inVentiv Health, Inc.

Employee Assistance & Work/Life Support Program
Summary Plan Description

Effective January 1, 2016

This booklet summarizes the main provisions of the Employee Assistance & Work/Life Support Program (EAP) made available to eligible inVentiv Health employees effective January 1, 2016.

We encourage you to read this SPD carefully and share it with your family members. If you have any questions about your benefits, please contact the Benefits Group or Cigna Behavioral Health, our benefit administrator, directly.

This is a summary of the most important provisions of the EAP, a component plan of the inVentiv Health, Inc. Employee Health Care Program. While this summary should answer most of your questions, it does not provide all the details found in the official plan document. To request a copy of the inVentiv Health, Inc. Employee Health Care Program document, please contact the Benefits Group.

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About Your Participation

This section includes important information about your participation in the Employee Assistance & Work/Life Support Program (the EAP), including eligibility information, when to enroll, when you can make election changes, paying for coverage and when coverage ends.

Who Is Eligible for EAP Coverage

Employee Eligibility

You are eligible to participate in the EAP if you are a full-time or part-time employee of inVentiv Health (the Company) or a former employee continuing inVentiv Health medical benefit coverage under COBRA.

You are not eligible for this plan if you are a retiree or a per diem employee.

Dependent Eligibility

Your eligible dependents can also participate in the EAP if they live in the same household as you. For the EAP, the definition of dependent is much broader than for other inVentiv Health benefit plans. As long as a person is part of your household, they are eligible for the EAP.

When Coverage Begins

You and your eligible dependents are automatically eligible to participate in the EAP when you are hired by inVentiv Health.

Paying for the EAP

inVentiv Health pays the full cost of your and your dependents' coverage in the EAP.

When EAP Coverage Ends

In general, coverage under this EAP will end on the last day of the month in which your employment with inVentiv ends.

Upon your termination of employment with inVentiv Health when your EAP coverage would otherwise end, if you elect to continue your inVentiv Health medical coverage under COBRA, your EAP coverage will also continue. (See the "Continuation of Coverage under COBRA" section for more on this continuation.). If you do not elect to continue your medical coverage under COBRA, your EAP coverage will end.

Your coverage under the plan will also end as of:

- The date inVentiv Health ends the plan
- The last day of the month in which the required contributions are not made

- The last day of the month Cigna Behavioral Health receives written notice from inVentiv Health to end your coverage, or the date requested in the notice, or
- The last day of the month you retire or are pensioned under the plan, unless specific coverage is available for retired or pensioned persons and you are eligible for that coverage.

Coverage for your eligible household members will end on the earliest of:

- The date your coverage ends
- The last day of the month in which required contributions are not made
- The last day of the month Cigna Behavioral Health receives written notice from inVentiv Health to end your coverage, or the date requested in the notice, if later, or
- The last day of the month your dependents no longer qualify as eligible household members under this plan.

Other Events Ending Your Coverage

The plan will provide prior written notice to you that your coverage will end on the date identified in the notice if:

- You commit an act, practice or omission that constituted fraud, or an intentional misrepresentation of a material fact including, but not limited to, false information relating to another person's eligibility or status as a dependent, or
- You commit an act of physical or verbal abuse that imposes a threat to inVentiv Health's staff, Cigna Behavioral Health's staff, a provider or another covered person.

Note: inVentiv Health has the right to demand that you pay back benefits inVentiv Health paid to you, or paid in your name, during the time you were incorrectly covered under the plan.

Continuing Coverage When It Might Otherwise End

If you lose your inVentiv Health EAP coverage, you may have the right to extend it under the Consolidated Budget Reconciliation Act of 1985 (COBRA). See the "Continuation of Coverage under COBRA" section later in this SPD for more information.

You also may be able to continue coverage if you are on military leave (see the "Continuation of Coverage for Employees in the Uniformed Services (USERRA)" section or if you are on an approved Family and Medical Leave Act (FMLA) leave (see the "Continuation of Coverage While on a Family and Medical Leave (FMLA)" section).

