PAREXEL International Corporation

Cafeteria Plan

PREAMBLE AND EXECUTION

WHEREAS, PAREXEL International Corporation ("the Company") maintains the PAREXEL International Corporation Cafeteria Plan; and

WHEREAS, the Company desires to amend and restate the plan;

NOW, THEREFORE by virtue and in exercise of the amending power reserved to the Company and pursuant to the authority delegated to the undersigned agent of the Company the PAREXEL International Corporation Cafeteria Plan (the "Plan") is hereby amended and restated in its entirety effective upon execution as of the date below.

IN WITNESS WHEREOF, the undersigned has caused the Plan to be executed by its duly authorized officer this 27th day of July, 2018.

PAREXEL International Corporation

By _____

Title Corporate VP and Chief HR Officer

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ARTICLE I

PLAN ESTABLISHMENT

1.1 Effective Date

The PAREXEL International Corporation Cafeteria Plan ("the Plan") is amended and restated effective upon execution as stated in the Preamble.

1.2 Purpose

The Plan is created exclusively for Employees, as defined in Article II. The Plan's purpose is to provide Covered Employees, as defined in Article II, the means to exchange all or part of their compensation for other Plan benefits they select.

1.3 Qualification

The Plan is intended to qualify as a cafeteria plan under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code"); the Plan is not intended to be an employee benefit plan under Section 3(3) of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This document is intended to satisfy the written plan document requirement of Department of Treasury Proposed Regulations Section 1.125-1(c).

The Dependent Care Flexible Spending Account Plan, as defined in Article II and set forth in Appendix A, is part of this Plan and is intended to qualify as a dependent care assistance program under Section 129 of the Code. Appendix A is intended to satisfy the written plan document requirement of Code Section 129(d)(1).

The Health Care Flexible Spending Account Plan, as defined in Article II and set forth in Appendix B, is part of this Plan and is intended to qualify as a health plan under Section 105(e) of the Code. Appendix B is also intended to satisfy the written plan document requirement of Code regulation Section 1.105-11(b)(1)(i).

The Combination Limited Purpose Health Care Flexible Spending Account Plan, as defined in Article II and set forth in Appendix C, is part of this Plan and is intended to qualify as a health plan under Section 105(e) of the Code. Appendix C is also intended to satisfy the written plan document requirement of Code regulation Section 1.105-11(b)(1)(i).

1.4 Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Company, as defined in Article II, in its sole discretion and in accordance with the provisions of Article VIII may amend or terminate the Plan or any provision of the Plan at any time.

ARTICLE II

DEFINITIONS

The following words and phrases, when capitalized, shall have the following meanings.

2.1 Change in Status

Change in Status means:

A. A “special enrollment” event under HIPAA,

B. The Covered Employee's marriage, divorce, legal separation or annulment,

C. The birth, adoption, placement for adoption, or change in dependency or custody of a Covered Employee's Dependent child,

D. The death of the Employee's Spouse or Dependent child,

E. A change in employment status by the Covered Employee, Spouse or Dependent, including commencement or termination of employment, a change in work shift, a change in worksite, a reduction or increase in hours of employment including changing from part-time to full-time employment status, a strike or lockout,

F. Commencement or return from an unpaid leave of absence by the Employee, Spouse or Dependent,

G. A change in worksite or personal residence resulting in eligibility or loss of eligibility of coverage for the Covered Employee, Spouse or Dependent under any health maintenance organization offered through the Plan,

H. A change in legal custody (including the issuance of a qualified medical child support order) that affects the child’s eligibility for coverage under this Plan or the plan of the child's other parent,

I. Entitlement or loss of entitlement to Medicare or Medicaid by an Employee, Spouse, or Dependent,

J. Attainment by Dependent child of limiting age for a benefit provided under this Plan,

K. Loss of “Qualifying Individual” status, as defined in Article II of the Dependent Care Flexible SpendingAccount Plan,

L. Experiencing a change in employment that does not affect eligibility for coverage under the Plan, after which the Covered Employee is reasonably expected to average less than 30 hours of service per week, if the Covered Employee (and any Dependents also revoking coverage) intend(s) to enroll in another plan that provides minimum essential coverage effective no later than the first day of the second month after the date that Plan coverage is revoked. This rule permits the Covered Employee to revoke group health plan benefits only, for the Covered Employee and his or her Dependents, and does not apply to Health Care Flexible Spending Account or Combination Limited Purpose Health Care Flexible Spending Account elections.

M. Eligibility for special enrollment in a qualified health plan (QHP) through the public Marketplace, or seeking to enroll in a QHP offered through the public Marketplace during the Marketplace's annual open enrollment. This rule permits the Covered Employee to revoke group health plan benefits only, for the Covered Employee and his or her Dependents, and must correspond with the intended enrollment of the Covered Employee and his or her Dependents in a QHP effective beginning no later than the day immediately following the last day of the Plan coverage that is revoked. This rule does not apply to Health Care Flexible Spending Account or Combination Limited Purpose Health Care Flexible Spending Account elections, or

N. Any other event the Plan Administrator determines permits revocation of an election without violating the Code.

2.2 Claim Administrator

Claim Administrator means the person(s) or entity (or entities) authorized and responsible for receiving and reviewing claims for benefits under the Plan; determining what amount, if any, is due and payable; making appropriate disbursements to persons entitled to benefits under the Plan; and reviewing and determining denied claims and appeals.

2.3 Code

Code means Internal Revenue Code of 1986, as amended, and regulations issued thereunder or pursuant thereto.

2.4 COBRA

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272, Title X), as amended, and the regulations issued thereunder or pursuant thereto.

2.5 Company

Company means PAREXEL International Corporation, a corporation, and any successor, by merger or otherwise.

2.6 Covered Employee

Covered Employee means an Employee who satisfies the eligibility, participation, and coverage requirements of Article III and who has made an election to participate in the benefits described in Section 4.3.

2.7 Dependent

Dependent means a Covered Employee's dependent as defined in Code Section 152 (without regard to (b)(1), (b)(2), and (d)(1)(B)) and, for health and accident benefits, the Covered Employee's child as defined in Code Section 152(f)(1)) who has not attained age 27 as of the end of the taxable year.

2.8 Dependent Care Flexible Spending Account Plan

Dependent Care Flexible SpendingFlexible Account Plan means the plan set forth in Appendix A.

2.9 Effective Date

Effective Date means the date the Plan becomes effective, as set forth in Article I.

2.10 Employee

For purposes of this Plan only, the term Employee means a common law employee of the Employer.

The term *Employee* includes, but is not limited to, a person who is:

A. a leased employee, as defined in Code Section 414(n),

B. a nonresident alien who receives no earned income (within the meaning of Code Section 911(d)(2)) from an Employer that constitutes income from sources within the United States, as defined in Code Section 861(a)(3),

C. a collectively bargained employee.

The term *Employee* does not mean:

D. a self-employed individual, as defined in Code Section 401(c)(1)(A),

E. a member of the board of directors who is not otherwise an employee,

F. a person whom the Plan Administrator determines has been engaged by the Employer as an independent contractor, and

G. a person whom the Plan Administrator determines has been engaged by the Employer as a consultant or advisor on a retainer or fee basis.

A person the Plan Administrator determines is not an “Employee” as defined above shall not be eligible to participate in the Plan regardless of whether such determination is upheld by a court or tax or regulatory authority having jurisdiction over such matters. However, a person the Company determines is not an “Employee” as defined above and who later is required to be reclassified as an Employee shall be eligible to participate in the Plan prospectively only, provided that the Employee is otherwise eligible pursuant to Section 3.1.

2.11 Employer

Employer means the Company and any subsidiary or affiliated organization and any successor(s) of any of them which, with the approval of the Company, and subject to such conditions as the Company may impose, adopts the Plan.

For purposes of satisfying the nondiscrimination requirements of Code Section 125(b), Section 105(h) and 129(d), the term “Employer” shall include any other corporation or other business entity which must be aggregated with the Employer under Section 414(b), (c), (m) or (o) of the Code, but only for such period of time when the Employer or such other corporation or other business entity must be aggregated as aforesaid.

2.12 FMLA

FMLA means the Family and Medical Leave Act of 1993, as amended, and the regulations issued thereunder or pursuant thereto.

2.13 Health Care Flexible Spending Account Plan

Health Care Flexible Spending Account Plan means the plan set forth in Appendix B.

2.14 Health Savings Account

Health Savings Account means an individual savings account described in Appendix D.

2.15 HIPAA

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended, and the regulations issued thereunder or pursuant thereto.

2.16 Combination Limited Purpose Health Care Flexible Spending Account Plan

Combination Limited Purpose Health Care Flexible Spending Account Plan means the plan set forth in Appendix C. The Combination Limited Purpose Health Care Flexible Spending Account Plan may also be referred to as the Combination Limited Purpose Flexible Spending Account (FSA) in enrollment materials and other plan-related materials and systems.

2.17 Plan

Plan means the PAREXEL International Corporation Cafeteria Plan as herein set forth and as amended from time to time.

2.18 Plan Administrator

Plan Administrator means the person(s) authorized and responsible for managing and directing the operation and administration of the Plan.

2.19 Plan Sponsor

Plan Sponsor means the Company.

2.20 Plan Year

Plan Year means the 12-month period beginning January 1 and ending December 31.

2.21 Salary Deduction Agreement

Salary Deduction Agreement means the authorization to the Employer by the Employee to reduce such Employee's pay by an amount on an after-tax basis for selected Plan benefits.

2.22 Salary Deduction Contributions

Salary Deduction Contributions means the contributions taken from the Covered Employee's salary on an after-tax basis, pursuant to a Salary Deduction Agreement.

