to this Section 2.1.

Section 2.2 Termination of Employment or Service.

(a) *Termination Due to Death.* If an Optionee's employment or service terminates due to the Optionee's death, any unvested portion of the Option shall immediately vest and shall remain outstanding until (i) the first (1st) anniversary of the date of the Optionee's death or (ii) the Option's Final Expiration Date, whichever is earlier, after which any unexercised portion of the Option shall immediately terminate.

(b) *Termination Due to Disability.* If an Optionee's employment or service terminates due to the Optionee's Disability, any unvested portion of the Option shall not be forfeited and instead shall continue to vest in accordance with Section 2.1(a) of this Agreement. Any vested portion of the Option shall remain outstanding until (i) the later of the first (1st) anniversary of either (x) the date of termination due to Disability or (y) the date of vesting or (ii) the Option's Final Expiration Date, whichever is earlier, after which any unexercised portion of the Option shall immediately terminate.

(c) *Termination for Cause.* If the Optionee's employment or service terminates for Cause, the Option, whether vested or unvested, shall be immediately forfeited and canceled, effective as of the date of the Optionee's termination of employment or service. Notwithstanding the foregoing, unless otherwise determined by the Administrator and set forth in writing, any portion of the Option that vested during the twenty-four (24) months prior to or any time after the Optionee engaged in the conduct that gave rise to the termination for Cause shall upon demand by the Administrator be immediately forfeited and disgorged or paid to the Company together with all gains earned or accrued due to the exercise of such Option or sale of Company Common Stock issued pursuant to such Option.

(d) *Termination for Any Other Reason.* Unless otherwise determined by the Administrator and set forth in writing, if an Optionee's employment or service terminates for any reason other than death, Disability or by the Company or Employer for Cause, any portion of the Option that is unvested shall be immediately forfeited and canceled, effective as of the date of the Optionee's termination of employment or service, and any portion of the Option that is vested shall remain outstanding until (x) the ninetieth (90th) day after the date of termination of Optionee's employment or service or (y) the Final Expiration Date, whichever is earlier, after which any unexercised portion of the Option shall immediately terminate.

Section 2.3 Additional Forfeiture Provisions. Subject to Section 11.4 of the Plan, the Optionee acknowledges and agrees that the Option shall be immediately forfeited and cease to be exercisable, and the Optionee shall be required to disgorge to the Company all gains earned or accrued due to the exercise of the Option or sale of any Shares issued pursuant to such Option (i) if the Optionee engages in or fails to prevent, as applicable, any financial or other misconduct (including but not limited to engaging in Competitive Activity (but excluding, only if the Optionee is located in California, clause (a) of the definition of Competitive Activity contained in the Plan)), (ii) as required by Applicable Law or regulations or (iii) as otherwise provided in Section 11.4 of the Plan or generally applicable Company policies as to forfeiture, disgorgement and recoupment of Awards, including but not limited to any clawback policy adopted to comply with Section 303A.14 of the New York Stock Exchange Listed Company Manual.

Section 2.4 Exercisability of the Option. The Optionee (or the Optionee's Eligible Representative) shall not have the right to exercise any portion of the Option until the date such portion of the Option becomes vested and exercisable pursuant to Section 2.1 or Section 2.2 of this Agreement. The date that the applicable portion of the Option becomes vested and exercisable is referred to herein as the "Exercise Commencement Date." Subject to Section 14.1 of the Plan, following the Exercise Commencement Date, such applicable portion of the Option shall remain exercisable by the Optionee (or the Optionee's Eligible Representative) until it becomes unexercisable under Section 2.5 of this Agreement. Once the Option becomes unexercisable, it shall be forfeited immediately.

Section 2.5 Expiration of Option. The Option may not be exercised after the first to occur of the following events:

- (a) the Final Expiration Date;
- (b) except for such longer period of time as the Administrator may otherwise approve, ninety (90) days following the date of the Optionee's termination of employment or service as a Service Provider for any reason other than Cause, death, or Disability;
- (c) except as the Administrator may otherwise approve, the date that the Company or the Employer terminates the Optionee's employment or service as a Service Provider for Cause;
- (d) except for such longer period of time as the Administrator may otherwise approve, the first (1st) anniversary of the Optionee's termination of employment or service as a Service Provider by reason of the Optionee's death;
- (e) except for such longer period of time as the Administrator may otherwise approve, in the event of the Optionee's termination of employment or service as a Service Provider by reason of the Optionee's Disability, the first (1st) anniversary of the later of (A) the Optionee's termination of employment or service due to the Optionee's Disability or (B) the date of vesting of the applicable Option; or
- (f) upon forfeiture of an Option as provided in Section 2.3 of this Agreement and Section 11.4 of the Plan.

Section 2.6 Partial Exercise. Any exercisable portion of the Option or the entire Option, if then wholly exercisable, may be exercised in whole or in part at any time prior to the date on which the Option or portion thereof becomes unexercisable under Section 2.5 of this Agreement.

Section 2.7 Exercise of Option. The exercise of the Option shall be governed by the terms of this Agreement and the terms of the Plan, including, without limitation, the provisions of Article V of the Plan.

Section 2.8 Manner of Exercise.

(a) As a condition to the exercise of the Option or any portion thereof, the Optionee shall (i) notify the Company at least three (3) days prior to exercise and no earlier than ninety (90) days prior to exercise that the Optionee intends to exercise and specifically stating the number of Shares with respect to such Option is being exercised, and (ii) provide the Company with payment of the aggregate Option Price of the Shares with respect to which such Option is being exercised, together with any amounts necessary to satisfy all Tax-Related Items (as defined in Section 3.1 below), which shall be payable to the Company in full as set forth in this Section 2.8.

(b) To the extent permitted by law or the applicable listing rules, if any, the Optionee may pay for the Shares with respect to which such Option or portion of such Option is exercised through (i) payment in cash; (ii) with the consent of the Administrator, the delivery of Shares which are owned by the Optionee, duly endorsed for transfer to the Company with a Fair Market Value on the date of delivery equal to the aggregate Option Price of such Shares with respect to which the Option is being exercised; (iii) with the consent of the Administrator, the surrender of Shares then-issuable upon exercise of the Option having a Fair Market Value on the date of the exercise of the Option equal to the aggregate Option Price of such Shares with respect to which the Option is being exercised; (iv) with the consent of the Administrator, a broker-assisted cashless exercise program established by the Company; or (v) with the consent of the Administrator, delivery of a notice that the Optionee has placed a market sell order with a broker with respect to Shares then-issuable upon exercise of the Option, and that the broker has been directed to pay a sufficient portion of the net proceeds of the sale to the Company in satisfaction of the aggregate Option Price; provided, that payment of such proceeds is then made to the Company upon settlement of such sale. Notwithstanding the foregoing, the consent of the Administrator shall not be required with respect to clauses (iii) and (v) of this Section 2.8(b) if the Optionee exercises such Option on or after the date of the Optionee's Retirement (as defined in the Company's Retirement Policy).

(c) Notwithstanding any provision of the Agreement to the contrary, if the Optionee resides and/or works outside of the United States, the Company may require that the Optionee (i) exercise the Option in a method other than specified above, (ii) exercise the Option only by means of a "same day sale" transaction (either a sell-all transaction or a sell-to-cover transaction) as it determines in its sole discretion, or (iii) sell any Shares he or she acquires under the Plan immediately or within a specified period following the termination of the Optionee's employment or service with the Company, the Employer or any Subsidiary (in which case, the Optionee hereby agrees that the Company shall have the authority to issue sale instructions in relation to such Shares on the Optionee's behalf).

Section 2.9 Exercise by the Administrator. If the Optionee has not exercised the Option or any portion thereof immediately prior to the expiration of the Option under Section 2.5 of this Agreement, and the Fair Market Value on the date of expiration exceeds the Option Price of such Option, the Administrator may, in its sole discretion, exercise the Option on behalf of the Optionee by causing the Option Price to be paid through a broker-assisted cashless exercise program established by the Company. For the avoidance of doubt, the Administrator will not be required to obtain the Optionee's consent prior to such exercise.

Section 2.10 Change in Control. In the event of a Change in Control prior to the Vesting Date, notwithstanding anything in Article XIII of the Plan to the contrary, any unvested Options shall remain outstanding and shall vest on the applicable Vesting Date, subject to the continued employment or service of the Optionee by the Company or any Subsidiary thereof through such date; provided, that, if the Optionee's employment or service is terminated by the Company or the Employer without Cause or by the Optionee for Good Reason (each, a "Qualifying CIC Termination") within two (2) years following the

effective date of the Change in Control, such outstanding Options shall vest as of the date of such Qualifying CIC Termination.

Article III.
OTHER PROVISIONS

Section 3.1 Tax Withholding. The Optionee acknowledges that, regardless of any action taken by the Company or, if different, the Optionee's employer (the "Employer") with respect to any or all income tax (including U.S. federal, state and local taxes and/or non-U.S. taxes), social insurance, payroll tax, fringe benefits tax, payment on account or other tax-related items related to the Optionee's participation in the Plan and legally applicable to the Optionee ("Tax-Related Items"), the ultimate liability for all Tax-Related Items is and remains the Optionee's personal responsibility and may exceed the amount, if any, actually withheld by the Company or the Employer. The Optionee further acknowledges that the Company and/or the Employer (a) make no representations or undertakings regarding the treatment of any Tax-Related Items in connection with any aspect of the Optionee's participation in the Plan, including, but not limited to, the grant of the Option, the vesting of the Option, the exercise of the Option, the issuance or sale of Shares, or the receipt of any dividends; and (b) do not commit to and are under no obligation to structure the terms of the Option or any aspect of the Plan to reduce or eliminate the Optionee's liability for Tax-Related Items or achieve any particular tax result. Further, if the Optionee is subject to Tax-Related Items in more than one jurisdiction, the Optionee acknowledges that the Company and/or the Employer (or former employer, as applicable) may be required to withhold or account for Tax-Related Items in more than one jurisdiction.

Section 3.2 In connection with any relevant taxable or tax withholding event, as applicable, the Optionee agrees to make arrangements satisfactory to the Company and/or the Employer to satisfy all Tax-Related Items. In this regard, the Optionee authorizes the Company and/or the Employer, or their respective agents, at their discretion, to satisfy their withholding obligations with regard to any Tax-Related Items by one or a combination of the following: (a) withholding from the Optionee's wages or other cash compensation payable to the Optionee by the Company and/or the Employer, (b) withholding from proceeds of the sale of Shares under the Plan, either through a voluntary sale or through a mandatory sale arranged by the Company (on the Optionee's behalf pursuant to this authorization without further consent) to cover the Tax-Related Items required to be withheld, and (c) withholding in Shares to be issued upon exercise of the Option.

Section 3.3 If the obligation for Tax-Related Items is satisfied by withholding in Shares, for tax purposes, the Optionee will be deemed to have been issued the full number of Shares, notwithstanding that a number of the Shares are held back solely for the purpose of paying the Tax-Related Items.