About the Employee Assistance & Work/Life Support Program

The EAP is a confidential service that helps you and your household members solve personal problems that may affect your health, family life and/or job performance. Cigna Behavioral Health provides professional counseling and referral services for this program.

The EAP is available to you as a benefit-eligible employee and to members of your household, regardless of whether you enroll in a medical plan offered under the inVentiv Health Employee Health Care Program. EAP services can help you and your family members with:

- Family or marital problems
- Job-related issues
- Drug or alcohol abuse, or
- Stress, anxiety or other emotional problems.

The EAP is available any time, day or night, by calling the EAP's toll-free hotline at 1-855-251-1204. Say "EAP" when prompted. Once you call the EAP, a confidential appointment with a counselor or other appropriate resource may be scheduled. The counselor will help you assess your situation and identify possible solutions and available resources. The telephone call and the first three visits to a counselor are fully paid for, so you pay nothing. You must call the EAP toll-free hotline in order to ensure that the services of your EAP counselor are covered.

Services are also available online at www.cignabehavioral.com (enter your employer ID: inventiv):

- Select "Find a Provider" and enter search parameters
- Once you select a provider, follow the easy online directions to submit an online authorization.

If you need additional treatment for the same problem, further treatment may be covered under the mental health/substance abuse benefits that are available through the inVentiv Health Employee Health Care Program under a medical plan option.

When you request that covered EAP services be provided, Cigna Behavioral Health will provide you with a list of participating providers in the Cigna EAP network from which you may choose. If you want additional referral options or wish to change EAP providers, simply contact Cigna Behavioral Health. You will not lose any benefits if you change from one participating provider to another participating provider with Cigna Behavioral Health's approval.

Benefits are not provided for services provided by non-participating providers.

Service Providers

inVentiv Health contracts with Cigna Behavioral Health to administer the EAP. Cigna Behavioral Health is staffed by professionals who are specifically trained to identify problems and help develop solutions to those problems.

Cigna Behavioral Health offers a nationwide EAP network comprised of licensed health care professionals who are credentialed and contracted to provide EAP evaluation and short term counseling assistance. The EAP network is comprised of Masters and Doctoral level clinicians. Given the scope of EAP services, the EAP network does not include psychiatrists.

If your participating provider is terminated by Cigna Behavioral Health from the participating provider network, you will be able to complete EAP counseling services with that provider up to the plan's maximum limit of three sessions per problem per plan year, unless the reason for termination prevents this.

Confidentiality

Your discussions with EAP counselors are completely confidential. No one will know when you contact the EAP unless you choose to tell someone or give written permission to release information. Contact with the EAP will not jeopardize current employment or advancement opportunities.

What Is Covered

The EAP offers you and your household members the following services:

- Assessment, consultation and problem solving
- Risk screening and crisis intervention
- Advocacy to help you address your situation
- Referral to a licensed network clinician for up to three counseling sessions at no charge per participant and/or eligible household member per issue per plan year (based on clinical necessity)
- Referral to community resources
- Educational materials specific to your issue
- Legal consultation from a licensed network attorney
- Mediation services, and
- Financial counseling from a credentialed financial professional through the EAP.

These services include a full range of individual, couple, and family assessments for most types of personal problems including:

- Single parenting
- Eating disorders
- Dual careers
- Anxiety
- Depression
- Parent/child conflict
- Job burnout
- Work-related problems
- Life transition
- Aging parents
- Death and dying
- Unresolved grief
- Marital problems
- Sexual problems
- Retirement concerns
- Career change
- Financial and legal concerns
- Physical abuse
- Alcohol or drug problems
- Problems of adolescence
- Stress, and
- Compulsive gambling.