2.23 Salary Reduction Agreement

Salary Reduction Agreement means the authorization to the Employer by the Employee to reduce such Employee's pay by an amount on a before-tax basis for selected Plan benefits.

2.24 Salary Reduction Contributions

Salary Reduction Contributions means the contributions taken from the Covered Employee's salary on a before-tax basis, pursuant to a Salary Reduction Agreement.

2.25 Spouse

Spouse means, for purposes of this Plan only, a person recognized as married to the Covered Employee by a state, possession, or territory of the United States in which the marriage is entered into, regardless of domicile. Where the marriage was entered into in a foreign jurisdiction, a person is recognized as married to the Covered Employee if the relationship is recognized as marriage under the laws of at least one state, possession or territory of the United States, regardless of domicile.

ARTICLE III

ELIGIBILITY, PARTICIPATION AND COVERAGE

3.1 Eligibility

An Employee who is eligible to participate in one or more of the applicable benefits listed in Section 4.3 and who enrolls in the Plan as required in Section 5.1 is eligible to participate in this Plan. Eligibility requirements for the benefits listed in Section 4.3 shall be set forth in the PAREXEL International Corporation Health and Welfare Plan Summary Plan Description.

3.2 Participation

Employees become Plan participants on the date they satisfy the eligibility requirements of Section 3.1 and the enrollment and election requirements of Section 5.1.

3.3 Coverage

A. Date Coverage Begins

Eligible Employees become Covered Employees as of the date specified in Section 5.1(C)(1).

B. Coverage During Leave of Absence

1. Paid Leave

During a paid leave of absence, a Covered Employee continues to participate in the premium payment benefits he or she elected.

2. Unpaid Leave

Except as otherwise provided below, Plan coverage for a Covered Employee on an approved unpaid leave of absence is suspended on the last date of coverage for which a premium payment benefit has been paid. The terms of the plan to which the participant's selected premium payment benefits were paid control whether and to what extent coverage and benefits under that plan continue.

To the extent the Covered Employee may continue coverage during an unpaid leave, and except as required below, the Covered Employee is required to pay for coverage on an after-tax basis.

If the unpaid leave of absence is taken pursuant to FMLA, Covered Employees may elect to continue participation in premium payment benefits described in Sections 4.3(A), (B), (C), (E) and (F) by (i) paying premium payment benefits during the FMLA leave on an after-tax basis, or to the extent possible on a before-tax basis, or (ii) paying on a before-tax basis upon return from the leave the premium payment benefits for coverage during the leave, and adjusting the Salary Reduction Contribution accordingly for the balance of the Plan Year. Benefits described in Section 4.3(D) are suspended.

With respect to the Health Care Flexible Spending Account and Combination Limited Purpose Health Care Flexible Spending Account premium payment benefits described in Section 4.3, if the Covered Employee elects to revoke such coverage

during the unpaid leave, no expenses incurred during the leave shall be reimbursed. Upon return from leave, the Employee can either: (i) elect to be reinstated in the prior election amount, reduced by the dollar amount of the annual election not contributed during the unpaid leave, or (ii) elect to be reinstated to the full annual election amount, with the Salary Reduction Contribution adjusted accordingly for the balance of the Plan Year.

C. Date Coverage Ceases

Plan coverage ceases on the earliest of:

1. for Medical, Dental and Vision benefits, the last day of the month in which the Covered Employee last satisfies the eligibility and participation requirements of Sections 3.1 and 3.2, respectively,

2. for AD&D and Flexible Spending Account benefits, the date the Covered Employee last satisfies the eligibility and participation requirements of Sections 3.1 and 3.2, respectively,

3. except where participation continues during an unpaid leave of absence, the last day of the last pay period for which a Covered Employee makes a Salary Reduction Contribution or Salary Deduction Contribution as required for Plan participation,

4. the effective date of a Plan amendment that terminates coverage for the Covered Employee's job category, or

5. the date the Plan terminates.

D. Effect of Terminated Coverage

Termination of coverage automatically cancels a Covered Employee's Salary Reduction Agreement and Salary Deduction Agreement on the date coverage terminates. The plan's terms governing the Covered Employee's selected premium payment benefit control whether and to what extent coverage and benefits under that plan continue.

E. Reinstatement of Coverage

1. If Previously Suspended

A Covered Employee who returns to an Employer's service during the same Plan Year that he or she took an unpaid leave of absence will have reinstated automatically the benefit elections in effect when Plan coverage was suspended provided such benefits continue to be provided by the Company. If an unpaid leave of absence was taken in accordance with FMLA, such Covered Employee may reinstate his or her election and Salary Reduction Agreement for the remainder of the Plan Year if participation has not continued pursuant to Section 3.3(B). In all other cases, the Covered Employee may only make any new benefit elections for the remainder of the Plan Year, as described in Section 5.1(F).

2. If Previously Terminated

A former Covered Employee who returns to an Employer's service shall be eligible to participate in the Plan and make new benefit elections, provided such Employee satisfies the eligibility requirements of Section 3.1.

Notwithstanding the foregoing, if a former Covered Employee returns to service during the same Plan Year and within 30 days of the date prior participation ended, he shall have his prior benefit elections reinstated and may not make any new benefit elections for the remainder of the Plan Year, except as described in Section 5.1(F). The above rule shall not apply and the rehired Employee shall be eligible to make new elections for the balance of the Plan Year, if it is determined to the satisfaction of the Plan Administrator that the prior termination of employment and reinstatement was bona fide and not an attempt to avoid the irrevocable rule described in Section 5.1(F)(1).

F. Coverage under the Family and Medical Leave Act and Section 609 of ERISA

1. Family and Medical Leave Act of 1993

If not otherwise provided for herein, the Plan shall provide coverage for a Covered Employee solely to the extent necessary to comply with FMLA, and the Plan shall be interpreted and administered as necessary to comply with FMLA and the rulings and regulations issued thereunder.

2. Section 609 of ERISA

If not otherwise provided for herein, the Plan shall provide coverage to a child solely to the extent required by a qualified medical child support order defined under Section 609(a) of ERISA or to an adoptive child solely to the extent required by Section 609(c) of ERISA. Further, the Plan shall be interpreted and administered as necessary to comply with Section 609 of ERISA and the rulings and regulations issued thereunder.

3. Coverage Contingent Upon Contribution

Any coverage provided as a result of this Section 3.3(F) shall be conditioned upon payment of applicable contributions by the Employee.

G. Uniformed Services Employment and Reemployment Rights Act

Solely to the extent required by the Uniformed Services Employment and Reemployment Rights Act (hereinafter the “Uniformed Services Act”), an Employee who is a Covered Employee and who enters military service shall have the right to continue coverage under the Plan for the period prescribed under the Uniformed Services Act. Continuation of coverage shall be conditioned upon payment of the required premiums.

This Section shall be interpreted and applied to give an Employee only those rights as are prescribed under the Uniformed Services Act and rulings and regulations issued thereunder.

ARTICLE IV

BENEFITS

4.1 Benefit Options

A. As a condition of Plan participation, Covered Employees must elect one of the following:

1. to receive the full unreduced compensation benefit described in Section 4.2, or

2. to forego all or part of the unreduced compensation benefit described in Section 4.2 and make Salary Reduction Contributions or Salary Deduction Contributions in exchange for one or a combination of premium payment benefits described in Section 4.3.

Employee contributions for benefits described in Sections 4.3 must be made on an entirely before-tax basis through a Salary Reduction Agreement.

4.2 Unreduced Compensation Benefit

In lieu of all or some of the premium payment benefits described in Section 4.3 that a Covered Employee otherwise could elect, he or she may elect to receive unreduced compensation in an amount equal to the value of the premium payment benefits not elected. The unreduced compensation benefit is subject to the Employer's regular payroll practices; applicable local, state, and federal income tax withholding; and other applicable deductions. The unreduced compensation benefit is not additional compensation; it is the amount by which a Covered Employee's compensation is not reduced each pay period by not electing a premium payment benefit. The unreduced compensation benefit shall cease whenever the Covered Employee commences an unpaid leave of absence, terminates employment, or the Covered Employee's Employer determines, in its sole discretion, that compensation is not payable to such Employee.

4.3 Benefits

By electing one or more premium payment benefits, an Employee agrees to convert a portion of his or her compensation for the Plan Year into contributions to the plan that governs the selected benefit. That plan's terms, as amended from time to time, govern a Covered Employee's rights and obligations under it. Covered Employees may elect one or more of these premium payment benefits:

A. Medical Premium Payment

A Covered Employee may elect any available coverage level and/or option as the medical premium payment benefit.

B. Dental Premium Payment

A Covered Employee may elect any available coverage level and/or option as the dental premium payment benefit.

C. Vision Premium Payment

A Covered Employee may elect any available coverage level and/or option as the vision premium payment benefit.

D. Dependent Care Flexible Spending Account Premium Payment

A Covered Employee may elect any whole dollar annual contribution amount of not less than 60 and not more than $5,000 as the dependent care flexible spending account plan premium benefit.

E. Health Care Flexible Spending Account Premium Payment

If under the terms of the Health Care Flexible Spending Account Plan, an Employee is eligible to participate in that plan and he or she has does not participate in the Health Savings Account Premium Payment Benefit described in Section 4.3(G), he or she may elect any whole dollar annual contribution amount of not less than $60 and not more than an amount to be communicated annually by the Plan Administrator, which shall not exceed the maximum amount allowed under Section 125 of the Code, as the health care flexible spending account plan premium benefit.