Section 3.4 Nature of Grant. By accepting the Option, the Optionee acknowledges, understands and agrees that:

- (a) the Plan is established voluntarily by the Company, it is discretionary in nature and it may be modified, terminated, suspended or amended by the Company at any time, to the extent permitted by the Plan;
- (b) the Plan is operated and the Options are granted solely by the Company and only the Company is a party to this Agreement; accordingly, any rights the Optionee may have under this Agreement may be raised only against the Company but not any Subsidiary (including, but not limited to, the Employer);
- (c) no Subsidiary (including, but not limited to, the Employer) has any obligation to make any payment of any kind to the Optionee under this Agreement;

- (d) the grant of the Option is exceptional, voluntary and occasional, and does not create any contractual or other right to receive future Options or benefits in lieu of Options, even if Options have been granted in the past;
- (e) all decisions with respect to future Options or other grants, if any, will be at the sole discretion of the Administrator;
- (f) the grant of the Option and the Optionee's participation in the Plan shall not create a right to employment or be interpreted as forming an employment or service contract with the Company, the Employer or any other Subsidiary and shall not interfere with the ability of the Company, the Employer or any other Subsidiary to terminate the Optionee's employment or service relationship (if any);
- (g) the Optionee is voluntarily participating in the Plan;
- (h) the Option and any Shares acquired pursuant to such Option, and the income from and value of the same, are not intended to replace any pension rights or compensation;
- (i) the Option and any Shares acquired pursuant to such Option, and the income from and value of the same, are extraordinary items that do not constitute compensation of any kind for services of any kind rendered to the Company, the Employer or any other Subsidiary, and which are outside the scope of the Optionee's employment or service and the Optionee's employment or service agreement, if any;
- (j) the Option and any Shares acquired pursuant to such Option, and the income from and value of the same, are not part of normal or expected compensation or salary for any purpose, including, without limitation, calculating any severance, resignation, termination, redundancy, dismissal, end-of-service payments, holiday pay, bonuses, long-service awards, leave-related payments, pension or retirement or welfare benefits or similar mandatory payments;
- (k) the future value of the Shares underlying the Option is unknown, indeterminable and cannot be predicted with certainty and the value of such Shares may increase or decrease in the future;
- (l) if the underlying Shares do not increase in value, the Option will have no value;
- (m) if the Optionee exercises the Option and acquires Shares, the value of such Shares may increase or decrease in value, even below the Option Price;
- (n) no claim or entitlement to compensation or damages shall arise from forfeiture of the Option or recoupment of any gains earned or accrued due to the sale of Shares acquired upon exercise of the Option resulting from, but not limited to, the (1) termination of the Optionee's employment or service (regardless of the reason for the termination and whether or not the termination is later found to be invalid or in breach of employment laws in the jurisdiction where the Optionee is employed or the terms of the Optionee's employment or service agreement, if any) and/or (2) the application of any Applicable Law or regulations, or any recoupment policy or any recovery or clawback policy maintained by the Company or otherwise required by Applicable Law; and
- (o) neither the Company, the Employer nor any other Subsidiary shall be liable for any foreign exchange rate fluctuation between the Optionee's local currency and the United States Dollar that may affect the value of the Shares or any amounts due pursuant to the issuance of the Shares, or the subsequent sale of any Shares acquired pursuant to the Option.

Section 3.5 Shares Subject to Plan; Restrictions on the Transfer of Option and Company Common Stock. The Optionee acknowledges that this Option and any Shares acquired upon exercise of the Option are subject to the terms of the Plan, including, without limitation, the restrictions set forth in Section 5.8 and Section 5.9 of the Plan.

Section 3.6 Registration of Shares. The Company may postpone the issuance and delivery of Company Common Stock upon the exercise of the Option until such Shares may be issued in compliance with any applicable state or federal law, rule or regulation. Notwithstanding any other provision in this Agreement, the Optionee may not sell the Shares acquired upon exercise of the Option unless such Shares are registered under the Securities Act, or, if such Shares are not then so registered, such sale would be exempt from the registration requirements of the Securities Act. The sale must also comply with other Applicable Law and regulations governing the Shares, and the Optionee shall not sell the Shares if the Administrator determines that such sale would not be in compliance with such laws and regulations.

Section 3.7 Construction. This Agreement shall be administered, interpreted and enforced under the laws of the State of Delaware.

Section 3.8 Conformity to Securities Laws. The Optionee acknowledges that the Plan is intended to conform to the extent necessary with all provisions of the Securities Act and the Exchange Act and any and all regulations and rules promulgated thereunder by the Securities and Exchange Commission, including without limitation Rule 16b-3. Notwithstanding anything herein to the contrary, the Plan and this Agreement shall be administered, and the Option is granted and may be exercised, only in such a manner as to conform to such laws, rules and regulations. To the extent permitted by Applicable Law, the Plan and this Agreement shall be deemed amended to the extent necessary to conform to such laws, rules and regulations.

Section 3.9 Amendment, Suspension and Termination. This Agreement may be wholly or partially amended or otherwise modified, suspended or terminated at any time or from time to time by the Administrator, provided that, except as provided by Section 14.1 of the Plan, neither the amendment, modification, suspension nor termination of this Agreement (including the Grant Notice) shall, without the consent of the Optionee, materially alter or impair any rights or obligations under this Agreement.

Section 3.10 Employee Data Privacy. The collection, use, disclosure and transfer, in electronic or other form, of personally identifiable information by and among, as applicable, the Company, the Employer and its Subsidiaries and Affiliates, or any agent of the Company administering or providing Plan services, for the purpose of implementing, administering and managing the Optionee's participation in the Plan is governed by the Employee Privacy Notice (the "Privacy Notice") that Optionee received in the course of his or her relationship with the Company. The Optionee understands that he or she may review the Privacy Notice or contact his or her local human resources representative to request a copy of the Privacy Notice. Please contact ethics@bah.com if the Optionee has any questions or concerns about how the Company or its Subsidiaries and Affiliates process personally identifiable information.

Section 3.11 No Advice Regarding Grant. The Optionee acknowledges that neither the Company nor the Employer are providing any tax, legal or financial advice, or making any recommendations regarding the Optionee's participation in the Plan. The Optionee should consult his or her own personal tax, legal and financial advisors regarding the Optionee's participation in the Plan before taking any action related to the Plan.

Section 3.12 Country-Specific Provisions. The Optionee's participation in the Plan shall be subject to any additional or different terms and conditions set forth in Appendix B attached hereto applicable to the Optionee's country. Moreover, if the Optionee relocates to one of the countries included in Appendix B, the additional or different terms and conditions applicable to such country will apply to the Optionee, to the extent the Company determines that the application of such terms and conditions is necessary or advisable for legal or administrative reasons. Appendix B constitutes a part of this Agreement.

Section 3.13 Other Requirements. The Company reserves the right to impose other requirements on the Optionee's participation in the Plan and on any Shares acquired upon exercise of the Option granted hereunder, to the extent the Company determines it is necessary or advisable for legal or administrative

reasons, and to require the Optionee to sign any additional agreements or undertakings that may be necessary to accomplish the foregoing.

Section 3.14 Electronic Delivery. The Company may, in its sole discretion, decide to deliver any documents related to any Option granted under the Plan, including this Agreement, by electronic means or request the Optionee's consent to participate in the Plan by electronic means. The Optionee hereby explicitly and unambiguously consents to receive such documents (including, without limitation, information required to be delivered to the Optionee pursuant to applicable securities laws) by electronic delivery and, if requested, agrees to participate in the Plan through an on-line or electronic system established and maintained by the Company or another third-party designated by the Company, and such consent shall remain in effect throughout the Optionee's term of employment or service with the Company and thereafter until withdrawn in writing by the Optionee. The Optionee acknowledges that he or she may receive from the Company a paper copy of any documents delivered electronically at no cost to the Optionee by contacting the Company by telephone or in writing. The Optionee further acknowledges that the Optionee will be provided with a paper copy of any documents if the attempted electronic delivery of such documents fails. Similarly, the Optionee understands that the Optionee must provide the Company or any designated third-party administrator with a paper copy of any documents if the attempted electronic delivery of such documents fails.

Section 3.15 Miscellaneous.

(a) The Optionee shall have no rights as a stockholder of the Company with respect to the Shares subject to the Option until such time as the Option Price has been paid and the other requirements of Section 2.8 above have been satisfied, and the Shares have been issued and delivered to the Optionee.

(b) This Agreement shall be subject to all applicable laws, rules, and regulations, and to such approvals by any governmental agencies or United States or foreign securities exchanges as may be required.

(c) The Optionee acknowledges that the Company is organized under the laws of the State of Delaware. The Optionee and the Company agree that 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 that would apply the laws of any other jurisdiction.

(d) The Optionee acknowledges that the Company's principal place of business is in, and a substantial portion of the Company's business is based out of, the Commonwealth of Virginia, U.S.A. The Optionee also acknowledges that, as such, during the course of the Optionee's service with the Company and its Subsidiaries, the Optionee shall have substantial contacts with the Commonwealth of Virginia, U.S.A. Accordingly, the Optionee and the Company agree that the exclusive forum for any action, demand, claim or counterclaim relating to the terms and provisions of this Agreement, or to their breach, shall be in the appropriate state or federal court located in the Commonwealth of Virginia, U.S.A. The Optionee and the Company hereby consent to the personal jurisdiction of such courts over the parties to this Agreement. The Optionee expressly waives any defense that such courts lack personal jurisdiction or are inconvenient. The Optionee and the Company further agree that in any such action for breach or enforcement of this Agreement, no party will seek to challenge the validity or enforceability of any part of this Agreement.

(e) Neither this Agreement nor any right, remedy, obligation or liability arising hereunder or by reason hereof shall be assignable by the Company or the Optionee 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) All obligations of the Company under this Agreement and the Plan, with respect to the Option, shall be binding on any successor to the Company, whether the existence of such successor is the result of a direct or indirect purchase, merger, consolidation, or otherwise, of all or substantially all of the business and/or assets of the Company.

(g) In the event that any provision of this Agreement shall be held illegal or invalid for any reason, the illegality or invalidity shall not affect the remaining parts of this Agreement, and this Agreement shall be construed and enforced as if the illegal or invalid provision had not been included.

(h) This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original and all of which together shall constitute one and the same instrument.

Restricted Stock Unit Agreement
2023 EQUITY INCENTIVE PLAN OF
BOOZ ALLEN HAMILTON HOLDING CORPORATION
RESTRICTED STOCK UNIT AGREEMENT
GRANT NOTICE

Unless otherwise defined herein, the terms defined in the 2023 Equity Incentive Plan (the “Plan”) of Booz Allen Hamilton Holding Corporation (the “Company”) shall have the same defined meanings in this Restricted Stock Unit Agreement, which includes the terms in this Grant Notice, including Exhibit A attached hereto (the “Grant Notice”) and Appendix A attached hereto, and any special terms and conditions set forth in Appendix B attached hereto with respect to your country of employment and/or residence (collectively, the “Agreement”). Capitalized terms used in this Grant Notice or in Appendix A without definition have the meanings given in the Plan.

You, #ParticipantName+C# (the “Participant”), have been granted #QuantityGranted+C# restricted stock units on #GrantDate+C# (the “Grant Date”), in each case as set forth on the Fidelity NetBenefits system at www.netbenefits.com (the “Restricted Stock Units”), subject to the terms and conditions of the Plan and this Agreement, including but not limited to the vesting schedule as set forth in Exhibit A to this Agreement, which shall be deemed part of and incorporated by reference into this Grant Notice.