There can be treatment needs that may fall outside the scope of the EAP benefit of short-term counseling. If this is the case, you will be assisted with accessing the appropriate resource.

In order to receive EAP benefits, all services must be pre-authorized and provided by Cigna EAP participating providers. When you call Cigna Behavioral Health, you will speak with a personal advocate who will refer you to a licensed EAP clinician in your area. You will typically be given more than one referral option from which to choose. You do not have to file a claim form for any covered EAP benefits. Your EAP participating provider will file your claim form for you.

If care is needed beyond the initial EAP sessions, you may be referred for additional care by the clinician as follows:

- Participants in the plan may be referred to a provider or other resource covered under their health benefit program
- Participants who require services that are not covered under the terms of the health care plan or who are not enrolled in a medical plan offered through inVentiv Health may continue privately with the Cigna Behavioral Health network clinician, or
- Participants may be referred to other appropriate community resources.

Work/Life Resource Referrals

You and your household members can also receive assistance through the EAP for referral resources that match your individual family needs:

- Dependent care and related referral services, including resources for childcare, as well as for elderly or disabled
- Adoption assistance
- Pet care and pet training resources
- Education programs and schools for pre-K through 12
- College and post-graduate program search, adult learning, and summer camps
- Caregiver resources and tools, and
- Convenience services.

Additional work/life resources and tools are available at www.cignabehavioral.com, Employer ID: inventiv, under “Find Work/Life Resources” and click Accept.

Legal and Financial Consultation Services

You and your household members can also receive assistance through the EAP for legal and financial concerns, such as:

- Legal consultation, including a free half hour consultation with a network attorney in your area. If you decide to retain the network attorney, there is a 25% discount on fees

- Financial consultation, ranging from individual telephonic sessions focusing on personal finances, to online resource tools to seminars covering such issues as saving for college and retirement planning, and
- ID theft and fraud resolution guidance and support services.

Community Resource Referrals

You and your household members can also receive a referral through the EAP to services offered by the community and other local resources such as financial assistance programs and self-help groups.

What Is Not Covered

The EAP does not cover the following services:

- Face-to-face assessment services in excess of three sessions per problem type
- Services not provided or coordinated by the EAP
- Services from a provider other than a participating provider that has been arranged by Cigna Behavioral Health
- Physician services, including services from a psychiatrist
- Hospital and facility-based services (inpatient and outpatient services)
- Diagnostic laboratory and diagnostic and therapeutic radiological services
- Psychological testing
- Home health services
- Emergency health care services
- Drugs and medications, or
- Legal referrals tied to employment law.

Additional Rules that Apply to this Plan

Qualified Medical Child Support Order (QMCSO)

The EAP will comply with all the terms of a qualified medical child support order (QMCSO). A QMCSO is an order or judgment from a court or administrative body that directs the plan to cover a child of a participant under the EAP. Federal law provides that a medical child support order must meet certain form and content requirements in order to be a qualified medical child support order. When an order is received, each affected participant and each child (or the child's representative) covered by the order will be given notice of the receipt of the order and a copy of the plan's procedure for determining if the order is valid.

Coverage under the plan pursuant to a medical child support order will not become effective until the plan administrator determines that the order is a QMCSO. If you have any questions or if you would like to receive a copy of the written procedure for determining whether a QMCSO is valid, please contact the Benefits Group.

Circumstances That May Result in Denial, Loss, Forfeiture or Rescission of Benefit

Under certain circumstances, plan benefits may be denied or reduced from those described in this SPD. Cancellation or discontinuance of coverage is permitted if it has only a prospective effect on coverage, or is effective retroactively due to failure to pay required premiums or contributions.

Rescission of coverage is cancellation or discontinuance of coverage retroactively for reasons other than failure to pay required premiums or contributions. For example, rescission of coverage may be permitted in limited circumstances such as fraud or the intentional misrepresentation of a material fact. If coverage is subject to rescission, all affected participants must be provided with a written notice at least 30 days prior to the date of rescission.