F. Combination Limited Purpose Health Care Flexible Spending Account Premium Payment

If under the terms of the Combination Limited Purpose Health Care Flexible Spending Account Plan, an Employee is eligible to participate in that plan, and he or she participates in the Health Savings Account Premium Payment Benefit described in Section 4.3(G), he or she may elect any whole dollar annual contribution amount of not less than $60 and not more than an amount to be communicated annually by the Plan Administrator, which shall not exceed the maximum amount allowed under Section 125 of the Code, as the combination limited purpose health care flexible spending account plan premium benefit.

G. Health Savings Account Premium Payment

An Employee who participates in an Employer-sponsored high deductible health plan that meets the requirements of Section 223 of the Code and who is not enrolled in an Employer Sponsored low deductible health plan, may elect any whole dollar annual contribution amount if not more than the maximum allowed under Section 223 of the Code as the health savings account premium benefit.

Covered Employees forfeit unused Salary Reduction Contributions and/or Salary Deduction Contributions, if any. Covered Employees may not receive a cash out of Salary Reduction Contributions that are forfeited, nor may Covered Employees apply such forfeitures toward any other Plan benefit.

4.4 Limits for Certain Employees

Benefits payable under the Plan to each highly compensated participant, as defined in Code Section 125(e)(1) or highly compensated individual, as defined in Code Section 125(e)(2), shall be limited to the extent necessary to avoid violating Code Section 125(b)(1).

Benefits payable under the Plan to each key employee, as defined in Code Section 416(i)(1), are limited to the extent necessary to avoid violating Code Section 125(b)(2).

Benefits payable under the Plan to each highly compensated individual, as defined in Code Section 105(h)(5) shall be limited to the extent necessary to avoid violating Code Section 105(h)(1) as applicable.

Benefits payable under the Dependent Care Flexible Spending Account Plan to a highly compensated employee, as defined in Code Section 414(q), are limited to the extent necessary to

avoid violating Code Section 129(d)(8). The Employer may determine prior to or during a Plan Year that the Salary Reduction Contributions of a highly compensated employee must be reduced to avoid violating Code Section 129(d)(8). Any amounts that are in excess of the Code Section 129(d)(8) limit and have not been used shall be returned to a highly compensated employee in the form of taxable compensation.

4.5 Notification of Premium Payment Benefit Amounts

The Company shall provide written notification to eligible Employees of the amount of the premium payment benefits prior to the initial and annual enrollment/election period. The amount of the premium payment benefits shall be the contributions required of the Employee to participate in the group health or welfare benefit plan(s) for which a premium payment benefit is available under the Plan. Any such written notification is hereby incorporated by reference and made part of the Plan.

4.6 Application of Other Plans

Notwithstanding any other provision of the Plan, Covered Employees electing one or more premium payment benefits under the Plan shall be subject to the provisions, conditions, limitations, and exclusions of the health and/or welfare benefit plan(s) listed in Section 4.3 for which they elect the premium payment benefit. Such plans are hereby incorporated by reference to the extent that they apply to the operation of this Plan.

ARTICLE V

PROCEDURES

5.1 Enrollment/Election Procedures

A. Forms and Agreements

Employees may enroll, make elections, and direct their Employer to make Salary Reduction Contributions and/or Salary Deduction Contributions only by filing the appropriate, completed forms or agreements, whether paper or electronic, with the Plan Administrator before the deadline described in Section 5.1(C).

B. Annual Enrollment

Prior to each Plan Year, the Plan Administrator shall conduct an enrollment during which Employees may make new elections or change existing ones for the next Plan Year.

C. Deadlines

1. Initial Enrollment/Election

For Employees who become eligible as of the Effective Date, the deadline for enrolling and making elections is the date the Plan Administrator specifies, but no later than the first day of the Plan Year to which the enrollment, elections and Salary Reduction Agreement and Salary Deduction Agreement apply.

For Employees who become eligible after the Effective Date but before the annual enrollment described in Section 5.1(B), the deadline for enrolling and making initial elections is the 30 day period after the Employee's date of hire. Salary Reduction Agreements and/or Salary Deduction Agreements completed by eligible Employees shall be effective as of the Employee's date of hire.

2. Annual Enrollment/Election

For Covered Employees and Employees who become eligible as of the first day of a Plan Year, the deadline for enrolling and making elections is the date the Plan Administrator specifies, but no later than the day preceding the first day of the Plan Year to which the enrollment, elections, and Salary Reduction Agreements and/or Salary Deduction Agreements apply.

D. Missed Deadline Yields Default Election

1. Initial Enrollment

A newly eligible Employee who fails to submit a valid enrollment/election Salary Reduction Agreement and/or Salary Deduction Agreement, as required in Section 5.1(A), is deemed to elect the maximum unreduced compensation benefit, described in Section 4.2, unless the Plan Administrator approves a supplemental election, as described in Section 5.1(F)(2).

2. Annual Enrollment

The Plan Administrator shall conduct an enrollment during which Employees may make new elections or change existing ones for the next Plan Year. For any year in which the Plan Administrator allows a passive enrollment, unless the Plan Administrator approves a supplemental election, as described in Section 5.1(F)(2), a Covered Employee who fails to submit a valid enrollment/election and Salary Reduction Agreement and/or Salary Deduction Agreement, as required in Section 5.1(A), is deemed to have reelected premium payment benefits in effect for the prior year, except that the Covered Employee will be deemed to have declined participation in the Dependent Care Flexible Spending Account Plan, Health Care Flexible Spending Account Plan and Combination Limited Purpose Health Care Flexible Spending Account Plan and the Employee shall be deemed to have elected no contributions to his/her Health Savings Account.

Contributions required for the reelected premium payment benefits shall be deducted from the Employee's pay as Salary Reduction Contributions, as permitted under the Code, or as Salary Deduction Contributions, and will be adjusted automatically to reflect any increase or decrease in the premium payment benefit cost.

E. Validity of Enrollment/Elections and Salary Reduction Agreement and/or Salary Deduction Agreement

1. Plan Administrator Approval

Enrollments and elections and Salary Reduction Agreements and/or Salary Deduction Agreements take effect only if valid, as determined by the Plan Administrator. Except for supplemental elections described in Section 5.1(F)(2), the Plan Administrator shall substitute the unreduced compensation benefit, described in Section 4.2, for any invalid premium payment benefit election.

2. Remedial Modification or Rejection

The Plan Administrator may modify or reject any enrollment or election and/or Salary Reduction Agreement and/or Salary Deduction Agreement or take other action the Plan Administrator deems appropriate under rules uniformly applicable to similarly situated persons to satisfy nondiscrimination requirements of Code Section 125(b). Any remedial modification, rejection, or other action the Plan Administrator takes must be on a reasonable basis that does not discriminate in favor of highly compensated individuals or participants, as defined in Code Section 125(e)(1) and (2), respectively, or key employees, as defined in Code Section 416(i)(1).

F. Changing Elections

1. General Rule

All elections (including default elections described in Section 5.1(D)) and Salary Reduction Agreements and/or Salary Deduction Agreements stay in force during the entire Plan Year to which they apply unless changed or revoked as provided in this Section 5.1(F). During annual enrollment, however, Covered Employees may make new benefit elections or change existing ones for the forthcoming Plan Year.

This rule does not apply to the Health Savings Account. With respect solely to the Health Savings Account, a participant who makes an election to contribute Salary Reduction Contributions to his or her Health Savings Account may change such election on a prospective basis at least once per month. Such election change is effective no later than the first day of the next calendar month following the date that the election was filed.

2. Supplemental Elections

Section 5.1(F)(1) notwithstanding, the Plan Administrator may approve a supplemental election to correct an enrollment or election form or Salary Reduction Agreement and/or Salary Deduction Agreement, whether paper or electronic, that is invalid for any reason if approval would not violate Code Section 125.

3. Revocation of Elections

Except as provided in Section 3.3(C), Covered Employees may revoke elections (including default elections) and Salary Reduction Agreements during a Plan Year only in accordance with the provisions described in this Section 5.1(F)(3). Except for changes made in accordance with Section 5.1(F)(3)(g) and changes made pursuant to a HIPAA special enrollment due to initial entitlement to state premium assistance under Medicaid or CHIP or loss of entitlement to Medicaid or a state children's health insurance program (CHIP), a Covered Employee must make the change within 30 days of the event giving rise to the election change. In the event of a HIPAA special enrollment due to the loss of Medicaid or a state children's health insurance program (CHIP) or initial entitlement to state premium assistance by an Employee, Spouse or Dependent, a Covered Employee will have 60 days from the date of the event to make an election change. Notwithstanding the provisions of this Section 5.1(F), an Employee's or Covered Employee's ability to elect or revoke certain benefit options mid-year may be restricted by the terms of the plan governing that benefit option.

a. Separation from Service

Covered Employees may revoke elections and Salary Reduction Agreements and/or Salary Deduction Agreements on separating from the Employer's service. Regardless of previous claims or reimbursements, the Plan Administrator must reimburse a Covered Employee for any amounts the Covered Employee already paid for coverage relating to the period after the effective date of termination of coverage.

b. Change in Status

A Covered Employee may revoke any election (including a default election) and make a new one if such revocation and new election are both on account of and necessary or appropriate because of a Change in Status.

Election and Salary Reduction Agreement changes must be consistent with the Change in Status, except for elections:

(1) Made pursuant to the special enrollment provisions of HIPAA,

(2) Made pursuant to a Change in Status event expressly identified in Article II as not requiring that Plan eligibility be affected, and only to the extent permitted under applicable law or guidance, or

(3) Made to increase Salary Reduction Contributions in the event the Employee, Spouse or Dependent elects COBRA coverage.