Your acceptance of this grant indicates your agreement and understanding that the Restricted Stock Units granted herein are subject to the terms and conditions contained in the Agreement and the Plan. **ACCORDINGLY, PLEASE BE SURE TO READ THE PLAN AND THE AGREEMENT, EACH OF WHICH CONTAINS THE SPECIFIC TERMS AND CONDITIONS OF THE RESTRICTED STOCK UNITS.** In order to view the grant details and to accept this grant, please go to Fidelity NetBenefits at www.netbenefits.com and follow the instructions regarding this grant.

APPENDIX A TO RESTRICTED STOCK UNIT AGREEMENT

1. Grant of Restricted Stock Units. Subject to the terms, conditions, and restrictions set forth in the Plan and this Agreement (including the Grant Notice and any special terms and conditions applicable to the Participant's country set forth in Appendix B to this Agreement), the Company hereby evidences and confirms its grant to the Participant, effective as of the Grant Date, of the number of Restricted Stock Units specified in the Grant Notice. The Participant hereby agrees that, except as required or permitted by Applicable Law, he or she will not disclose to any Person other than the Participant's spouse and/or tax or financial advisor (if any) the grant of the Restricted Stock Units or any of the terms or provisions hereof without prior approval from the Administrator.

2. Restricted Stock Units Subject to Plan. This Agreement is subordinate to, and the terms and conditions of the Restricted Stock Units granted hereunder are subject to, the terms and conditions of the Plan, which are incorporated by reference herein. If there is any inconsistency between the terms hereof and the terms of the Plan, the terms of the Plan shall govern.

3. Vesting of Restricted Stock Units.

(a) Vesting. Except as otherwise provided in this Section 3, the Restricted Stock Units shall become vested in the amount(s) and on the vesting date(s) as set forth in Exhibit A (each, a "Vesting Date"), subject to the continued employment or service of the Participant with the Company or any Subsidiary thereof through such applicable Vesting Date.

(b) Termination of Employment or Service.

(i) Termination Due to Death. If a Participant's employment or service terminates due to the Participant's death, all unvested Restricted Stock Units shall immediately vest.

(ii) Termination Due to Disability. If a Participant's employment or service terminates due to Disability, all unvested Restricted Stock Units shall not be forfeited upon such termination and instead shall continue to vest in accordance with Section 3(a) of this Agreement.

(iii) Termination for Cause. If a Participant's employment or service terminates for Cause, all unvested Restricted Stock Units shall be immediately forfeited and canceled, effective as of the date of the Participant's termination of service. In addition, any Restricted Stock Units that vested during the twenty-four (24) months prior to or any time after the Participant engaged in the conduct that gave rise to the termination for Cause (and any stock or cash issued in settlement of such Restricted Stock Units) shall upon demand by the Administrator be immediately forfeited and disgorged or paid to the Company together with all gains earned or accrued due to the sale of Company Common Stock issued in settlement of any Restricted Stock Units.

(iv) Termination for Any Other Reason. If a Participant's employment or service is terminated for any reason other than death, Disability or by the Company or Employer for Cause, all unvested Restricted Stock Units shall immediately be forfeited and canceled, effective as of the date of the Participant's termination of service.

(c) Change in Control. In the event of a Change in Control prior to the applicable Vesting Date, notwithstanding anything in Article XIII of the Plan to the contrary, any unvested Restricted Stock Units shall remain outstanding and shall vest on the applicable Vesting Date, subject to the continued employment or service of the Participant with the Company, the Employer or any other Subsidiary through such date; provided, that, if the Participant's employment or service is terminated by the Company or the Employer without Cause or by the Participant for Good Reason (each, a "Qualifying CIC Termination") within two (2) years following the effective date of the Change in Control, such

outstanding Restricted Stock Units shall vest as of the date of such Qualifying CIC Termination. Vested Restricted Stock Units shall be settled as set forth in Section 4 of this Agreement.

(d) Other Forfeiture Provisions. Subject to Section 11.4 of the Plan, the Restricted Stock Units (including any gains earned or accrued due to the sale of Company Common Stock issued in settlement of such Restricted Stock Units) shall also be forfeited and subject to disgorgement and/or repayment to the Company (i) in the event the Participant (x) engages in or fails to prevent, as applicable, any financial or other misconduct (including but not limited to engaging in Competitive Activity (but excluding, only if the Participant is located in California, clause (a) of the definition of Competitive Activity contained in the Plan)) or (y) materially violates any restrictive covenant agreement (or any other agreement containing restrictive covenants) that the Participant has entered into with the Company, (ii) as required by Applicable Law or regulations or (iii) as otherwise provided in Section 11.4 of the Plan or generally applicable Company policies as to forfeiture, disgorgement and recoupment of Awards, including but not limited to any clawback policy adopted to comply with Section 303A.14 of the New York Stock Exchange Listed Company Manual.

(e) Administrator Discretion. Notwithstanding anything contained in this Agreement to the contrary, subject to Article XII of the Plan, the Administrator, in its sole discretion, may waive forfeiture provisions or accelerate the vesting with respect to any Restricted Stock Units under this Agreement, at such times and upon such terms and conditions as the Administrator shall determine; provided, however, that such waiver or acceleration of vesting shall not change the settlement date of the Restricted Stock Units provided in Section 4 of this Agreement.

(f) Post-Termination Informational Requirements. Before the settlement of any Restricted Stock Units following termination of employment or service, the Administrator may require the Participant (or the Participant's Eligible Representative, if applicable) to make such representations and provide such documents as the Administrator deems necessary or advisable to effect compliance with Applicable Law and determine whether Section 3(b)(iii) or Section 3(d) of this Agreement apply. Such representations and documents may include tax returns and all other relevant information and records from which the Administrator can determine the current or former employment status of the Participant during the vesting period. Notwithstanding anything in this Agreement to the contrary, the settlement of the Restricted Stock Units may be withheld until information deemed sufficient by the Administrator is delivered to it, and any unvested Restricted Stock Units shall be forfeited if the requested information is not provided in sufficient detail to the Administrator before the earlier of (i) ninety (90) calendar days after the issuance of a request from the Administrator for such information and (ii) December 31 of the calendar year in which the applicable Vesting Date occurs.

4. Settlement of Restricted Stock Units. Subject to Section 3(f) and Section 9 of this Agreement, the Company shall deliver to the Participant one (1) Share (or the value thereof) in settlement of each outstanding Restricted Stock Unit granted hereunder that has vested as provided in Section 3 on the first to occur of (i) the applicable Vesting Date (or within thirty (30) days thereafter), (ii) in the event of a termination of employment or service due to death, as soon as practicable following the Participant's termination of employment or service by reason of death or (iii) in the event of a Qualifying CIC Termination, within thirty (30) days following the effective date of the Participant's Qualifying CIC Termination, in each case (A) in Company Common Stock by either, (x) issuing one or more certificates evidencing the Company Common Stock to the Participant or (y) registering the issuance of the Company Common Stock in the name of the Participant through a book entry credit in the records of the Company's transfer agent, or (B) in the event of settlement upon a Change in Control, a cash payment equal to the Change in Control Price, multiplied by the number of vested Restricted Stock Units. No fractional Shares shall be issued in settlement of the Restricted Stock Units. Fractional Shares shall be rounded up to the nearest whole share; provided, that the Participant may not vest in more than the number of Restricted Stock Units specified in the Grant Notice.

5. Notwithstanding the foregoing, the Administrator, in its sole discretion, may provide for the settlement of the Restricted Stock Units in the form of Company Common Stock, but require the Participant to sell such Common Stock immediately or within a specified period following the Participant's termination of service (in which case, the Participant hereby agrees that the Company shall have the authority to issue sale instructions in relation to such Common Stock on the Participant's behalf).

6. Securities Law Compliance. Notwithstanding any other provision of this Agreement, the Participant may not sell the Shares acquired upon vesting of the Restricted Stock Units unless such Shares are registered under the Securities Act, or, if such Shares are not then so registered, such sale would be exempt from the registration requirements of the Securities Act. The sale of such Shares must also comply with other Applicable Law and regulations governing the Shares, and the Participant may not sell the Shares if the Company determines that such sale would not be in material compliance with such laws and regulations.

7. Participant's Rights with Respect to the Restricted Stock Units.

(a) Restrictions on Transferability. The Restricted Stock Units granted hereby are not assignable or transferable, in whole or in part, and may not, directly or indirectly, be offered, transferred, sold, pledged, assigned, alienated, hypothecated or otherwise disposed of or encumbered (including without limitation by gift, operation of law or otherwise) other than by will or by the laws of descent and distribution to the estate of the Participant upon the Participant's death; provided that the deceased Participant's beneficiary or representative of the Participant's estate shall acknowledge and agree in writing, in a form reasonably acceptable to the Company, to be bound by the provisions of this Agreement and the Plan as if such beneficiary or the estate were the Participant.

(b) No Rights as Stockholder. The Participant shall not have any rights as a stockholder, including any voting, dividend or other rights or privileges as a stockholder of the Company with respect to Shares underlying the Restricted Stock Units granted hereby unless and until such Shares are issued to the Participant in respect thereof.

(c) Dividend Equivalents. The Restricted Stock Units granted hereunder include the right for the Participant to be credited with Dividend Equivalents in the form of a right to a cash payment when cash dividends are paid on the Company Common Stock. Such cash payment shall equal the amount obtained by multiplying the amount of the dividend declared and paid for each Share by the number of Restricted Stock Units held by the Participant on the record date for such dividend. Notwithstanding anything in the Plan to the contrary, any cash amounts in respect of the Dividend Equivalents credited to the Participant's account shall be paid to the Participant on the applicable payment date for the related cash dividend.

8. Participant's Representations, Warranties and Covenants.

(a) No Conflicts; No Consents. The execution and delivery by the Participant of this Agreement, the consummation of the transactions contemplated hereby and the performance of the Participant's obligations hereunder do not and will not (i) materially conflict with or result in a material violation or breach of any term or provision of any law applicable to either the Participant or the Restricted Stock Units or (ii) 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 the 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 the Participant is a party.

(b) Compliance with Rule 144. If any Shares issued in respect of the Restricted Stock Units are to be disposed of in accordance with Rule 144 of the Securities Act, the Participant shall transmit to

the Company an executed copy of Form 144 (if required by Rule 144) no later than the time such form is required to be transmitted to the Securities and Exchange Commission for filing and such other documentation as the Company may reasonably require to assure compliance with Rule 144 in connection with such disposition.

(c) Participant Status. The Participant represents and warrants that, as of the date hereof, the Participant is an officer or other Service Provider of the Company, the Employer or a Subsidiary.

9. Adjustment in Capitalization. Subject to Section 14.1 of the Plan, the number and kind of Shares subject to any outstanding Restricted Stock Units, or the other terms and conditions of any such Restricted Stock Units, shall be adjusted by the Administrator to reflect any stock dividend, stock split or share combination or any recapitalization, business combination, merger, consolidation, spin-off, exchange of shares, liquidation or dissolution of the Company or other similar transaction affecting the Company Common Stock in such manner as it determines in its sole discretion.