How to Reach Your Provider

Plan	Telephone Number	Website Address
Employee Assistance & Work/Life Support Program (offered through Cigna Behavioral Health)	1-855-251-1204	www.cignabehavioral.com Log in with Employer ID: inventiv

Continuation of Your EAP Coverage

Continuation of Coverage under COBRA

If you experience a qualifying event as defined by the federal Consolidated Omnibus Reconciliation Act of 1985 (COBRA), and elect to continue your medical coverage under the inVentiv Health, Inc. Employee Health Care Program, your EAP coverage will also continue. COBRA coverage is available under certain conditions. Please refer to your inVentiv Health medical plan SPD for information on when COBRA continuation coverage may be available to you. If you do not elect to continue your medical coverage in the inVentiv Health, Inc. Employee Health Care Program under COBRA, you will not be able to continue your EAP coverage when it would otherwise end.

If you do continue your medical coverage in the inVentiv Health, Inc. Employee Health Care Program under COBRA, your EAP coverage, for you and your eligible household members, will continue as long as the medical coverage is in effect.

Continuation of Coverage for Employees in the Uniformed Services

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) guarantees certain rights to eligible employees who enter military service. The terms “Uniformed Services” or “Military Service” mean the Armed Forces (i.e., Army, Navy, Air Force, Marine Corps, Coast Guard), the reserve components of the Armed Services, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Upon reinstatement, you are entitled to the seniority, rights and benefits associated with the position held at the time employment was interrupted, plus any additional seniority, rights and benefits that you would have attained if employment had not been interrupted.

The maximum period of continuation coverage available to you and your eligible dependents is the lesser of (a) 24 months after the leave begins or (b) the period running from the day the leave begins through the day the leave ends.

When you go on military leave, your work hours are reduced. As a result, you and your covered dependents may become eligible for COBRA. Any COBRA continuation period for which you are eligible will run concurrently with any USERRA continuation period for which you are eligible.

Continuation of Coverage While on a Family and Medical Leave

Under the federal Family and Medical Leave Act (FMLA), employees are generally allowed to take up to 12 weeks of unpaid leave for certain family and medical situations and continue their elected EAP coverage benefits during this time. The Company is required to maintain group health insurance coverage for an employee on FMLA leave: a) if the employee had such insurance before taking the leave, and b) on the same terms as if the employee had continued to

work. If applicable, employees may need to make arrangements to pay their share of health insurance premiums while on leave. In some instances, the Company may recover premiums it paid to maintain health coverage for an employee who fails to return to work from FMLA leave.

If you are eligible, you can take up to 12 weeks of unpaid leave in a 12-month period for the following reasons:

- For the birth and care of your newborn child or a child that is placed with you for adoption or foster care
- For the care of a spouse, child, or parent who has a serious health condition
- For your own serious health condition
- For “any qualifying exigency” (a qualifying urgent situation or pressing need) arising out of the fact that the spouse, son, daughter or parent of the employee is on active duty or called to active duty status as a member of the National Guard or Reserves in support of a contingency operation.

In addition, an eligible employee who is the spouse, son, daughter, parent or next of kin (that is, nearest blood relative) of a covered service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to up to 26 weeks of leave in a single 12-month period to care for the service member. This military caregiver leave is available during “a single 12-month period” during which an eligible employee is entitled to a combined total of 26 weeks for all types of FMLA leave. See U.S. Department of Labor, Employment Standards Administration, Wage and Hour Division, for Fact Sheets #28 and #28A, which provide further details on FMLA (http://www.dol.gov/compliance/laws/comp-fmla.htm).

Depending on the state where you live, the number of weeks of unpaid leave available to you for family and medical reasons may vary based on state law requirements.

Complaint Process and Claims Procedures

You must use and exhaust this plan's administrative claims and appeals procedure before bringing a suit in either state or federal court. Similarly, failure to follow the plan's prescribed procedures in a timely manner will also cause you to lose your right to sue regarding an adverse benefit determination.