For purposes of this subparagraph (b), the term “consistent” means that the Change in Status event must cause the Employee or Employee’s Spouse or Dependent children to gain or lose eligibility under an employer-sponsored benefit offered through this Plan or the plan of the Spouse or Dependent, including a Change in Status that results in an increase or decrease in the number of an Employee’s Dependents who may benefit from coverage under the Plan. Coverage may be retroactive to the date of the event, to the extent permitted by the terms of the plan governing that benefit option; in no event will the Employee pay for retroactive coverage on a pre-tax basis unless permitted under Section 125 of the Code. With respect to an election change made pursuant to a birth, adoption or placement for adoption of a child, the election change shall take effect as of the birth, adoption or placement for adoption.

The Plan Administrator may require such evidence as it deems necessary to satisfy the consistency requirement imposed by Section 125 of the Code.

c. Cost Changes

If the cost of a premium payment benefit increases or decreases during a Plan Year, the Plan may, on a reasonable and consistent basis, automatically make a prospective change to Covered Employees' contributions to reflect the cost of this change.

If the Plan Administrator determines that the increase in cost of such premium payment benefit is significant, however, Covered Employees who have elected that premium payment benefit may either change their Salary Reduction Agreement correspondingly or revoke their premium payment benefit election and — in lieu thereof — elect, prospectively, a premium payment benefit with similar coverage, or may revoke the existing premium payment benefit if no other option providing similar coverage is available. Employees who previously waived participation may elect benefits if the cost of the coverage significantly decreases during the Plan Year.

This opportunity for making new elections does not apply to the Health Care Flexible Spending Account Plan Premium Payment Benefit orCombination Limited Purpose Health Care Flexible Spending Account Plan Premium Payment Benefit and applies to the Dependent Care Flexible Spending Account Plan only if a cost increase or decrease is imposed by a dependent care provider who is not a relative of the Covered Employee. For purposes of this subparagraph (c), a “relative” is an individual who is related as described in Code Section 152(d)(2) (A) through (G), incorporating the rules of Code Sections 152(f)(1)(B) and 152(f)(4).

d. Coverage Changes

This subparagraph does not apply to the Health Care Flexible Spending Account Plan or Combination Limited Purpose Health Care Flexible Spending Account Plan.

(1) Significant curtailment without a *loss of coverage*

If coverage offered under the Plan is significantly curtailed without a *loss of coverage* during a Plan Year, affected Covered Employees may revoke their election and make a new election on a prospective basis for coverage under another option providing similar coverage. For purposes of this subsection, a significant curtailment occurs if there is an overall reduction in coverage generally.

(2) Significant curtailment with *loss of coverage*

If coverage offered under the Plan is significantly curtailed to the extent that the Covered Employee experiences a *loss of coverage*, affected Covered Employees may revoke their election and make a new election on a prospective basis for coverage under another option providing similar coverage, or may revoke existing coverage if no other option providing similar coverage is available. For purposes of this subsection, a *loss of coverage* means a complete loss of coverage under the benefit option and shall include the elimination of a benefit option, an HMO ceasing to be available where the individual resides, the individual losing all coverage under the option by reason of an overall lifetime or annual limitation, or other fundamental loss of coverage as determined by the Plan Administrator.

(3) Significantly Improved or New Benefit Option

If the coverage offered under the Plan is significantly improved or if a new benefit option is made available under the Plan, then: (A) a Covered Employee who is enrolled in a benefit option other than the new or significantly improved benefit option may change their election on a prospective basis to elect the new or significantly improved benefit option, or (B) a Eligible Employee who had previously elected to waive coverage under a benefit option may elect to enroll on a prospective basis in the new or significantly improved benefit option. The Plan Administrator, in its sole discretion, will determine whether there has been an addition of, or a significant improvement in, a benefit option in accordance with Internal Revenue Service guidance.

e. Change in Coverage of Employee, Spouse or Dependent under Another Employer's Plan

This subparagraph does not apply to the Health Care Flexible Spending Account Plan or Combination Limited Purpose Health Care Flexible Spending Account Plan.

If the Employee or the Employee's Spouse or Dependent is covered under another plan of the Employer or a plan of the employer of the Employee's

Spouse or Dependent, the Employee may make an election change under this Plan in the following situations, provided such election change is on account of and corresponds with a change under the other plan:

(1) if the plan year of such other employer plan is different than the Plan Year of this Plan, or

(2) if the other employer plan permits the Employee, Spouse or Dependent to make changes for any of the situations described in this Section 5.1(F)(3).

f. Loss of Coverage under Another Health Plan

This subparagraph does not apply to the Health Care Flexible Spending Account Plan or Combination Limited Purpose Health Care Flexible Spending Account Plan.

If an Employee, Spouse or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, the Employee may make a new election on a prospective basis for health coverage provided under this Plan, provided such Employee, Spouse or Dependent is otherwise eligible for coverage under this Plan. For purposes of this subsection, a governmental or educational institution shall include the following:

(1) A state children's health program (CHIP) under Title XXI of the Social Security Act,

(2) A medical program of an Indian Tribal government (as defined in Section 7701(a)(40) of the Code), the Indian Health Service, or a tribal organization,

(3) A state health benefits risk pool, or

(4) A foreign government group health plan.

g. Automatic Adjustment of Election

The election and Salary Reduction Agreement of a Covered Employee who loses a Spouse or Dependent due to death for purposes of a premium payment benefit described in Section 4.3, but fails to make a timely election in accordance with this Section 5.1 shall be automatically adjusted in accordance with this subsection.

5.2 Claim Procedures

Claims relating to a plan governing a premium payment benefit are reviewable only under that plan's terms.

Claim procedures for the Dependent Care Flexible Spending Account Plan shall be as set forth in Article VI of Appendix A.

Claim procedures for the Health Care Flexible Spending Account Plan shall be as set forth in Article VII of Appendix B.

Claim procedures for the Combination Limited Purpose Health Care Flexible Spending Account Plan shall be as set forth in Article VII of Appendix C.

Claim procedures for the Health Savings Account shall not be subject to this Article V, but shall be subject to the terms set forth by the trustee for the Health Savings Account.

ARTICLE VI

CONTRIBUTIONS AND FUNDING

6.1 Contributions

A. Employer Contributions

The Employer shall pay premium payment benefits listed in Section 4.3 to the Employer-sponsored health and welfare plans to which such benefits are payable provided that the Covered Employee shall authorize Salary Reduction and/or Salary Deduction Contributions in a corresponding amount pursuant to Section 6.1(B)(2).

Notwithstanding any contrary Plan provision, the Employer is not obligated to contribute to the Plan after it is terminated except to the extent required to pay benefits outstanding on the date the termination is adopted or, if later, effective.

The Employer shall make the required contribution elected by the Covered Employee to a Health Savings Account for Employees who elect such premium payment benefit under Article IV.

The Employer may make Employer contributions to Health Savings Accounts. Such amounts will be communicated to Employees annually by the Plan Administrator prior to the beginning of the Plan Year.

B. Salary Reduction and/or Salary Deduction Contributions

As a condition of Plan participation, Employees must agree to direct the Employer to:

1. not reduce their compensation and not provide premium payment benefits pursuant to Section 4.3, or

2. reduce their compensation and make Salary Reduction Contributions and/or Salary Deduction Contributions to the plan(s) governing their selected premium payment benefits.

Any election of premium payment benefits shall be null and void unless the Employee authorizes a Salary Reduction Agreement and/or a Salary Deduction Agreement as provided for herein. An Employer must take Salary Reduction Contributions and/or Salary Deduction Contributions and apply them as directed, except that the Employer may not apply a Salary Reduction Contribution or a Salary Deduction Contribution for a selected premium payment benefit to any other premium payment benefit nor may a Salary Reduction Contribution or a Salary Deduction Contribution be applied during a subsequent Plan Year to any participating plan that provides benefits or coverage. Any such Salary Reduction Agreements and/or a Salary Deduction Agreements are hereby incorporated by reference into the Plan as if set forth in full herein.

C. Priority of Contributions

Contributions shall be deemed to come first from amounts contributed by Covered Employees and then from amounts contributed by the Employer.

D. COBRA Contributions

To the extent a former Covered Employee, Dependent or Spouse has exercised his or her continuation rights under the Consolidated Omnibus Reconciliation Act of 1985 (COBRA) with respect to benefits described in Section 4.3 (A), (B), (C), (E) and (F), the Plan shall accept contributions from such individuals as COBRA premiums.

6.2 Funding

The Employer shall establish and carry out, and may revise from time to time, the funding policy for the Plan. The Employer shall make payments provided for in Section 6.1(A) from its general assets. The Employer shall make payments provided for in Section 6.1(B) and (D) by collecting Employee contributions and COBRA contributions and transmitting such amounts to the applicable benefits described in Article IV.

ARTICLE VII

ADMINISTRATION

7.1 Plan Administrator

The Company shall appoint a person, entity or committee to serve as Plan Administrator. In the absence of such appointment, the Company shall be the Plan Administrator. The Plan Administrator shall be the "named fiduciary" for purposes of any plan benefits subject to ERISA.