10. Tax Withholding. The Participant acknowledges that, regardless of any action taken by the Company or the Employer with respect to any or all income tax (including U.S. federal, state and local taxes and/or non-U.S. taxes), social insurance, payroll tax, fringe benefits tax, payment on account or other tax-related items related to the Participant's participation in the Plan and legally applicable to the Participant ("Tax-Related Items"), the ultimate liability for all Tax-Related Items is and remains the Participant's personal responsibility and may exceed the amount, if any, actually withheld by the Company or the Employer. The Participant further acknowledges that the Company and/or the Employer (a) make no representations or undertakings regarding the treatment of any Tax-Related Items in connection with any aspect of the Participant's participation in the Plan, including, but not limited to, the grant of the Restricted Stock Units, the vesting of the Restricted Stock Units, the issuance or sale of Shares, or the receipt of any dividends or Dividend Equivalents; and (b) do not commit to and are under no obligation to structure the terms of the Restricted Stock Units or any aspect of the Plan to reduce or eliminate the Participant's liability for Tax-Related Items or achieve any particular tax result. Further, if the Participant is subject to Tax-Related Items in more than one jurisdiction, the Participant acknowledges that the Company and/or the Employer (or former employer, as applicable) may be required to withhold or account for Tax-Related Items in more than one jurisdiction.

In connection with any relevant taxable or tax withholding event, as applicable, the Participant agrees to make arrangements satisfactory to the Company and/or the Employer to satisfy all Tax-Related Items. In this regard, the Participant authorizes the Company and/or the Employer, or their respective agents, at their discretion, to satisfy their withholding obligations with regard to any Tax-Related Items by one or a combination of the following: (a) withholding from the Participant's wages or other cash compensation payable to the Participant by the Company and/or the Employer, (b) withholding from proceeds of the sale of Shares under the Plan, either through a voluntary sale or through a mandatory sale arranged by the Company (on the Participant's behalf pursuant to this authorization without further consent) to cover the Tax-Related Items required to be withheld, and (c) withholding in Shares to be issued upon vesting of the Restricted Stock Units.

If the obligation for Tax-Related Items is satisfied by withholding in Shares, for tax purposes, the Participant will be deemed to have been issued the full number of Shares, notwithstanding that a number of the Shares are held back solely for the purpose of paying the Tax-Related Items.

The Company or the Employer may defer the settlement of Restricted Stock Units until such withholding or other tax requirements are satisfied and if the Participant has not satisfied such withholding or other tax requirements as of the last day of the calendar year in which the Vesting Date occurs, the Restricted Stock Units shall be forfeited.

11. Nature of Grant. By accepting the Restricted Stock Units, the Participant acknowledges, understands and agrees that:

- (a) the Plan is established voluntarily by the Company, it is discretionary in nature and it may be modified, terminated, suspended or amended by the Company at any time, to the extent permitted by the Plan;
- (b) the Plan is operated and the Restricted Stock Units are granted solely by the Company and only the Company is a party to this Agreement; accordingly, any rights the Participant may have under this Agreement may be raised only against the Company but not any Subsidiary (including, but not limited to, the Employer);
- (c) no Subsidiary (including, but not limited to, the Employer) has any obligation to make any payment of any kind to the Participant under this Agreement;
- (d) the grant of the Restricted Stock Units is exceptional, voluntary and occasional, and does not create any contractual or other right to receive future Restricted Stock Units or benefits in lieu of Restricted Stock Units, even if Restricted Stock Units have been granted in the past;
- (e) all decisions with respect to future Restricted Stock Units or other grants, if any, will be at the sole discretion of the Administrator;
- (f) the grant of the Restricted Stock Units and the Participant's participation in the Plan shall not create a right to employment or be interpreted as forming an employment or service contract with the Company, the Employer or any other Subsidiary and shall not interfere with the ability of the Company, the Employer or any other Subsidiary to terminate the Participant's employment or service relationship (if any);
- (g) the Participant is voluntarily participating in the Plan;
- (h) the Restricted Stock Units and any Shares acquired pursuant to such Restricted Stock Units, and the income from and value of the same, are not intended to replace any pension rights or compensation;
- (i) the Restricted Stock Units and any Shares acquired pursuant to such Restricted Stock Units, and the income from and value of the same, are extraordinary items that do not constitute compensation of any kind for services of any kind rendered to the Company, the Employer or any other Subsidiary, and which are outside the scope of the Participant's employment or service and the Participant's employment or service agreement, if any;
- (j) the Restricted Stock Units and any Shares acquired pursuant to such Restricted Stock Units, and the income from and value of the same, are not part of normal or expected compensation or salary for any purpose, including, without limitation, calculating any severance, resignation, termination, redundancy, dismissal, end-of-service payments, holiday pay, bonuses, long-service awards, leave-related payments, pension or retirement or welfare benefits or similar mandatory payments;
- (k) the future value of the Shares underlying the Restricted Stock Units is unknown, indeterminable and cannot be predicted with certainty and the value of such Shares may increase or decrease in the future;
- (l) no claim or entitlement to compensation or damages shall arise from forfeiture of the Restricted Stock Units or recoupment of any gains earned or accrued due to the sale of Shares acquired in settlement of such Restricted Stock Units resulting from, but not limited to, the (1) termination of the Participant's employment or service (regardless of the reason for the termination and whether or not the

termination is later found to be invalid or in breach of employment laws in the jurisdiction where the Participant is employed or the terms of the Participant's employment or service agreement, if any) and/or (2) application of any Applicable Law or regulations, or any recoupment policy or any recovery or clawback policy maintained by the Company or otherwise required by Applicable Law; and

(m) neither the Company, the Employer nor any other Subsidiary shall be liable for any foreign exchange rate fluctuation between the Participant's local currency and the United States Dollar that may affect the value of the Shares or any amounts due pursuant to the issuance of the Shares, or the subsequent sale of any Shares acquired pursuant to the Restricted Stock Units.

12. Employee Data Privacy. The collection, use, disclosure and transfer, in electronic or other form, of personally identifiable information to facilitate the grant of the Restricted Stock Units and the administration of the Plan by and among, as applicable, the Company and the Employer, if different, any of the Company's Subsidiaries or Affiliates, or any agent of the Company administering or providing Plan services is governed by the Employee Privacy Notice (the "Privacy Notice") that Participant received in the course of his or her relationship with Company. The Participant understands that he or she may review the Privacy Notice or contact his or her local human resources representative to request a copy of the Privacy Notice. Please contact ethics@bah.com if the Participant has any questions or concerns about how the Company or its Subsidiaries and Affiliates process personally identifiable information.

13. Miscellaneous.

(a) 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.

(b) No Advice Regarding Grant. The Participant acknowledges that neither the Company nor the Employer are providing any tax, legal or financial advice, or making any recommendations regarding the Participant's participation in the Plan. The Participant should consult his or her own personal tax, legal and financial advisors regarding the Participant's participation in the Plan before taking any action related to the Plan.

(c) Interpretation. For purposes of this Agreement, if the Participant is not employed by the Company, "Employer" means the Subsidiary that employs the Participant. This Agreement and the Restricted Stock Units granted hereunder are subject to the terms and conditions of the Plan, which are incorporated by reference herein. In the event of any inconsistency between the provisions of this Agreement and the Plan, the Plan shall govern. The Administrator, acting pursuant to the Plan, as constituted from time to time, shall, except as expressly provided otherwise herein, have the right to determine reasonably and in good faith any questions that arise in connection with this Agreement, and any such determination shall be final, binding and conclusive on all Participants and other individuals claiming any right under the Plan. The failure of the Company or the Participant to insist upon strict performance of any provision hereunder, irrespective of the length of time for which such failure continues, shall not be deemed a waiver of such party's right to demand strict performance at any time in the future. No consent or waiver, express or implied, to or of any breach or default in the performance of any obligation or provision hereunder shall constitute a consent or waiver to or of any other breach or default in the performance of the same or any other obligation hereunder.

(d) Country-Specific Provisions. The Participant's participation in the Plan shall be subject to any additional or different terms and conditions set forth in Appendix B attached hereto applicable to the Participant's country. Moreover, if the Participant relocates to one of the countries included in Appendix B, the additional or different terms and conditions applicable to such country will apply to the

Participant, to the extent the Company determines that the application of such terms and conditions is necessary or advisable for legal or administrative reasons. Appendix B constitutes a part of this Agreement.

(e) Other Requirements. The Company reserves the right to impose other requirements on the Participant's participation in the Plan and on any Shares acquired in settlement of the Restricted Stock Units granted hereunder, to the extent the Company determines it is necessary or advisable for legal or administrative reasons, and to require the Participant to sign any additional agreements or undertakings that may be necessary to accomplish the foregoing.

(f) Applicable Law. The Participant acknowledges that the Company is organized under the laws of the State of Delaware. The Participant and the Company agree that 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 that would apply the laws of any other jurisdiction.

(g) Forum Selection. The Participant acknowledges that the Company's principal place of business is in, and a substantial portion of the Company's business is based out of, the Commonwealth of Virginia. The Participant also acknowledges that, as such, during the course of the Participant's service with the Company, the Employer or any other Subsidiary, the Participant shall have substantial contacts with the Commonwealth of Virginia. Accordingly, the Participant and the Company agree that the exclusive forum for any action, demand, claim or counterclaim relating to the terms and provisions of this Agreement, or to their breach, shall be in the appropriate state or federal court located in the Commonwealth of Virginia. The Participant and the Company hereby consent to the personal jurisdiction of such courts over the parties to this Agreement. The Participant expressly waives any defense that such courts lack personal jurisdiction or are inconvenient. The Participant and the Company further agree that in any such action for breach or enforcement of this Agreement, no party will seek to challenge the validity or enforceability of any part of this Agreement.

(h) Amendment. This Agreement may not be amended, modified or supplemented orally, but only by a written instrument executed by the Participant and the Company.

(i) 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.

(j) 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.

(k) Consent to Electronic Delivery. By entering into this Agreement and accepting the Restricted Stock Units evidenced hereby, 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, this Agreement and the Restricted Stock Units via the Company's website, the Fidelity NetBenefits website or any other online access system of the Company's third-party Plan administrator, email or other form of electronic delivery.

(l) Section 409A of the Code. This Agreement is intended to be administered in a manner consistent with the requirements, where applicable, of Section 409A of the Code and the regulations promulgated thereunder ("Section 409A"). Where reasonably practicable, the Agreement shall be administered in a manner to avoid the imposition on the Participant of immediate tax recognition and additional taxes pursuant to Section 409A. In addition, to the extent permissible under Section 409A, any series of installment payments under this Agreement shall be treated as a right to a series of separate payments. Notwithstanding the foregoing, the Company shall not have any liability to any Person in the

event Section 409A applies to any payment hereunder in a manner that results in adverse tax consequences to the Participant or any of the Participant's beneficiaries.