Complaint Resolution Process

If you ever need to file a complaint regarding the EAP benefits provided under the plan, Cigna Behavioral Health has a problem resolution procedure in place to help you resolve coverage-related issues such as:

- Access to providers
- Delivery of care
- Covered services, or
- Any other matter.

You are encouraged to call the EAP at 1-855-251-1204 (say "EAP") to discuss all complaints. There is no time limit for filing a complaint. The Cigna EAP personal advocate will document your complaint and seek to resolve your issue right away. If additional research or follow up is needed, you generally will receive a letter of resolution within thirty calendar days of the notification of your complaint.

While you are encouraged to call with any complaints, you may also choose to send a written complaint to the address noted below. If you are dissatisfied with the resolution of the complaint, you may call or file a written complaint. There is no time limit for submitting a follow up to your complaint for further resolution.

Written complaints may be sent to:

Cigna Behavioral Health Complaints
PO Box 188064
Chattanooga, TN 37422

Cigna Behavioral Health generally will respond within 30 days of receiving your written complaint, unless Cigna Behavioral Health notifies you that more time is needed to respond.

Claims Procedures

For claims that involve health care services (i.e. referrals to a licensed network clinician for counseling sessions), Cigna Behavioral Health will respond in accordance with the following process.

Notice of Initial Benefit Determination

Cigna Behavioral Health will notify you of its initial benefit determination as follows:

Pre-Service Claims. If you request prior authorization of benefits, or otherwise file a claim with respect to benefits that must be pre-approved by Cigna Behavioral Health prior to receiving health care services, Cigna Behavioral Health will generally notify you in writing of its decision (whether your claim is approved or denied) within 15 days after receiving your claim.

Cigna Behavioral Health may extend this initial 15-day period for up to an additional 15 days (for a total of 30 days to make a decision) if it determines it needs more time due to circumstances beyond its control.

Cigna Behavioral Health will notify you in writing of this extension, and the reasons for it, before the initial 15-day period ends. This notice will explain the special circumstances requiring the extension and indicate the date by which Cigna Behavioral Health expects to make a decision. This notice will also explain the standards on which entitlement to a benefit is based, and indicate any unresolved issues that prevent a decision on your claim.

If additional information is required, the extension notice will also explain what information is needed, and you will have 45 days from the date you receive the extension notice to provide the requested information to Cigna Behavioral Health. Cigna Behavioral Health's 30-day determination period for making a decision will be suspended from the date of the extension notice until the earlier of (a) the date you respond to the request for additional information, or (b) 45 days from the date of the extension notice. If you do not provide the additional requested information to Cigna Behavioral Health within the 45-day period, your claim may be denied in whole or in part.

Cigna Behavioral Health will notify you within five days of receiving your claim if you fail to properly follow the plan's procedures for filing a claim, unless your claim fails to provide enough information for Cigna Behavioral Health to identify a specific claimant, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested.

Post-Service Claims. If you file a claim for benefits for services that you have already received, Cigna Behavioral Health will generally notify you in writing of its denial of your claim for medical benefits within 30 days after receiving your claim.

Cigna Behavioral Health may extend this initial 30-day period for up to an additional 15 days (for a total of 45 days to make a decision) if it determines it needs more time due to circumstances beyond its control.

Cigna Behavioral Health will notify you in writing of this extension, and the reasons for it, before the initial 30-day period ends. This notice will explain the special circumstances requiring the

extension and indicate the date by which Cigna Behavioral Health expects to make a decision. This notice will also explain the standards on which entitlement to a benefit is based, and indicate any unresolved issues that prevent a decision on your claim.