7.2 Plan Administrator's Duties

The Plan Administrator shall:

A. manage and carry out the Plan's operation and administration according to the Plan's terms;

B. maintain:

1. whatever records and data are necessary or desirable for the Plan's proper operation and administration, and

2. the Plan's governing documentation for inspection by anyone who participates or is eligible to participate in the Plan;

C. notify Employees eligible to participate in the Plan of:

1. the Plan's availability and terms,

2. the premium payment benefits available for election,

3. the maximum annual Salary Reduction Contribution and/or Salary Deduction Contribution amounts for each available premium payment benefit, and

4. the procedures for enrolling and making and changing elections;

D. supply eligible Employees with any forms and agreements they must complete;

E. prepare and file all annual reports or returns, plan descriptions, financial statements, and other documents required by law or under the Plan's terms; and

F. record its and the Employer's acts and determinations regarding the Plan and preserve these records in its custody.

7.3 Plan Administrator's Powers

Except as expressly limited or reserved in the Plan to the Company or an Employer, the Plan Administrator shall have the right to exercise, in a uniform and nondiscriminatory manner, full discretion with respect to the administration, operation, and interpretation of the Plan. Without limiting the generality of the foregoing rights, the Plan Administrator shall have full power and discretionary authority to:

A. require any person to furnish such information as the Plan Administrator may request from time to time and as often as the Plan Administrator determines reasonably necessary for

the purpose of proper administration of the Plan and as a condition to the individual's receiving benefits under the Plan;

B. make and enforce such rules and prescribe the use of such forms as the Plan Administrator determines reasonably necessary for the proper administration of the Plan;

C. interpret the Plan and decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions;

D. determine all questions concerning the eligibility of any individual to participate in, be covered by, and receive benefits under the Plan pursuant to the provisions of the Plan;

E. determine whether objective criteria set forth in the Plan have been satisfied respecting any term, condition, limitation, exclusion, and restriction or waiver thereof;

F. determine the amount of benefits payable, if any, to any person or entity in accordance with the provisions of the Plan; to inform the Employer or any other third party, as appropriate, of the amount of such benefits; to make claims decisions under the terms of the Plan; and to provide a full and fair review to any individual whose claim for benefits has been denied in whole or in part; provided however, that any claim for benefits under a health and welfare plan shall be determined solely in accordance with the terms of such plan;

G. delegate to other person(s) any duty that otherwise would be a fiduciary responsibility of the Plan Administrator under the terms of the Plan;

H. engage the services of such person(s) and entity or entities as it deems reasonably necessary or appropriate in connection with the administration of the Plan;

I. make such administrative or technical amendments to the Plan as may be reasonably necessary or appropriate to carry out the intent of the Employer, including such amendments as may be required or appropriate to satisfy the requirements of the Code or ERISA and the rules and regulations from time to time in effect under any such laws, or to conform the Plan with other governmental regulations or policies; and

J. pay all reasonable and appropriate expenses incurred in connection with the management and administration of the Plan including, but not limited to, premiums or other considerations payable under the Plan and fees and expenses of any actuary, accountant, legal counsel, or other specialist engaged by the Plan Administrator.

7.4 Finality of Decisions

The Plan Administrator shall have full power, authority and discretion to enforce, construe, interpret and administer the Plan. All decisions and determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on Covered Employees and all other interested parties.

7.5 Compensation and Bonding of Plan Administrator

Unless otherwise agreed to by the Company, the Plan Administrator shall serve without compensation for services as such, but all reasonable expenses incurred in the performance of the Plan Administrator's duties shall be paid as specified in Section 9.17. Unless otherwise determined by the Company or unless required by federal or state law, the Plan Administrator shall not be required to furnish bond or other security in any jurisdiction.

7.6 Liability Insurance

The Company may obtain liability coverage at the Company's expense to insure any Employee serving as Plan Administrator against legal liability that may arise from being the Plan Administrator or performing the Plan Administrator's duties.

7.7 Reserved Powers

The Company reserves the powers, among others:

A. to adopt the Plan;

B. to amend, terminate, or merge the Plan according to Article VIII; and

C. to appoint and remove any Plan Administrator.

ARTICLE VIII

AMENDMENT, TERMINATION OR MERGER OF PLAN

8.1 Right to Amend the Plan

Except as provided in Section 8.3, the Company reserves the unlimited right to amend the Plan in any way. Any amendment to the Plan shall be in writing and shall be adopted by Company in accordance with its normal procedures. However, the Plan Administrator shall have the authority to amend the Plan to comply with applicable law or regulation or to reflect the Company's intent.

8.2 Right to Terminate or Merge the Plan

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, the Company (or its duly authorized representative) reserves the unlimited right to terminate or merge the Plan. Any termination or merger of the Plan shall be in writing and shall be adopted by the duly authorized representative of the Company acting in accordance with its regular duties for the Company.

8.3 Effect of Amendment, Termination or Merger

Any amendment, termination or merger of the Plan shall be effective at such date as the Company shall determine except that no amendment, termination or merger may be retroactive unless remedial to comply with a law or regulatory requirement the Company or the Plan is subject to.

ARTICLE IX

MISCELLANEOUS

9.1 No Employment Rights

The Plan is a voluntary undertaking of the Employer and does not constitute a contract with any person. The Plan is not an inducement or condition of an Employee's employment with any Employer. Neither the establishment of the Plan, nor any modification thereof, nor any payments hereunder, shall be construed as giving to any Employee or any other person, any legal or equitable rights against his or her Employer, the Company or their shareholders, directors, officers, employees or agents, or as giving any person the right to be retained in the employ of the Employer.

9.2 Exclusive Rights

No individual shall have a right to benefits under the Plan except as specified herein; and in no event shall any right to benefits under the Plan be or become vested. This Plan is not a guarantee of continuation of any benefits or coverage offered through the Plan.

9.3 No Property Rights

No one has any right, title, or interest in the property of the Company or the Employer by virtue of the Plan, nor is any person entitled to interest on any benefit amounts that may be allocated or available to him or her.

9.4 No Assignment of Benefits

Benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge of any kind, and any attempt to effect same shall be void. Notwithstanding the foregoing, a Covered Person may request, in writing, and at the discretion of the Plan Administrator or Claims Administrator, that benefits payable to him or her be paid instead to an institution in which he or she is or was hospitalized or to a provider who has provided the services for which reimbursement is claimed. However, the Plan reserves the right to make payment directly to the Covered Person. Where payments are made directly to a doctor, hospital, or other provider of care, such direct payments are provided at the discretion of the Plan Administrator or Claims Administrator as a convenience to the Covered Person, and do not imply an enforceable assignment of benefits or the right to receive such benefits or the right to bring any cause of action against the Plan or the Plan Administrator under any federal or state law, including ERISA.

9.5 Right to Offset Future Payments

In the event a payment or the amount of a payment is made erroneously to an individual, the Plan shall have the right to reduce future payments payable to or on behalf of such individual by the amount of the erroneous or excess payment. This right to offset shall not limit the right of the Plan to recover an erroneous or excess payment in any other manner.

9.6 Right to Recover Payments

Whenever a payment has been made by the Plan, including erroneous payments, in a total amount in excess of the amount payable under the Plan, irrespective of to whom paid, the Plan shall have the right to recover such payments, to the extent of the excess, from the person to or for whom the payment was made.

9.7 Misrepresentation or Fraud

A Covered Employee who receives benefits under the Plan as a result of false, incomplete, or incorrect information or a misleading or fraudulent representation may be required to repay all amounts paid by the Plan and may be liable for all costs of collection, including attorney's fees and court costs. The Plan Administrator shall decide such matters on a case by case basis. An Employee may be asked to provide proof of eligibility for his or her Dependents. If a Covered Person makes any intentional misrepresentation or uses fraudulent means concerning eligibility for coverage, changing existent coverage, or benefits under the Plan, the Employee's and his or her Dependents' coverage may be terminated irrevocably (retroactively to the extent permitted by law), and could be grounds for Employee discipline up to and including termination. Failure to provide timely notice of loss of eligibility will be considered intentional misrepresentation.

9.8 Legal Action

Before pursuing legal action, a person claiming Plan benefits or seeking redress related to the Plan must first exhaust the Plan's claim, review, and appeal procedures. Unless otherwise provided by law, the Company and the Plan Administrator are the only necessary parties to any action or proceeding that involves the Plan or its administration. No Employee, Employer, or other person or entity is entitled to notice of any legal action, unless a court with appropriate jurisdiction orders otherwise.

No action at law or in equity in any court or agency shall be brought to recover benefits under the Plan prior to the exhaustion of the claims and appeals procedures set forth in Article V, nor shall an action be brought at all unless within 36 months after the date a claim is incurred under the Plan.

9.9 Governing Law

The provisions of the Plan shall be administered, and all questions pertaining to the validity or construction of the Plan and the acts and transactions of the parties shall be determined, construed, and enforced, in accordance with applicable and, to the extent not preempted, the laws of the Commonwealth of Massachusetts.

9.10 Governing Instrument

This document, together with any documentation incorporated by reference herein, is the legal instrument governing the Plan. In case of conflict between this document and any other writing or evidence, the terms of this document shall govern.

9.11 Savings Clause

If a provision of the Plan or the application of a provision of the Plan to any person, entity, or circumstance is held invalid under governing law by a court of competent jurisdiction, the remainder of the Plan and the application of the provision to any other person, entity, or circumstance shall not be affected.

9.12 Captions and Headings

The captions and headings of an Article, Section or provision of the Plan are for convenience and reference only and are not to be considered in interpreting the terms and conditions of the Plan.

9.13 Notices

No notice or communication in connection with the Plan made by a claimant or an Employee shall be effective unless duly executed on a form provided or approved by, and filed with, the appropriate Plan Administrator (or his or her representative).

9.14 Waiver

No term, condition, or provision of the Plan shall be deemed waived unless the purported waiver is in a writing signed by the party to be charged. No written waiver shall be deemed a continuing waiver unless so specifically stated in the writing, and only for the stated period, and such waiver shall operate only as to the specific term, condition, or provision waived.

9.15 Parties' Reliance

The Company, the Employer, the Plan Administrator and anyone to whom the Plan's operation or administration is delegated may rely conclusively on any advice, opinion, valuation, or other information furnished by any actuary, accountant, appraiser, legal counsel, or physician the Plan engages or employs. A good faith action or omission based on this reliance is binding on all parties, and no liability can be incurred for it except as the law requires. No liability shall be incurred for any other action or omission of the Company, the Employer or their employees, except for willful misconduct or willful breach of duty to the Plan.