(m) Specified Employee Delay. Subject to Section 14.13 of the Plan, if the Participant is deemed a "specified employee" within the meaning of Section 409A, as determined by the Administrator, at a time when the Participant becomes eligible for settlement of the Restricted Stock Units upon his or her "separation from service" within the meaning of Section 409A, then to the extent necessary to comply with, and avoid the imposition on the Participant of any accelerated or additional tax, under Section 409A, such settlement will be delayed until the earlier of (a) the six (6)-month anniversary of the Participant's termination of service and (b) the Participant's death. Notwithstanding anything to the contrary in this Agreement, if settlement is to occur upon a termination of service other than due to death or Disability and the Participant is a specified employee, to the extent necessary to comply with, and avoid imposition on the Participant of any additional tax or interest imposed under, Section 409A, settlement shall instead occur on the first business day following the six (6)-month anniversary of the Participant's termination of service (or, if earlier, upon the Participant's death), or as soon thereafter as practicable (but no later than ninety (90) days thereafter).

(n) Headings and Captions. 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.

(o) Notices. All notices under this Agreement shall be (i) delivered by hand, (ii) sent by commercial overnight courier service, (iii) sent by registered or certified mail, return receipt requested, and first-class postage prepaid, (iv) sent by e-mail or any other form of electronic transfer or delivery approved by the Administrator, or (v) faxed, in each case to the parties at their respective addresses and facsimile numbers set forth in the records of the Company or at such other address or facsimile number as may be designated in a notice by either party to the other.

(p) Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original and all of which together shall constitute one and the same instrument.

Performance Restricted Stock Unit Agreement
2023 EQUITY INCENTIVE PLAN OF
BOOZ ALLEN HAMILTON HOLDING CORPORATION
PERFORMANCE RESTRICTED STOCK UNIT AGREEMENT
GRANT NOTICE

Unless otherwise defined herein, the terms defined in the 2023 Equity Incentive Plan (the “Plan”) of Booz Allen Hamilton Holding Corporation (the “Company”) shall have the same defined meanings in this Performance Restricted Stock Unit Agreement, which includes the terms in this Grant Notice, including Exhibit A attached hereto (the “Grant Notice”), and Appendix A attached hereto, and any special terms and conditions set forth in Appendix B attached hereto with respect to your country of employment and/or residence (collectively, the “Agreement”).

You, #ParticipantName+C# (the “Participant”), have been granted #QuantityGranted+C# target performance-based restricted stock units on #GrantDate+C# (the “Grant Date”), in each case as set forth on the Fidelity NetBenefits system at www.netbenefits.com (the “Restricted Stock Units”), subject to the terms and conditions of the Plan and this Agreement, including but not limited to the vesting schedule and the satisfaction of the performance goals for the applicable performance period as set forth on Exhibit A to this Agreement, as delivered and made available to you by the Company, which shall be deemed part of and incorporated by reference into this Grant Notice.

Your acceptance of this grant indicates your agreement and understanding that the Restricted Stock Units granted herein are subject to the terms and conditions contained in the Agreement and the Plan. **ACCORDINGLY, PLEASE BE SURE TO READ THE PLAN AND THE AGREEMENT, EACH OF WHICH CONTAINS THE SPECIFIC TERMS AND CONDITIONS OF THE RESTRICTED STOCK UNITS.** In order to view the grant details and to accept this grant, please go to Fidelity NetBenefits at www.netbenefits.com and follow the instructions regarding this grant.

APPENDIX A TO PERFORMANCE RESTRICTED STOCK UNIT AGREEMENT

1. Grant of Restricted Stock Units. Subject to the terms, conditions, and restrictions set forth in the Plan and this Agreement (including the Grant Notice and any special terms and conditions applicable to the Participant's country set forth in Appendix B to this Agreement), the Company hereby evidences and confirms its grant to the Participant, effective as of the Grant Date, of the Restricted Stock Units specified in the Grant Notice. Each Restricted Stock Unit represents the right to receive a number of Shares (which could be less than or greater than one Share), subject to the terms and conditions set forth in the Plan and this Agreement (including Exhibit A and Appendix B). Except as otherwise provided in Section 3 below, the number of Restricted Stock Units that the Participant shall actually earn for the Performance Period (up to the maximum specified in the Grant Notice) will be determined by the Administrator based on the level of achievement of the performance goals specified in Exhibit A attached hereto (the "Performance Goals"). The Participant hereby agrees that, except as required or permitted by Applicable Law, the Participant will not disclose to any Person other than the Participant's spouse and/or tax or financial advisor (if any) the grant of the Restricted Stock Units or any of the terms or provisions hereof without prior approval from the Administrator.

2. Restricted Stock Units Subject to Plan. This Agreement is subordinate to, and the terms and conditions of the Restricted Stock Units granted hereunder are subject to, the terms and conditions of the Plan, which are incorporated by reference herein. If there is any inconsistency between the terms hereof and the terms of the Plan, the terms of the Plan shall govern. Any capitalized terms used herein without definition shall have the meanings set forth in the Plan.

3. Vesting of Restricted Stock Units.

(a) Vesting. For purposes of this Agreement, the term "Performance Period" shall mean the period set forth in Exhibit A. Except as otherwise provided in this Section 3, the Restricted Stock Units shall become vested as of the vesting date specified in Exhibit A (the "Vesting Date"), subject to the continued employment or service of the Participant with the Company or any Subsidiary thereof through the Vesting Date, and to the achievement of the Performance Goals set forth in Exhibit A for the Performance Period as determined by the Administrator pursuant to Section 4(a) of this Agreement. Restricted Stock Units that do not vest in accordance with this Section 3 shall be forfeited.

(b) Termination of Employment or Service.

(i) Termination Due to Death. If a Participant's employment or service terminates due to the Participant's death prior to the Vesting Date, all unvested Restricted Stock Units shall vest on the effective date of such termination of employment or service at Target Award levels (as specified on Exhibit A attached hereto). Vested Restricted Stock Units shall be settled as set forth in Section 4.

(ii) Termination by Reason of Disability. If a Participant's employment or service terminates prior to the Vesting Date by reason of the Participant's Disability, all unvested Restricted Stock Units shall vest as of the Vesting Date in a *pro rata* amount of the Restricted Stock Units that would have been earned and vested in accordance with Section 3(a) based on actual achievement of the Performance Goals as if the Participant's employment or service had not terminated, with such amount prorated for the portion of the Performance Period that lapsed prior to the Participant's termination of employment or service; provided, that, any "transition period" (within the meaning of the Company's Transition Policy, as may be amended from time to time) shall not be considered a period of employment or service for purposes of calculating the *pro rata* amount. Vested Restricted Stock Units shall be settled as set forth in Section 4 of this Agreement.

(iii) Termination by Reason of Retirement. (A) If a Participant's employment or service terminates prior to the Vesting Date by reason of a Participant's Qualifying Permanent Retirement (as defined below), provided that such termination occurs on or after March 31 (or if March 31 is not a business day, the last business day prior to March 31) of the first fiscal year of the Performance Period, the unvested Restricted Stock Units shall vest in accordance with Section 3(a) based on actual achievement of the Performance Goals as if the Participant's employment or service had not terminated; (B) if a Participant's employment or service terminates prior to March 31 (or if March 31 is not a business

day, the last business day prior to March 31) of the first fiscal year of the Performance Period by reason of a Participant's retirement (notwithstanding that such retirement may otherwise qualify as a Qualifying Permanent Retirement), all unvested Restricted Stock Units shall immediately be forfeited as of the termination date; and (C) if a Participant's employment or service terminates at any point prior to the Vesting Date by reason of a Participant's retirement that at any point during the Performance Period does not constitute a Qualifying Permanent Retirement, all unvested Restricted Stock Units shall immediately be forfeited as of the termination date or, if later, the date such retirement does not constitute a Qualifying Permanent Retirement. Vested Restricted Stock Units shall be settled as set forth in Section 4 of this Agreement. "Qualifying Permanent Retirement" means a termination of the Participant's employment or service by reason of a retirement (I) in accordance with the applicable Company retirement policy (as may be amended from time to time) and (II) that is a permanent retirement from all current and future employment, including but not limited to self-employment, unless such employment is approved by the Company in writing in advance of the Participant commencing such employment.

(iv) Termination for Cause. If a Participant's employment or service terminates for Cause, all unvested Restricted Stock Units shall be immediately forfeited and canceled, effective as of the date of the Participant's termination of service. In addition, any Restricted Stock Units that vested during the twenty-four (24) months prior to or any time after the Participant engaged in the conduct that gave rise to the termination for Cause (and any stock or cash issued to the Participant in settlement of such Restricted Stock Units) shall upon demand by the Administrator be immediately forfeited and disgorged or paid to the Company together with all gains earned or accrued due to the sale of Company Common Stock issued in settlement of any Restricted Stock Units.

(v) Termination for Any Other Reason. If a Participant's employment or service terminates for any reason other than death, Disability, in a Qualifying Permanent Retirement or by the Company or Employer for Cause, all unvested Restricted Stock Units shall immediately be forfeited and canceled, effective as of the date of the Participant's termination of service.

(c) Change in Control. In the event of a Change in Control prior to the Vesting Date, notwithstanding anything in Article XIII of the Plan to the contrary, an amount of Restricted Stock Units equal to the Target Award (as specified on Exhibit A attached hereto) shall remain outstanding and shall vest on the Vesting Date, subject to the continued employment or service of the Participant with the Company, the Employer or any other Subsidiary through such date, but without regard to achievement of any Performance Goals; provided, that, if the Participant's employment or service is terminated by the Company or the Employer without Cause or by the Participant for Good Reason (each, a "Qualifying CIC Termination") within two (2) years following the effective date of the Change in Control, such outstanding Restricted Stock Units shall vest as of the date of such Qualifying CIC Termination. Vested Restricted Stock Units shall be settled as set forth in Section 4 of this Agreement.

(d) Other Forfeiture Provisions. Subject to Section 11.4 of the Plan, the Restricted Stock Units (including any gains earned or accrued due to the sale of Company Common Stock issued in settlement of such Restricted Stock Units) shall also be forfeited and subject to disgorgement and/or repayment to the Company (i) in the event the Participant (x) engages in or fails to prevent, as applicable, any financial or other misconduct (including but not limited to engaging in Competitive Activity (but excluding, only if the Participant is located in California, clause (a) of the definition of Competitive Activity contained in the Plan)) or (y) materially violates any restrictive covenant agreement (or any other agreement containing restrictive covenants) that the Participant has entered into with the Company, (ii) as required by Applicable Law or regulations or (iii) as otherwise provided in Section 11.4 of the Plan or generally applicable Company policies as to forfeiture, disgorgement and recoupment of Awards, including but not limited to any clawback policy adopted to comply with Section 303A.14 of the New York Stock Exchange Listed Company Manual.

(e) Administrator Discretion. Notwithstanding anything contained in this Agreement to the contrary, subject to Article XII of the Plan, the Administrator, in its sole discretion, may waive forfeiture provisions or accelerate the vesting with respect to any Restricted Stock Units under this Agreement, at such times and upon such terms and conditions as the Administrator shall determine; provided, however, that such waiver or acceleration of vesting shall not change the settlement date of the Restricted Stock Units provided in Section 4 of this Agreement.