If additional information is required, the extension notice will also explain what information is needed, and you will have 45 days from the date you receive the extension notice to provide the requested information to Cigna Behavioral Health. Cigna Behavioral Health's 45-day determination period for making a decision will be suspended from the date of the extension notice until the earlier of (a) the date you respond to the request for additional information, or (b) 45 days from the date of the extension notice. If you do not provide the additional requested information to Cigna Behavioral Health within the 45-day period, your claim may be denied in whole or in part.

Notice of Claim Denial. If your claim is denied, in whole or in part, Cigna Behavioral Health's written notice of denial will include the following**:**

- Specific reasons for the denial, including references to the specific plan provisions on which the denial is based
- A description of any additional material or information necessary for you to correct the claim and an explanation of why such material is necessary
- If applicable, a statement that you will be provided, upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in denying your claim, and
- A description of the plan's review procedures (including the time limits applicable to those review procedures) and a statement of your right to bring an action under ERISA Section 502(a) if your claim is denied on appeal.

Review and Appeal of Claim Denials

If your claim has been denied, in whole or in part, you should follow the procedures explained below to resolve your claim.

Appeals Procedures

To initiate an appeal, you must submit a request for an appeal in writing to Cigna Behavioral Health within 180 days after you receive the claim denial from Cigna Behavioral Health (or after you receive Cigna Behavioral Health's initial response to your complaint or other dispute). If you are unable or choose not to write, you may ask Cigna Behavioral Health to register your appeal by telephone.

When reviewing your appeal of a claim denial, complaint or other dispute, Cigna Behavioral Health will apply the following standards:

- You may submit written comments, documents, records, and other information relating to the claim for benefits, and Cigna Behavioral Health will take all of such information into account when reviewing your claim, without regard to whether such information was submitted or

considered during Cigna Behavioral Health's initial benefit determination or prior review on appeal

- You may receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information that is relevant to your claim for benefits (as determined by Cigna Behavioral Health in its sole discretion), and

- Cigna Behavioral Health's review of your claim will not give any deference to its initial review and claim denial or any prior appeal review. The review will be conducted by an individual who was not involved in any previous review of your claim, and this individual will not be the subordinate of any individuals involved in any previous review of your claim.

After reviewing your appeal, Cigna Behavioral Health will notify you of its decision on review of your appeal or complaint as follows:

- **Pre-Service Claims.** If you file an appeal of a claim denial or a complaint with respect to benefits that must be pre-approved by Cigna Behavioral Health prior to receiving health care services, Cigna Behavioral Health will generally notify you in writing of its decision on the review of your appeal or complaint within 30 days of receiving your appeal request or notice of complaint or other dispute. Cigna Behavioral Health's timeframe for making a benefit determination may not be extended. However, if you do not provide all of the relevant information Cigna Behavioral Health needs to make a decision when you submit your appeal or complaint, your appeal or complaint may be denied in whole or in part.

- **Post-Service Claims.** If you file an appeal of a claim denial or a complaint with respect to benefits for services that you have already received, Cigna Behavioral Health will generally notify you in writing of its decision on the review of your appeal or complaint within 60 days after receiving your appeal request or notice of complaint or other dispute. Cigna Behavioral Health's timeframe for making a benefit determination may not be extended. However, if you do not provide all of the relevant information Cigna Behavioral Health needs to make a decision when you submit your appeal or complaint, your appeal or complaint may be denied in whole or in part.

Notice of Claim Denial on Appeal

If your claim is denied, in whole or in part, after review on appeal, Cigna Behavioral Health's written or electronic notice of denial will include the following information:

- Specific reasons for the denial, including references to the specific plan provisions on which the denial is based

- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for plan benefits

- If applicable, a statement that you will be provided, upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in denying your claim

- A statement of your right to bring an action under ERISA Section 502(a) if your claim is denied on appeal, and

- A statement that you and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

Relevant Information

Relevant information is any document, record or other information which: (a) was relied upon in making the benefit determination; (b) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination; (c) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (d) constitutes a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Legal Action

You have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review and the outcome of the appeals procedure. In most instances, you may not initiate a legal action against the plan until you have completed the appeal process and exhausted all of your administrative remedies under the plan.