9.16 Disclaimer

The Company makes no assertion or warranty about:

A. whether Plan benefits are or will be excludable from a Covered Employee's gross income for federal or state income tax purposes, or

B. whether any other tax treatment is or will be applicable.

9.17 Expenses

All expenses of the Plan shall be paid from forfeitures, Employee contributions, or by the Plan, unless otherwise paid by the Employer. The Employer may advance expenses to the Plan, subject to reimbursement, without obligating itself to pay such expenses.

9.18 Indemnification

The Company, to the extent permitted by law, shall indemnify and hold harmless any employee or officer of the Company or the Employer from and against all loss, damages, liability and reasonable costs and expenses incurred in carrying out his or her responsibilities under the Plan, unless due to the bad faith or willful misconduct of such person, provided that such individual's attorney's fees and any amount paid in settlement shall be approved by the Company.

9.19 Employees' Tax Obligations

A. Excludability Determination

Covered Employees themselves must determine whether Plan benefits are excludable for tax purposes, and must notify the Plan Administrator if they have reason to believe a payment is not excludable.

B. Liability and Payment

If the Plan Administrator determines at any time after a Plan Year's end that Employees' Salary Reduction Contributions or Salary Deduction Contributions or other Employer contributions exceeded limits allowed by law for any reason including, but not limited to, erroneous information, administrative error, or a final determination that the Plan does not qualify as a cafeteria plan under Code Section 125 for the Plan Year, then Covered Employees must:

1. pay any local, state, and federal income taxes and related penalties and interest due with respect to the excess Salary Reduction Contributions or other Employer contributions for which the Covered Employee is liable, and

2. reimburse the Employer for the Employee's share of any local, state, and federal tax contributions the Employer would have withheld or other applicable deductions the Employer would have taken had the excess Salary Reduction Contributions or other Employer contributions been treated as taxable income.

APPENDIX A

PAREXEL INTERNATIONAL CORPORATION DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT PLAN

ARTICLE I

PLAN ESTABLISHMENT

1.1 Effective Date

The PAREXEL International Corporation Dependent Care Flexible Spending Account Plan ("the Plan") is amended and restated as of the Effective Date in Article I of the PAREXEL International Corporation Cafeteria Plan.

1.2 Purpose

The Plan is created exclusively for Employees, as defined in Article II of the Cafeteria Plan. The Plan's purpose is to reimburse Covered Employees, as defined in Article II of this Appendix, for Dependent Care Expenses, as defined in Article II of this Appendix.

1.3 Qualification

The Plan is intended to qualify as a dependent care assistance program under Section 129 of the Internal Revenue Code of 1986, as amended (the "Code"). The Plan's reimbursements of Dependent Care Expenses are intended to be eligible for exclusion from Covered Employees' gross income under Code Section 129(a). This document is intended to satisfy the written plan document requirement of Code Section 129(d)(1).

1.4 Incorporation by Reference

The term Cafeteria Plan as used in this Appendix means the PAREXEL International Corporation Cafeteria Plan. The terms of the Cafeteria Plan are incorporated by reference wherever they apply to this Plan's operation to the extent such provisions do not conflict with the terms of this Plan.

1.5 Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, the Company, as defined in Article II of the Cafeteria Plan, in its sole discretion and in accordance with the provisions of Article VIII of the Cafeteria Plan may amend or terminate the Plan or any provision of the Plan.

ARTICLE II

DEFINITIONS

In this Appendix, references to an Article or Section refer to an Article or Section of this Appendix unless otherwise specified. When capitalized in this document, these words and phrases have the following meanings:

2.1 Covered Employee

Covered Employee means an Employee who satisfies the participation requirements of Article III.

2.2 Dependent Care Expenses

Dependent Care Expenses means expenditures for dependent care as described in Section 4.4.

2.3 Dependent Care Flexible Spending Account Plan

Dependent Care Flexible Spending Account means the notational account established on behalf of each Covered Employee who elects the Dependent Care Flexible Spending Account premium payment benefit under the Cafeteria Plan to which the Covered Employee allocates Salary Reduction Contributions for the reimbursement of Dependent Care Expenses.

2.4 Effective Date

Effective Date means the date this Plan becomes operative, which is the effective date identified in Article I of the PAREXEL International Corporation Cafeteria Plan.

2.5 Exclusions

Exclusions means the exclusions in Article V.

2.6 Maximum Annual Benefit

Maximum Annual Benefit means the total Salary Reduction Contributions a Covered Employee authorizes to his or her Dependent Care Flexible Spending Account, according to the election requirements of Article VI, for Dependent Care Expense reimbursement, which amount must be not more than $5,000 except as otherwise limited under Section 4.5(B).

2.7 Plan

Plan means the PAREXEL International Corporation Dependent Care Flexible Spending Account Plan as herein set forth and as amended from time to time.

2.8 Qualifying Individual

Qualifying Individual means an individual who is either:

A. The Covered Employee's child under age 13 and claimable as a personal exemption deduction under Code Section 152(a)(1) on the Covered Employee's federal income tax return; or

B. the Spouse of a Covered Employee who is *physically or mentally incapable of caring for him or herself*, and who resides with the Employee for more than half of the year; or

C. Any other relative or household member who is *physically or mentally incapable of caring for him or herself* and is a qualifying relative under Section 152 of the Code (without regard to subsections (b)(1), (b)(2) and (d)(1)(B)) and who resides with the Employee for more than half of the year.

Physically or mentally incapable of caring for him or herself means:

D. incapable of caring for one's own hygienic or nutritional needs, or

E. requiring another person's full-time attention for one's own safety or the safety of others.

Whether a person is *physically or mentally incapable of caring for him or herself* is determined on a daily basis.

ARTICLE III

PARTICIPATION

3.1 Participation

An Employee is a Covered Employee and participates in the Plan during those periods in which the Employee:

A. participates in the Cafeteria Plan, and

B. has allocated an amount to his or her Dependent Care Flexible Spending Account.

Except for Dependent Care Expenses incurred before Plan coverage ceases and subject to satisfying the procedural requirements of Article VI, no Plan benefits are payable after coverage terminates.

3.2 Termination of Participation

A Covered Employee shall cease to participate in the Plan when he or she is no longer a participant in the Cafeteria Plan, when the Covered Employee revokes his or her election to participate in the Plan, or when the Covered Employee terminates employment, retires or dies.

ARTICLE IV

DEPENDENT CARE REIMBURSEMENT BENEFIT

4.1 Right to Benefit

Subject to the following terms and limits and the Exclusions, Covered Employees are entitled to reimbursement for Dependent Care Expenses.

4.2 Maintenance of Accounts

The Plan Administrator shall maintain a Dependent Care Flexible Spending Account for each Employee who elects the Dependent Care Flexible Spending Account premium payment benefit. The Dependent Care Flexible Spending Account premium payment benefit that the Employee elected under the Cafeteria Plan shall be credited to the Employee's Dependent Care Flexible Spending Account on a pro-rata basis over the period for which the Employee's election is effective.

4.3 Amount Payable

Subject to the procedural requirements of Article VI, payable Dependent Care Expenses may not exceed the Dependent Care Flexible Spending Account premium payment benefit the Covered Employee authorized and which was credited in accordance with Section 4.2, less any payments previously made during the Plan Year — up to the Maximum Annual Benefit.

If any balance remains in a Covered Employee's Dependent Care Flexible Spending Account at the end of the Plan Year after all reimbursements have been made, such balance shall not be carried over to reimburse the Covered Employee for Dependent Care Expenses incurred during a subsequent Plan Year nor returned to the Covered Employee, and the Covered Employee shall forfeit all rights with respect to such balance. Any amounts forfeited under this Section 4.3 shall not be segregated or invested in an interest bearing account, but shall remain the property of the Employer to be used to pay administrative expenses, to cover expense losses, or used in any other manner as the Employer in its discretion, exercised in a uniform and nondiscriminatory manner, directs.

4.4 Dependent Care Expenses

Dependent Care Expenses means *employment-related* expenses that a Covered Employee *incurs* — while employed — for:

A. *Household services*, and

B. *Care* of a Qualifying Individual.

Employment-related, as defined in Code Section 21(b), means incurred to enable a Covered Employee to be gainfully employed. In the case of a married Covered Employee, to be employment-related, the expense must also enable the Covered Employee's Spouse to: be gainfully employed, actively seek gainful employment, or be a *full-time student*, unless the Spouse is described in Section 2.8(B).

Incurs refers to the date services resulting in employment-related expenses are provided — not the date charged, billed, or paid.

Household services means services ordinarily necessary to maintain a Covered Employee's home and rendered as part of a Qualifying Individual's *care*.

Care means services primarily to assure the well-being and protection of at least one Qualifying Individual.

Full-time student means a person enrolled at and attending an educational institution during at least part of each of five calendar months of the Covered Employee's tax year for the number of course hours that the institution considers to be a full-time course of study.

4.5 Limits

A. On What the Plan Pays

1. For Care Furnished Outside Covered Employee's Household

Dependent Care Expenses for care provided outside a Covered Employee's home or in a *Qualified Dependent Care Center* is reimbursed only if such care is furnished for a Qualifying Individual:

a. described in Section 2.8(A), or

b. described in Section 2.8(B) or (C) who regularly spends at least 8 hours each day in the Covered Employee's home.

Qualified Dependent Care Center means a facility:

c. in compliance with all applicable state and local laws and regulations, and

d. providing care for more than 6 persons (other than facility residents) on a regular, compensation-for-service basis.