(f) Post-Termination Informational Requirements. Before the settlement of any Restricted Stock Units following termination of employment or service, the Administrator may require the Participant (or the Participant's Eligible Representative, if applicable) to make such representations and provide such documents as the Administrator deems necessary or advisable to effect compliance with Applicable Law and determine whether Section 3(b)(iii), 3(b)(iv) or 3(d) of this Agreement apply. Such representations and documents may include tax returns and all other relevant information and records from which the Administrator can determine the current or former employment status of the Participant during the Performance Period. Notwithstanding anything in this Agreement to the contrary, the settlement of the Restricted Stock Units may be withheld until information deemed sufficient by the Administrator is delivered to it, and any unvested Restricted Stock Units shall be forfeited if the requested information is not provided in sufficient detail to the Administrator before the earlier of (i) ninety (90) calendar days after the issuance of a request from the Administrator for such information and (ii) December 31 of the calendar year in which the Vesting Date occurs.

4. Administrator Certification; Settlement of Restricted Stock Units.

(a) Certification. As soon as practicable following completion of the Performance Period, the Administrator will review and determine (i) whether, and to what extent, the Performance Goals for the Performance Period have been achieved, in whole or in part, and (ii) the number of Restricted Stock Units that the Participant shall earn, if any, subject to compliance with the requirements of Section 3 (the "Administrator Certification"). All determinations of whether the Performance Goals have been achieved, the number of Restricted Stock Units earned by the Participant, and all other matters related to this Section 4(a) shall be made by the Administrator in its sole discretion and shall be final, conclusive and binding on the Participant.

(b) Settlement of Restricted Stock Units. Subject to Section 3(f), Section 4(a) and Section 9 of this Agreement, the Company shall deliver to the Participant one (1) Share (or the value thereof) in settlement of each Restricted Stock Unit granted hereunder that has become earned and vested as provided in Section 3 on the first to occur of the following: (i) on or as soon as practicable following the date of the Administrator Certification (but in no event later than 2½ months after the Vesting Date); (ii) in the event of a termination of employment or service due to death, as soon as practicable following the Participant's termination of employment or service by reason of death; or (iii) in the event of a Qualifying CIC Termination, within thirty (30) days following the effective date of the Participant's Qualifying CIC Termination, in each case (A) in Company Common Stock by either, (x) issuing one or more certificates evidencing the Company Common Stock to the Participant or (y) registering the issuance of the Company Common Stock in the name of the Participant through a book entry credit in the records of the Company's transfer agent, or (B) in the event of settlement upon a Change in Control, a cash payment equal to the Change in Control Price, multiplied by the number of vested Restricted Stock Units. No fractional Shares shall be issued in settlement of the Restricted Stock Units. Fractional Shares shall be rounded up to the nearest whole share; provided, that the Participant may not vest in more than the maximum number of Restricted Stock Units specified in the Grant Notice.

(c) Notwithstanding the foregoing, the Administrator, in its sole discretion, may provide for the settlement of the Restricted Stock Units in the form of Company Common Stock, but require the Participant to sell such Common Stock immediately or within a specified period following the Participant's termination of service (in which case, the Participant hereby agrees that the Company shall have the authority to issue sale instructions in relation to such Common Stock on the Participant's behalf).

5. Securities Law Compliance. Notwithstanding any other provision of this Agreement, the Participant may not sell the Shares acquired upon vesting of the Restricted Stock Units unless such Shares are registered under the Securities Act, or, if such Shares are not then so registered, such sale would be exempt from the registration requirements of the Securities Act. The sale of such Shares must also comply with other Applicable Law and regulations governing the Shares, and the Participant may not sell the Shares if the Company determines that such sale would not be in material compliance with such laws and regulations.

6. Participant's Rights with Respect to the Restricted Stock Units.

(a) Restrictions on Transferability. The Restricted Stock Units granted hereby are not assignable or transferable, in whole or in part, and may not, directly or indirectly, be offered, transferred, sold, pledged, assigned, alienated, hypothecated or otherwise disposed of or encumbered (including without limitation by gift, operation of law or otherwise) other than by will or by the laws of descent and distribution to the estate of the Participant upon the Participant's death; provided that the deceased Participant's beneficiary or representative of the Participant's estate shall acknowledge and agree in writing, in a form reasonably acceptable to the Company, to be bound by the provisions of this Agreement and the Plan as if such beneficiary or the estate were the Participant.

(b) No Rights as Stockholder. The Participant shall not have any rights as a stockholder, including any voting, dividend or other rights or privileges as a stockholder of the Company with respect to Shares underlying the Restricted Stock Units granted hereby unless and until such Shares are issued to the Participant in respect thereof.

(c) Dividend Equivalents. If the Company declares a cash dividend on the Company Common Stock, then the Participant shall be credited with Dividend Equivalents in the form of a right to a cash payment equal to (i) the amount of the dividend declared and paid for each Share, multiplied by (ii) (x) the number of Restricted Stock Units earned by the Participant as determined by the Administrator pursuant to Section 4(a) or (y) in the case of a termination of employment or service by reason of Death or a Qualifying CIC Termination, the number of Restricted Stock Units equal to the Target Award (as specified on Exhibit A attached hereto). Any Dividend Equivalents shall be subject to the same forfeiture restrictions as the Restricted Stock Units to which they are attributable and shall be paid on the same date the Restricted Stock Units to which they are attributable are settled in accordance with Section 4 hereof. Dividend Equivalents credited to a Participant's account shall be distributed in cash or, at the discretion of the Administrator, in Shares having a Fair Market Value equal to the amount of the Dividend Equivalents, if any.

(d)

7. Participant's Representations, Warranties and Covenants.

(a) No Conflicts; No Consents. The execution and delivery by the Participant of this Agreement, the consummation of the transactions contemplated hereby and the performance of the Participant's obligations hereunder do not and will not (i) materially conflict with or result in a material violation or breach of any term or provision of any law applicable to either the Participant or the Restricted Stock Units or (ii) 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 the 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 the Participant is a party.

(b) Compliance with Rule 144. If any Shares issued in respect of the Restricted Stock Units are to be disposed of in accordance with Rule 144 of the Securities Act, the Participant shall transmit to the Company an executed copy of Form 144 (if required by Rule 144) no later than the time such form is required to be transmitted to the Securities and Exchange Commission for filing and such other documentation as the Company may reasonably require to assure compliance with Rule 144 in connection with such disposition.

(c) Participant Status. The Participant represents and warrants that, as of the date hereof, the Participant is an officer or other Service Provider of the Company, the Employer or a Subsidiary.

8. Adjustment in Capitalization. Subject to Section 14.1 of the Plan, the number and kind of Shares subject to any outstanding Restricted Stock Units, or the other terms and conditions of any such Restricted Stock Units, shall be adjusted by the Administrator to reflect any stock dividend, stock split or share combination or any recapitalization, business combination, merger, consolidation, spin-off,

exchange of shares, liquidation or dissolution of the Company or other similar transaction affecting the Company Common Stock in such manner as it determines in its sole discretion.

9. Tax Withholding. The Participant acknowledges that, regardless of any action taken by the Company or the Employer with respect to any or all income tax (including U.S. federal, state and local taxes and/or non-U.S. taxes), social insurance, payroll tax, fringe benefits tax, payment on account or other tax-related items related to the Participant's participation in the Plan and legally applicable to the Participant ("Tax-Related Items"), the ultimate liability for all Tax-Related Items is and remains the Participant's personal responsibility and may exceed the amount, if any, actually withheld by the Company or the Employer. The Participant further acknowledges that the Company and/or the Employer (a) make no representations or undertakings regarding the treatment of any Tax-Related Items in connection with any aspect of the Participant's participation in the Plan, including, but not limited to, the grant of the Restricted Stock Units, the vesting of the Restricted Stock Units, the issuance or sale of Shares, or the receipt of any dividends or Dividend Equivalents; and (b) do not commit to and are under no obligation to structure the terms of the Restricted Stock Units or any aspect of the Plan to reduce or eliminate the Participant's liability for Tax-Related Items or achieve any particular tax result. Further, if the Participant is subject to Tax-Related Items in more than one jurisdiction, the Participant acknowledges that the Company and/or the Employer (or former employer, as applicable) may be required to withhold or account for Tax-Related Items in more than one jurisdiction.

In connection with any relevant taxable or tax withholding event, as applicable, the Participant agrees to make arrangements satisfactory to the Company and/or the Employer to satisfy all Tax-Related Items. In this regard, the Participant authorizes the Company and/or the Employer, or their respective agents, at their discretion, to satisfy their withholding obligations with regard to any Tax-Related Items by one or a combination of the following: (a) withholding from the Participant's wages or other cash compensation payable to the Participant by the Company and/or the Employer, (b) withholding from proceeds of the sale of Shares under the Plan, either through a voluntary sale or through a mandatory sale arranged by the Company (on the Participant's behalf pursuant to this authorization without further consent) to cover the Tax-Related Items required to be withheld, and (c) withholding in Shares to be issued upon vesting of the Restricted Stock Units.

If the obligation for Tax-Related Items is satisfied by withholding in Shares, for tax purposes, the Participant will be deemed to have been issued the full number of Shares, notwithstanding that a number of the Shares are held back solely for the purpose of paying the Tax-Related Items.

The Company or the Employer may defer the settlement of Restricted Stock Units until such withholding or other tax requirements are satisfied and if the Participant has not satisfied such withholding or other tax requirements as of the last day of the calendar year in which the Vesting Date occurs, the Restricted Stock Units shall be forfeited.

10. Nature of Grant. By accepting the Restricted Stock Units, the Participant acknowledges, understands and agrees that:

- (a) the Plan is established voluntarily by the Company, it is discretionary in nature and it may be modified, terminated, suspended or amended by the Company at any time, to the extent permitted by the Plan;
- (b) the Plan is operated and the Restricted Stock Units are granted solely by the Company and only the Company is a party to this Agreement; accordingly, any rights the Participant may have under this Agreement may be raised only against the Company but not any Subsidiary (including, but not limited to, the Employer);
- (c) no Subsidiary (including, but not limited to, the Employer) has any obligation to make any payment of any kind to the Participant under this Agreement;

(d) the grant of the Restricted Stock Units is exceptional, voluntary and occasional, and does not create any contractual or other right to receive future Restricted Stock Units or benefits in lieu of Restricted Stock Units, even if Restricted Stock Units have been granted in the past;

(e) all decisions with respect to future Restricted Stock Units or other grants, if any, will be at the sole discretion of the Administrator;

(f) the grant of the Restricted Stock Units and the Participant's participation in the Plan shall not create a right to employment or service or be interpreted as forming an employment or service contract with the Company, the Employer or any other Subsidiary and shall not interfere with the ability of the Company, the Employer or any other Subsidiary to terminate the Participant's employment or service relationship (if any);

(g) the Participant is voluntarily participating in the Plan;

(h) the Restricted Stock Units and any Shares acquired pursuant to such Restricted Stock Units, and the income from and value of the same, are not intended to replace any pension rights or compensation;

(i) the Restricted Stock Units and any Shares acquired pursuant to such Restricted Stock Units, and the income from and value of the same, are extraordinary items that do not constitute compensation of any kind for services of any kind rendered to the Company, the Employer or any other Subsidiary, and which are outside the scope of the Participant's employment or service and the Participant's employment or service agreement, if any;

(j) the Restricted Stock Units and any Shares acquired pursuant to such Restricted Stock Units, and the income from and value of the same, are not part of normal or expected compensation or salary for any purpose, including, without limitation, calculating any severance, resignation, termination, redundancy, dismissal, end-of-service payments, holiday pay, bonuses, long-service awards, leave-related payments, pension or retirement or welfare benefits or similar mandatory payments;

(k) the future value of the Shares underlying the Restricted Stock Units is unknown, indeterminable and cannot be predicted with certainty and the value of such Shares may increase or decrease in the future;

(l) no claim or entitlement to compensation or damages shall arise from forfeiture of the Restricted Stock Units or recoupment of any gains earned or accrued due to the sale of Shares acquired in settlement of such Restricted Stock Units resulting from, but not limited to, the (1) termination of the Participant's employment or service (regardless of the reason for the termination and whether or not the termination is later found to be invalid or in breach of employment laws in the jurisdiction where the Participant is employed or the terms of the Participant's employment or service agreement, if any) and/or (2) application of any Applicable Law or regulations, or any recoupment policy or any recovery or clawback policy maintained by the Company or otherwise required by Applicable Law; and

(m) neither the Company, the Employer nor any other Subsidiary shall be liable for any foreign exchange rate fluctuation between the Participant's local currency and the United States Dollar that may affect the value of the Shares or any amounts due pursuant to the issuance of the Shares, or the subsequent sale of any Shares acquired pursuant to the Restricted Stock Units.