You or the plan may have other voluntary alternative dispute resolution options such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor office. You may also contact the plan administrator.

Your Rights under ERISA

As a participant in the EAP, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue group health coverage for yourself, your spouse or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description, your inVentiv Health medical plan summary plan description and the documents governing the plan for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court – but only after you have exhausted the plan's claims and appeals procedure as described in the "Claims Procedures" section. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court.

If it should happen that plan fiduciaries misuse the plan's money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-EBSA, logging on to www.dol.gov, or contacting the EBSA field office nearest you.

Plan Administration

This information about the administration of the plan is provided in compliance with the Employee Retirement Income Security Act (ERISA) of 1974, as amended. While you should not need these details on a regular basis, the information may be useful if you have specific questions about your plan.

DETAILS ABOUT EAP PLAN ADMINISTRATION	
Plan Sponsor/Plan Administrator	Plan Administrator – Medical Plan inVentiv Health, Inc. 500 Atrium Drive Somerset, NJ 08873 (732) 537-4845 benefitsgroup@inventivhealth.com
Employer Identification Number	52-2181734
Official Plan Name and Number	inVentiv Health, Inc. Employee Health Care Program - 501
Plan Year	January 1 through December 31
Type of Plan	Group health plan providing employee assistance benefits
Agent for Service of Legal Process	Plan Administrator – Medical Plan inVentiv Health, Inc. 500 Atrium Drive Somerset, NJ 08873 (732) 537-4845 benefitsgroup@inventivhealth.com
Carrier/Claims Administrator	Cigna Behavioral Health, Inc. 11095 Viking Drive, Suite 350 Eden Prairie, MN 55344
Plan Funding	The EAP is an insured plan. This means inVentiv pays premiums to the insurer (Cigna Behavioral Health) with whom it has contracted to provide your coverage. Insurance premium costs are paid from the general assets of inVentiv Health.

Plan Administrator's Discretionary Authority to Interpret the Plan

The administration of the plan will be under the supervision of the plan administrator. To the fullest extent permitted by law, the plan administrator will have the exclusive discretionary authority to determine all matters relating to the plan, including eligibility, coverage and benefits.

The plan administrator will also have the exclusive discretionary authority to determine all matters relating to interpretation and operation of the plan. The plan administrator may delegate any of its duties and responsibilities to one or more persons or entities. Such delegation of authority must be in writing and must identify the delegate and the scope of the delegated responsibilities. Decisions by the plan administrator, or any authorized delegate, will be conclusive and legally binding on all parties.

inVentiv Health's Right to Amend or Terminate the Plan

It is inVentiv Health's intent that the EAP will continue indefinitely. However, inVentiv Health reserves the right to amend, modify, suspend or terminate the plan, in whole or in part. Any such action would be taken in writing and maintained with the records of the plan. Plan amendment, modification, suspension or termination may be made for any reason, and at any time, and may, in certain circumstances, result in the reduction of or elimination of benefits or other features of the plan to the extent permitted by law.

inVentiv Health's rights include the right to obtain coverage and/or administrative services from additional or different insurance carriers, third-party administrators, etc., at any time, and the right to require employee contributions. Employees will be notified of any material modification to the plan.

Limitation on Assignment

Your rights and benefits under the plan cannot be assigned, sold or transferred to your creditors or anyone else. However, you may assign your rights to benefits under the plan to the health provider who provided the medical services or supplies.

Your Employment

This SPD provides detailed information about the EAP and how it works. This SPD does not constitute an implied or express contract or guarantee of employment. Similarly, your eligibility or your right to benefits under the EAP should not be interpreted as an implied or express contract or guarantee of employment. inVentiv Health's employment decisions are made without regard to benefits to which you are entitled upon employment.