2. To Certain "Highly Compensated" Employees

Benefits payable under the Plan to each highly compensated employee, as defined in Code Section 414(q), are limited to the extent necessary to avoid violating Code Section 129(d)(8).

B. On Exclusion from Gross Income

1. Individual Exclusion Limit

Plan reimbursement for Dependent Care Expenses is excludable from a Covered Employee's gross income only to the extent the Dependent Care Expense does not exceed:

a. the sum of the Covered Employee's actual Salary Reduction Contributions for the Plan Year,

or, if less,

b. the Maximum Annual Benefit.

2. Gross Income Exclusion Limit

The amount of dependent care expenses reimbursed during a Covered Employee's taxable year by all plans, including the Plan, that qualify as dependent care plans under Code Section 129 may not exceed:

a. $5,000 (or $2,500 for a married Covered Employee filing a separate federal income tax return),

or, if less,

b. the Covered Employee's *earned income* (or if less, the Covered Employee's Spouse's *earned income*, if the Covered Employee was married at the end of his or her tax year).

Earned income means wages, salaries, tips, and other compensation, to the extent such amounts are includible in taxable income for the year, like strike benefits, disability pay reported as wages, and net earnings from self-employment.

Earned income does not include pensions, annuities, social security payments, workers' compensation, unemployment compensation, or a nonresident alien's income not connected with United States business.

Earned income is computed without considering community property laws.

Earned income of a Spouse who is a full-time student, as defined in Section 4.4, or who is *physically or mentally incapable of caring for him or herself*, as defined in Article II of this Appendix, is deemed to be not less than $250 per month for Covered Employees with one Qualifying Individual or $500 per month for Covered Employees with two or more Qualifying Individuals.

3. Reporting Identifying Information Limit

Plan reimbursement for Dependent Care Expenses is excludable from a Covered Employee's gross income only if the Covered Employee reports on the federal income tax return to which the exclusion relates, the name, address, and taxpayer identification number (or other information acceptable to comply with federal reporting requirements) of each dependent care service provider furnishing dependent care services to the Covered Employee during the year.

ARTICLE V

EXCLUSIONS

5.1 General Rules

A. The Plan pays only those Dependent Care Expenses incurred by an Employee:

1. during the current Plan Year,

2. while the Employee is a Covered Employee, and

3. to allow the Covered Employee (and Spouse, if married) to continue gainful employment (or, if married and the Spouse is unemployed, to allow the Covered Employee's Spouse to actively seek gainful employment or be a full-time student, as defined in Section 4.4, unless the Spouse is described in Section 2.8(B) of this Appendix).

B. Except as provided in Section 5.1(A)(3), the Plan does not reimburse amounts paid for Dependent Care Expenses incurred while a Covered Employee (or Spouse, if married) is off work for any reason, including illness or vacation. However, if Dependent Care Expenses are paid to the dependent care services provider on a weekly or longer basis, Dependent Care Expenses incurred during a temporary absence from work for illness or vacation will not be subject to this exclusion.

5.2 Specific Exclusions

The Plan does not reimburse amounts paid in connection with:

A. a Qualifying Individual's overnight camp;

B. services rendered by:

1. a Covered Employee's (and if married, the Covered Employee's Spouse's) child (within the meaning of Code Section 152(c)(3)) under age 19 at the Plan Year's end,

2. a Covered Employee’s Spouse or parent of the Covered Employee’s child, or

3. a person for whom the Covered Employee (or if married, the Covered Employee's Spouse) is entitled to a federal income tax deduction under Code Section 151(c) for the Covered Employee's tax year.

5.3 Conditional Exclusions

Unless incidental, minimal, and inseparable from the cost of caring for a Qualifying Individual, the Plan shall not pay any charges in connection with a Qualifying Individual's:

A. food,

B. clothing,

C. entertainment,

D. education (kindergarten and above), or

E. transportation between the Covered Employee's home and the place where dependent care is provided unless such transportation is furnished by the dependent care provider.

ARTICLE VI

PROCEDURES

6.1 Enrollment and Election Procedures

Employees may enroll and make elections only by filing the appropriate, completed forms with the Plan Administrator within prescribed time limits. Rules and deadlines for enrolling and making or changing elections are stated in the Cafeteria Plan.

6.2 Claim Procedures

No claim for benefits shall be payable unless a properly completed claim form, including all necessary documentation of services received, is received by the Claim Administrator within 90 days following the Plan Year to which the claim relates. This period of time may be referred to as the "Runout Period".

6.3 Claim Administrator

The Plan Administrator and/or the Company shall have the authority to appoint, remove, and replace one or more Claim Administrators. A Claim Administrator shall have the duties, powers, and responsibilities set forth herein. In the absence of such an appointment and except as hereinafter provided, the Plan Administrator shall also be the Claim Administrator.

6.4 Claims Administration

The Claim Administrator shall have the duty to receive and review claims for benefits under the Plan, to determine what amount, if any, is due and payable under the terms and conditions of the Plan, and to make appropriate disbursements of benefit payments to persons entitled thereto.

6.5 Proof of Claim

As a condition of receiving Plan benefits, claimants must:

A. submit to the Claim Administrator:

1. a properly completed and timely filed claim form,

2. a written declaration stating the dependent care expense has not been reimbursed and is not reimbursable under any other dependent care plan, and

3. a written declaration from an independent third party stating the Covered Employee has incurred the dependent care expense and the amount of such expense; and

B. prove any claimed status.

APPENDIX B

PAREXEL INTERNATIONAL CORPORATION HEALTH CARE SPENDING ACCOUNT PLAN

ARTICLE I

PLAN ESTABLISHMENT

1.1 Effective Date

The PAREXEL International Corporation Health Care Flexible Spending Account Plan ("the Plan") is amended and restated as of the Effective Date, as defined in Article I of the PAREXEL International Corporation Cafeteria Plan.

1.2 Purpose

The Plan is created exclusively for Employees, as defined in Article II of the Cafeteria Plan. The Plan's purpose is to reimburse Covered Employees, as defined in Article II of this Appendix, for Qualifying Medical Expenses, as defined in Article II of this Appendix.

1.3 Qualification

A. ERISA

The Plan is an *employee welfare benefit plan*, as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This document is intended to satisfy the written plan document requirement of ERISA Section 402.

B. Internal Revenue Code

The Plan is intended to qualify as a health plan under Section 105(e) of the Internal Revenue Code of 1986, as amended ("the Code"). The Plan's Qualifying Medical Expense reimbursements are intended to be eligible for exclusion from Covered Employees' gross income under Code Section 105(b). This document is intended to satisfy the written plan document requirement of Treasury regulations Section 1.105-11(b)(1)(i).

1.4 Incorporation by Reference

The term Cafeteria Plan as used in this Appendix means the PAREXEL International Corporation Cafeteria Plan. The terms of the Cafeteria Plan are incorporated by reference wherever they apply to this Plan's operation, to the extent such provisions do not conflict with the provisions of this Plan.

1.5 Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, Company, as defined in Article II of the Cafeteria Plan, in its sole discretion and in accordance with the provisions of Article VIII of the Cafeteria Plan may amend or terminate the Plan or any provision of the Plan.

ARTICLE II

DEFINITIONS

In this Appendix, references to an Article or Section refer to an Article or Section of this Appendix unless otherwise specified. When capitalized in this document, these words and phrases have the following meanings:

2.1 Covered Employee

Covered Employee means an Employee who satisfies the participation requirements of Article III.

2.2 Dependent

Dependent means a Covered Employee's:

A. Spouse, and

B. dependent(s) as defined in Code Section 152 (without regard to (b)(1), (b)(2), and (d)(1)(B)), and

C. the Covered Employee's child as defined in Code Section 152(f)(1) who has not attained age 27 as of the end of the taxable year.

2.3 Effective Date

Effective Date means the date this Plan becomes operative, which is the effective date identified in Article I of the PAREXEL International Corporation Cafeteria Plan.

2.4 Exclusions

Exclusions means the exclusions in Article V.

2.5 Health Care Flexible Spending Account

Health Care Flexible Spending Account means the notational account established on behalf of each Covered Employee who elects the Health Care Flexible Spending Account premium payment benefit under the Cafeteria Plan to which the Covered Employee allocates Salary Reduction Contributions for the reimbursement of Qualifying Medical Expenses.

2.6 Maximum Annual Benefit

Maximum Annual Benefit means the total Salary Reduction Contributions a Covered Employee authorizes to his or her Health Care Flexible Spending Account, according to the election procedures of Section 7.1, for Qualifying Medical Expense reimbursement, which amount must be not more than an amount communicated annually by the Plan Administrator, which amount shall not exceed the maximum amount allowed under Section 125 of the Code.

2.7 Plan

Plan means the PAREXEL International Corporation Health Care Flexible Spending Account Plan as herein set forth and as amended from time to time.

2.8 Qualifying Medical Expenses

Qualifying Medical Expenses means a Covered Employee's and a Dependent's expenses *incurred* during the Plan Year for medical care, as defined in Code Section 213(d)(1)(A) and (B). However, the Plan will allow a grace period of two and one half months following the end of the Plan Year in which Covered Employees and Dependents may incur Qualifying Medical Expenses to be reimbursed under the current Plan Year's election. To be a Qualifying Medical Expense, the medical care must be essential to diagnose, cure, mitigate, treat, or prevent a disease or disorder or to affect an unsound structure or function of the mind or body. *Incurred* refers to the date the medical care is provided — not to the date charged, billed, or paid.

ARTICLE III

PARTICIPATION

3.1 Participation

An Employee is a Covered Employee and participates in the Plan during those periods in which the Employee:

A. participates in the Cafeteria Plan, and

B. has allocated an amount to his or her Health Care Flexible Spending Account.

Except for Qualifying Medical Expenses incurred before Plan coverage ceases and subject to satisfying the procedural requirements of Article VII, no Plan benefits are payable after coverage terminates.