11. Employee Data Privacy. The collection, use, disclosure and transfer, in electronic or other form, of personally identifiable information to facilitate the grant of the Restricted Stock Units and the administration of the Plan by and among, as applicable, the Company and the Employer, if different, any of the Company's Subsidiaries or Affiliates, or any agent of the Company administering or providing Plan services is governed by the Employee Privacy Notice (the "Privacy Notice") that the Participant received in the course of his or her relationship with Company. The Participant understands that he or she may review the Privacy Notice or contact his or her local human resources representative to request a copy of the Privacy Notice. Please contact ethics@bah.com if the Participant has any questions or concerns about how the Company or its Subsidiaries and Affiliates process personally identifiable information.

12. Miscellaneous.

(a) 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.

(b) No Advice Regarding Grant. The Participant acknowledges that neither the Company nor the Employer are providing any tax, legal or financial advice, or making any recommendations regarding the Participant's participation in the Plan. The Participant should consult his or her own personal tax, legal and financial advisors regarding the Participant's participation in the Plan before taking any action related to the Plan.

(c) Interpretation. For purposes of this Agreement, if the Participant is not employed by the Company, "Employer" means the Subsidiary that employs the Participant. This Agreement and the Restricted Stock Units granted hereunder are subject to the terms and conditions of the Plan, which are incorporated by reference herein. In the event of any inconsistency between the provisions of this Agreement and the Plan, the Plan shall govern. The Administrator, acting pursuant to the Plan, as constituted from time to time, shall, except as expressly provided otherwise herein, have the right to determine reasonably and in good faith any questions that arise in connection with this Agreement, and any such determination shall be final, binding and conclusive on all Participants and other individuals claiming any right under the Plan. The failure of the Company or the Participant to insist upon strict performance of any provision hereunder, irrespective of the length of time for which such failure continues, shall not be deemed a waiver of such party's right to demand strict performance at any time in the future. No consent or waiver, express or implied, to or of any breach or default in the performance of any obligation or provision hereunder shall constitute a consent or waiver to or of any other breach or default in the performance of the same or any other obligation hereunder.

(d) Country-Specific Provisions. The Participant's participation in the Plan shall be subject to any additional or different terms and conditions set forth in Appendix B attached hereto applicable to the Participant's country. Moreover, if the Participant relocates to one of the countries included in Appendix B, the additional or different terms and conditions applicable to such country will apply to the Participant, to the extent the Company determines that the application of such terms and conditions is necessary or advisable for legal or administrative reasons. Appendix B constitutes a part of this Agreement.

(e) Other Requirements. The Company reserves the right to impose other requirements on the Participant's participation in the Plan and on any Shares acquired in settlement of the Restricted Stock Units granted hereunder, to the extent the Company determines it is necessary or advisable for legal or administrative reasons, and to require the Participant to sign any additional agreements or undertakings that may be necessary to accomplish the foregoing.

(f) Applicable Law. The Participant acknowledges that the Company is organized under the laws of the State of Delaware. The Participant and the Company agree that 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 that would apply the laws of any other jurisdiction.

(g) Forum Selection. The Participant acknowledges that the Company's principal place of business is in, and a substantial portion of the Company's business is based out of, the Commonwealth of Virginia. The Participant also acknowledges that, as such, during the course of the Participant's service with the Company, the Employer or any other Subsidiary, the Participant shall have substantial contacts with the Commonwealth of Virginia. Accordingly, the Participant and the Company agree that the exclusive forum for any action, demand, claim or counterclaim relating to the terms and provisions of this Agreement, or to their breach, shall be in the appropriate state or federal court located in the Commonwealth of Virginia. The Participant and the Company hereby consent to the personal jurisdiction of such courts over the parties to this Agreement. The Participant expressly waives any defense that such courts lack personal jurisdiction or are inconvenient. The Participant and the Company further agree that

in any such action for breach or enforcement of this Agreement, no party will seek to challenge the validity or enforceability of any part of this Agreement.

(h) Amendment. This Agreement may not be amended, modified or supplemented orally, but only by a written instrument executed by the Participant and the Company.

(i) 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.

(j) 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.

(k) Consent to Electronic Delivery. By entering into this Agreement and accepting the Restricted Stock Units evidenced hereby, 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, this Agreement and the Restricted Stock Units via the Company's website, the Fidelity NetBenefits website or any other online access system of the Company's third-party Plan administrator, email or other form of electronic delivery.

(l) Section 409A of the Code. This Agreement is intended to be administered in a manner consistent with the requirements, where applicable, of Section 409A of the Code and the regulations promulgated thereunder ("Section 409A"). Where reasonably practicable, the Agreement shall be administered in a manner to avoid the imposition on the Participant of immediate tax recognition and additional taxes pursuant to Section 409A. In addition, to the extent permissible under Section 409A, any series of installment payments under this Agreement shall be treated as a right to a series of separate payments. Notwithstanding the foregoing, the Company shall not have any liability to any Person in the event Section 409A applies to any payment hereunder in a manner that results in adverse tax consequences to the Participant or any of the Participant's beneficiaries.

(m) Specified Employee Delay. Subject to Section 14.13 of the Plan, if the Participant is deemed a "specified employee" within the meaning of Section 409A, as determined by the Administrator, at a time when the Participant becomes eligible for settlement of the Restricted Stock Units upon his or her "separation from service" within the meaning of Section 409A, then to the extent necessary to comply with, and avoid the imposition on the Participant of any accelerated or additional tax, under Section 409A, such settlement will be delayed until the earlier of (a) the six (6)-month anniversary of the Participant's termination of service and (b) the Participant's death. Notwithstanding anything to the contrary in this Agreement, if settlement is to occur upon a termination of service other than due to death or Disability and the Participant is a specified employee, to the extent necessary to comply with, and avoid imposition on the Participant of any additional tax or interest imposed under, Section 409A, settlement shall instead occur on the first business day following the six (6)-month anniversary of the Participant's termination of service (or, if earlier, upon the Participant's death), or as soon thereafter as practicable (but no later than ninety (90) days thereafter).

(n) Headings and Captions. 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.

(o) Notices. All notices under this Agreement shall be (i) delivered by hand, (ii) sent by commercial overnight courier service, (iii) sent by registered or certified mail, return receipt requested, and first-class postage prepaid, (iv) sent by e-mail or any other form of electronic transfer or delivery approved by the Administrator, or (v) faxed, in each case to the parties at their respective addresses and facsimile numbers set forth in the records of the Company or at such other address or facsimile number as may be designated in a notice by either party to the other.

(p) Counterparts. This Agreement may be executed in any number of counterparts, each of which shall be deemed to be an original and all of which together shall constitute one and the same instrument.

Insider Trading

SPONSORING ORGANIZATION: [Legal, Ethics & Compliance](#)

PURPOSE

Insider trading generally refers to buying or selling securities while in possession of material nonpublic information or providing material nonpublic information to another person who uses that information to buy or sell securities. Booz Allen is committed to conducting business with integrity and in compliance with the law, including insider trading laws.

POLICY REQUIREMENTS

Subsection 1—Prohibited Activities

The following activities are prohibited:

- Directly or indirectly buying, selling or gifting securities of Booz Allen while in possession of material nonpublic information concerning the company or its securities, except in the limited circumstances described below. This prohibition remains even after your employment with Booz Allen ends.
- Providing material nonpublic information about Booz Allen to another person.
- Buying or selling the securities of another company while in possession of material nonpublic information about that company.
- Providing material nonpublic information about another company to another person.
- Pledging Booz Allen securities as collateral for a loan (including a mortgage).
- Holding Booz Allen securities in a brokerage account that allows borrowing against the securities (commonly known as a margin account).
- Borrowing Booz Allen securities and then selling them (to profit from a decline in value) or using non-traditional financial vehicles (such as publicly traded options, puts, calls, or other derivative securities) relating to Booz Allen’s securities.
- Hedging transactions that allow a person to continue to own the applicable Booz Allen security, but without the full risks and rewards of ownership.
- Immediate family members and other persons living in your households engaging in any of the above transactions.

What is material nonpublic information?

Information is **material** if it would be likely to affect a company’s stock price or if it would be important to a reasonable investor in making a decision about whether to buy, hold or sell that company’s securities. Either positive or negative information may be material. Note also that material information may also include information about another company that you obtained in the course of your employment by, or relationship with, Booz Allen.

Information is generally **not public** unless it has been disclosed in a press release, in a public filing (such as a report filed on Form 10-K, Form 10-Q or Form 8-K) made with the U.S. Securities and Exchange Commission, in materials provided to stockholders broadly (such as an annual report, investor letter, prospectus or proxy statement), or is available through a news wire service or daily newspaper of wide circulation, and a sufficient amount of time has

Booz Allen Hamilton Internal
EverWatch Internal
Defy Security Internal

Version No. 8 | Effective Date: 4/8/2026

Scope

This policy applies to all employees, officers, directors, subsidiaries, and affiliates of the company (referred to as “Booz Allen people” and contractors, consultants or other affiliates who have access to material nonpublic information. Unless otherwise noted, references to “Booz Allen” refers to Booz Allen Hamilton Holding Corporation (“Booz Allen Holding”) and its subsidiaries.

Additional Resources

Booz Allen employees:
[Policy Library](#)

EverWatch employees:
[Policy Library](#)

Points of Contact

General questions regarding this policy can be directed to the Booz Allen Holding Corporate Secretary at ethics@bah.com.

passed (generally at least two full business days) so that the marketplace has had an opportunity to digest the information.

If you are unsure whether information about Booz Allen is either material or nonpublic, contact the Booz Allen Holding Corporate Secretary at ethics@bah.com.

Subsection 2—Additional Restrictions on Designated Insiders

Who is a “Designated Insider?”

Employees of Booz Allen who are identified as likely to have access to material nonpublic information in connection with carrying out their duties will be designated as Booz Allen “designated insiders.” Examples of designated insiders are members of the Booz Allen Holding board of directors, all Booz Allen partners and vice presidents and their administrative professional support, all chiefs of staff, all employees of the Legal, Ethics & Compliance Department and Financial Services, and all seniors and directors (and for certain departments, staff below senior level) in Enterprise Organization. However, employees of a Booz Allen subsidiary who do not have access to Booz Allen’s systems are generally not considered “designated insiders.”

Restrictions Applicable to Designated Insiders on Buying and Selling Booz Allen Securities

In addition to the general rule against buying and selling Booz Allen securities while in possession of material nonpublic information, designated insiders, as well as entities controlled by them (and their immediate family members and other individuals sharing their households) are prohibited from buying, selling or gifting Booz Allen securities during a “blackout period.” Blackout periods are:

- The period beginning 15 days prior to the end of each fiscal quarter and ending on the third full business day following the release of Booz Allen’s quarterly or annual earnings results.
- The period beginning when Booz Allen starts assembling information for purposes of issuing interim earnings guidance and other potentially material information by way of press release, SEC filing on Form 8-K or other means designed to achieve widespread dissemination and ending when the information has been released and fully absorbed into the market.
- Other periods which designated insiders will be specifically advised by email from the Corporate Secretary.

If you would like to buy or sell Booz Allen securities and you are unsure whether you are in a blackout period, contact the Booz Allen Holding Corporate Secretary at ethics@bah.com.

Subsection 3—Additional Restrictions on and Requirements for the Leadership Team and Members of Booz Allen’s Board of Directors, and Section 16 Officers

The Booz Allen Leadership Team, members of the Booz Allen Holding Board of Directors, and any others designated as Section 16 Officers of Booz Allen Hamilton Holding (e.g. Principal Accounting Officer) may not buy or sell securities of Booz Allen or engage in any other transaction involving securities of Booz Allen, including gifts of securities, without first obtaining approval from the Chief Legal Officer or General Counsel. After receiving approval, the transaction must be completed within five business days unless such period is extended by the Corporate Secretary. If you have a 10b5-1 plan approved by the Chief Legal Officer or General Counsel (see Buying and Selling Booz Allen Securities Pursuant to a Rule 10b5-1 Plan, below) that specifies the dates, prices and amounts of the planned trades, then you do not need further approval for those trades, but you must report those trades to the Corporate Secretary or the Corporate Secretary’s designee the same day.

In addition, Section 16 Officers of Booz Allen Holding and members of the Booz Allen Holding Board of Directors are subject to the “short-swing profit” liability provisions of Section 16 of the Securities Exchange Act of 1934 and

therefore may not, under any circumstances, buy and then within six months sell, or sell and then within six months buy, Booz Allen's securities.

Subsection 4—Exceptions to Prohibitions in this Policy

The general prohibitions on insider trading (see Prohibited Activities, above) and additional restrictions applicable to designated insiders (see Additional Restrictions on Designated Insiders, above) **do not** apply in the following situations:

- The exercise of an employee stock option (but **do** apply to the sale of the underlying stock).
- The exercise of a tax withholding right pursuant to which you elect to have Booz Allen withhold shares subject to an option to satisfy tax withholding requirements.
- Stock purchases pursuant to Booz Allen's Employee Stock Purchase Plan.

Buying or selling Booz Allen securities (including during a blackout period applicable to designated insiders) pursuant to a Rule 10b5-1 plan that: (A) is in writing and in a form acceptable to Booz Allen; (B) is approved in writing by the Chief Legal Officer or General Counsel prior to the plan being entered into; (C) contains terms and conditions as are required by Rule 10b5-1 (including the cooling-off periods and certifications required by Rule 10b5-1(c)); (D) is entered into and operated in compliance with Rule 10b5-1; and (E) is **not** entered into during a blackout period, at any time when you are in possession of material nonpublic information. You are required to obtain approval from Booz Allen's Chief Legal Officer or General Counsel before terminating a Rule 10b5-1 plan other than in accordance with its terms.

Subsection 5—Discipline

Any employee found to be in violation of this policy can be subject to disciplinary action, up to and including termination of employment, in accordance with applicable laws and company policies.

Subsection 6—Application of Policy After Termination

This policy continues to apply to transactions in Booz Allen's securities even after termination of employment or other services to Booz Allen. Accordingly, Booz Allen people who are aware of material nonpublic information upon termination of their relationship with Booz Allen may not trade in Booz Allen securities until that information has become public or is no longer material.

REPORTING CONCERNS

At Booz Allen, speaking up is critical—and it is safe. We expect Booz Allen people to comply with our policies and Code of Business Ethics and Conduct. As outlined in the Mandatory Reporting and Non-Retaliation Policy, if you observe or have reasonable suspicion that a Booz Allen policy or the Code has been violated, you have a responsibility as part of your employment to promptly report your concerns via one of our official company reporting channels:

- Your career manager, job leader, or any more senior leader or person in a supervisory capacity
- An [Ethics Advisor](#)
- [Employee Relations](#) or Human Resources
- The company's [Legal, Ethics & Compliance Team](#)
- The [Chief Ethics and Compliance Officer](#)
- Our Ethics HelpLine at +1-800-501-8755 (US) or +1-888-475-0009 (International) or speakup.bah.com. Concerns may be raised anonymously.

Not sure where to turn? Choose the reporting channel with which you are most comfortable. We will take it from there. Know that when you speak up, we listen.

We take all allegations of misconduct seriously, investigate them promptly, and strictly prohibit retaliation against any person who raises a good faith ethical or legal concern.

RELATED POLICIES

None

DEFINITIONS

None

CHANGE LOG

Revision Date	Policy Revision #	Revisions Completed	POC (Team)
4/8/2026	8	Expanded scope to include individuals with access to material nonpublic information and Defy Security. Added subsection 6 – Application of Policy After Termination.	Legal, Ethics & Compliance
4/7/2026	7	Policy reviewed and renewed.	Legal, Ethics & Compliance
4/1/2025	7	Added standard Discipline subsection language.	Legal, Ethics & Compliance
3/25/2025	7	Policy reviewed and renewed.	Legal, Ethics & Compliance

**List of Subsidiaries of Booz Allen Hamilton Holding Corporation
as of May 22, 2026**

Name	Jurisdiction of Organization
Booz Allen Commercial Cyber (SG), Pte. Ltd.	Singapore
Booz Allen Commercial Cyber (UK), Ltd.	United Kingdom
Booz Allen Commercial Cyber Holdings, LLC	Delaware
Booz Allen Commercial Cyber, LLC	Delaware
Booz Allen Cyber Solutions, LLC	Delaware
Booz Allen Hamilton (Dubai) Limited	United Arab Emirates
Booz Allen Hamilton (Ireland) Limited	Ireland
Booz Allen Hamilton Australia PTY LTD	Australia
Booz Allen Hamilton Bahrain W.L.L.	Bahrain
Booz Allen Hamilton Consulting Pte. Ltd.	Singapore
Booz Allen Hamilton Egypt, LLC	Egypt
Booz Allen Hamilton Engineering Holding Co., LLC	Delaware
Booz Allen Hamilton Engineering Services, LLC	Delaware
Booz Allen Hamilton Germany GmbH	Germany
Booz Allen Hamilton Inc.	Delaware
Booz Allen Hamilton Intellectual Property Holdings, LLC	Delaware
Booz Allen Hamilton International (U.K.) Ltd.	United Kingdom
Booz Allen Hamilton International Pte. Ltd.	Singapore
Booz Allen Hamilton International, Inc.	Delaware
Booz Allen Hamilton Investor Corporation	Delaware
Booz Allen Hamilton Japan G.K.	Japan
Booz Allen Hamilton Lebanon S.a.r.l.	Lebanon
Booz Allen Hamilton Netherlands B.V.	Netherlands
Booz Allen Hamilton Philippines Inc.	Philippines
Booz Allen Hamilton Saudi	Saudi Arabia
Booz Allen Hamilton Singapore Holding Company Pte. Ltd.	Singapore
Booz Allen Hamilton Singapore LLP	Singapore
Booz Allen Hamilton Tanzania Limited	Tanzania
Booz Allen Ventures, LLC	Delaware
PT Booz Allen Hamilton Indonesia	Indonesia
EverWatch Solutions Inc.	Maryland
Aquilent, Inc.	Delaware
BrainTrust Holdings, LLC	Maryland
Cloud Solutions Group, Inc.	Delaware
DataPoint Services, LLC	Delaware
eGov Holdings, Inc.	Delaware
Epic Acquisition Software, Inc.	Delaware
Epidemico, Inc.	Delaware
EverWatch Corp.	Delaware
HELworks, LLC	Delaware
Ian, Evan & Alexander Corporation	Colorado
Liberty IT Solutions, LLC	Delaware

Morphick, Inc.	Delaware
Nextgen-H Integration Services, LLC	Delaware
Northwood Global Solutions, LLC	Virginia
PAR Government Systems Corporation	New York
RAI Government Services LLC	Virginia
Riverside Engineering, LLC	Delaware
Shore Systems and Solutions, LLC	Delaware
ThunderYard Liberty JV LLC	Delaware
Thunderyard Liberty JV II LLC	Delaware
ThunderYard Solutions LLC	Delaware
Tracepoint Holdings, LLC	Delaware
Tracepoint LLC	Delaware
Warrior Technology LLC	Delaware
Sagewatch, LLC	Delaware
EagleTrust JV, LLC	Maryland
InTrust JV, LLC	Maryland
Drift Acquisition, Inc.	Delaware
DeFY Security LLC	Delaware

Consent of Independent Registered Public Accounting Firm

We consent to the incorporation by reference in the following Registration Statements of Booz Allen Hamilton Holding Corporation:

- Form S-3 No. 333-273531
- Form S-3 No. 333-273531-01
- Form S-8 No. 333-205956
- Form S-8 POS No. 333-205956
- Form S-8 No. 333-171288
- Form S-8 POS No. 333-171288

of our reports dated May 22, 2026, 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, 2026.

/s/ Ernst & Young LLP

Tysons, Virginia
May 22, 2026

**CERTIFICATION OF THE CHIEF EXECUTIVE OFFICER PURSUANT TO RULE 13A-14(A) OF THE
SECURITIES EXCHANGE ACT OF 1934, AS AMENDED**

I, Horacio D. 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 22, 2026

By: /s/ Horacio D. Rozanski

Horacio D. Rozanski
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, Troy Lahr, 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 22, 2026

By: /s/ Troy Lahr

Troy Lahr
Executive Vice President and Chief Financial Officer
(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, 2026, as filed with the Securities and Exchange Commission on the date hereof (the “Report”), the undersigned 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 22, 2026

By: /s/ Horacio D. Rozanski

Horacio D. Rozanski
Chief Executive Officer
(Principal Executive Officer)

A signed original of this written statement required by Section 906, or other document authenticating, acknowledging, or otherwise adopting the signature that appears in typed form within the electronic version 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, 2026, as filed with the Securities and Exchange Commission on the date hereof (the “Report”), the undersigned Executive Vice President and Chief Financial Officer 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 22, 2026

By: /s/ Troy Lahr

Troy Lahr
Executive Vice President and Chief Financial Officer (Principal
Financial Officer)

A signed original of this written statement required by Section 906, or other document authenticating, acknowledging, or otherwise adopting the signature that appears in typed form within the electronic version 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.