3.2 Termination of Participation

A Covered Employee shall cease to participate in the Plan when he or she is no longer eligible to participate in the Cafeteria Plan, when the Covered Employee revokes his or her election to participate in the Plan, or when the Covered Employee terminates employment, retires or dies.

ARTICLE IV

MEDICAL EXPENSE BENEFIT

4.1 Right to Benefit

Subject to the following terms and limits and the Exclusions, Covered Employees are entitled to reimbursement for Qualifying Medical Expenses.

4.2 Maintenance of Accounts

The Plan Administrator shall maintain a Health Care Flexible Spending Account for each Employee who elects the health care spending account premium payment benefit. The health care spending account premium payment benefit elected by the Employee shall be credited to his or her Health Care Flexible Spending Account as of the first day that the Employee's election is effective.

4.3 Amount Payable

Subject to the procedural requirements of Article VII, payable Qualifying Medical Expenses may not exceed the health care spending account premium payment benefit the Covered Employee elected to be credited to his or her Health Care Flexible Spending Account for the Plan Year, less any payments previously made during the Plan Year — up to the Maximum Annual Benefit.

4.4 Qualifying Medical Expenses

Qualifying Medical Expenses, as defined in Article II of this Appendix, that are not covered by any other health plan and include, for example, expenses for:

A. abortion, if legal where performed

B. acupuncture

C. ambulance service

D. birth control pills

E. breast pumps and supplies that assist lactation

F. capital expenses for home improvements and special equipment installed in the car or home, if the main reason for the improvement or equipment is for medical care, but only to the extent the expenditure exceeds any increase in the improved property's value

G. Christian Science practitioners

H. crutches

I. dental treatment

J. doctor's fees including, but not limited to: anesthesiologists, gynecologists, chiropodists, chiropractors, dermatologists, neurologists, obstetricians, ophthalmologists, osteopaths, podiatrists, pediatricians, psychiatrists, and psychologists

K. eye examinations, eyeglasses, and contact lenses

L. hearing examinations and hearing aids

M. hospital services

N. laboratory fees and diagnostic testing

O. mental health treatment

P. nursing home services, including meals and lodging

Q. nursing services

R. organ transplant expenses

S. over-the-counter drugs or items only as permitted under applicable law or regulation

T. oxygen and oxygen equipment

U. prescription drugs

V. prostheses

W. smoking cessation products

X. special schooling and equipment for the mentally or physically handicapped

Y. sterilization

Z. substance abuse treatment

AA. surgery

BB. therapy

CC. transportation for medical reasons

DD. wheelchairs

EE. X-ray fees

4.5 Limits

The Plan reimburses Qualifying Medical Expenses only to the extent the charge is not compensated for by any prepaid health coverage, group health plan, medical insurance, or otherwise. Qualifying Medical Expenses may include certain deductibles and co-payments if not reimbursed through coordination of benefits with a secondary payor.

ARTICLE V

EXCLUSIONS

5.1 General Rules

A. The Plan pays only those Qualifying Medical Expenses incurred by an Employee or the Employee's Dependent:

1. during the current Plan Year, except that, the Plan will allow a grace period of two and one half months following the end of the Plan Year in which Covered Employees may incur Qualifying Medical Expenses for reimbursement from amounts remaining unused at the end of the immediately preceding Plan Year. This reimbursement will be treated as if the expenses had been incurred in the prior year, and

2. while the Employee is a Covered Employee.

B. The Plan does not reimburse amounts paid for services or supplies that merely improve health or morale generally.

5.2 Specific Exclusions

The Plan does not reimburse amounts paid in connection with:

A. cosmetic surgery or similar procedure unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease

B. custodial or domiciliary care

C. diaper service

D. funeral and burial expenses

E. health club membership fees and dues

F. household and domestic help

G. illegal services and supplies

H. insurance premiums of any kind including those for health maintenance organizations, life insurance, long term care, loss of earnings, accidental death or dismemberment, automobile insurance, and group medical or other health insurance

I. meals and lodging at a non-medical facility

J. maternity clothes or uniform

K. nursing services for a normal, healthy newborn baby, except for breast pumps and supplies that assist lactation

L. over-the-counter or nonprescription drugs or items unless specifically permitted under applicable law or regulation

M. personal use items like cosmetics, toiletries, and items for personal hygiene or beautification

N. schooling or tuition for scholastic improvement or discipline

O. social activities like dancing or swimming lessons

P. special foods or dietary supplements like vitamins, minerals, bottled water, and diet foods

Q. transportation for non-medical reasons

R. trips or vacations

S. long term care expenses

ARTICLE VI

COBRA CONTINUATION COVERAGE

6.1 Eligibility for Continuation Coverage

Certain Employees and Dependents shall have the right to purchase continuation coverage under this Plan in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, Title X (COBRA), provided such individuals were Covered Persons under the Plan on the date immediately preceding the date of a Qualifying Event or become Covered Persons during the continuation period because such Dependent is born to or placed for adoption with the Employee.

COBRA rights are explained in detail in the PAREXEL International Corporation Health and Welfare Plan Wrap Around Summary Plan Description and applicable Incorporated Documents.

ARTICLE VII

PROCEDURES

7.1 Enrollment and Election Procedures

Employees may enroll and make elections only by filing the appropriate, completed forms, whether paper or electronic, with the Plan Administrator within prescribed time limits. Rules and deadlines for enrolling and making or changing elections are stated in the Cafeteria Plan.

7.2 Claim Administrator

The Plan Administrator and/or the Company shall have the authority to appoint, remove, and replace one or more Claim Administrators. A Claim Administrator shall have the duties, powers, and responsibilities set forth herein. In the absence of such an appointment and except as hereinafter provided, the Plan Administrator shall also be the Claim Administrator.

7.3 Claims Administration

The Claim Administrator shall have the duty to receive and review claims for benefits under the Plan, to determine what amount, if any, is due and payable under the terms and conditions of the Plan, and to make appropriate disbursements of benefit payments to persons entitled thereto.

7.4 Claimants

A Covered Employee (or his or her duly authorized representative) may file a claim for benefits to which such claimant believes he or she is entitled.

7.5 Claim Forms

The Claim Administrator shall furnish to a claimant, upon request, the form(s) required for filing a claim for benefits under the Plan.

7.6 Deadline for Filing a Claim

No claim for benefits shall be payable unless a properly completed claim, including all necessary documentation of services or supplies received, is received by the Claim Administrator within 90 days following the Plan Year to which the claim relates. This period of time may be referred to as the “Runout Period”.

Failure to submit a properly completed claim form within the prescribed period shall neither invalidate nor reduce a claim if it is shown that it was not reasonably possible to furnish the claim form within that time and that the claim form was submitted as soon as reasonably possible.

7.7 Proof of Claim

As a condition of receiving Plan benefits, claimants must:

A. submit to the Claim Administrator:

1. a properly completed and timely filed claim form,

2. a written declaration stating the Qualifying Medical Expense has not been reimbursed and is not reimbursable under any other health plan, and

3. a written declaration from an independent third party stating the Covered Employee has incurred the medical expense and the amount of such expense; and

B. prove any claimed status.

7.8 Decision on the Claim

The Plan has up to 30 days, to evaluate and process claims for benefits covered by ERISA. The 30-day period begins on the date the claim is first filed. This period may be extended by 15 days provided the Claim Administrator or its delegate determines that an extension is necessary due to matters beyond the control of the Plan and notifies the claimant within the initial period, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. The claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A. Notification of Denial

An "adverse benefit determination" is a denial, reduction or termination of a benefit, failure to provide or pay for (in whole or in part) a benefit, a denial to participate in the Plan, or a claim denial on the grounds that the treatment is experimental, investigational or not medically necessary. This also includes concurrent care determinations.

In the event of an adverse benefit determination, the claimant will receive notice of the determination.

If a claim is denied, in whole or in part, the claimant shall be notified of the adverse benefit determination in writing. The notice of adverse benefit determination shall contain the following information:

1. the specific reason(s) for the adverse benefit determination;

2. a reference to the specific provision(s) in the Plan on which the adverse benefit determination is based;

3. a description of additional material or information necessary to perfect the claim and an explanation of why the material or information is needed;

4. a description of the Plan's claim and appeal procedures and applicable timeframes;

5. a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA after the Plan's appeal procedure (set forth below) has been exhausted;

6. if any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and

7. for adverse benefit determinations based on medical necessity, experimental treatment, or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

7.9 Right to Appeal

A claimant who has received an adverse benefit determination or is otherwise adversely affected by action of the Claim Administrator, shall have the right to request review of the claim. Such request must be in writing and must be made within 180 days after such claimant is advised of the Claim Administrator's action. If written request for review is not made within the 180-day period, the claimant shall forfeit his or her right to review. The claimant or a duly authorized representative of the claimant may review all relevant information and submit issues and comments in writing.

The Claim Administrator or Plan Administrator or its delegate, as applicable, shall then review the claim. It shall issue a written decision reaffirming, modifying, or setting aside its former action within a reasonable period of time, but not later than sixty (60) days after receipt of the request for review (or 30 days following each appeal if there are two mandatory appeals).

A copy of the review determination shall be furnished to the claimant. If the claim is denied, the review determination notice shall contain the following information:

A. the specific reason(s) for the adverse benefit determination;

B. a reference to the specific provision(s) in the Plan on which the adverse benefit determination is based;

C. a statement that the claimant is entitled to receive, upon request and free of charge, reasonable access and copies of all relevant information;

D. a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA;

E. a description of any voluntary appeals procedures offered by the Plan, if any;

F. a statement that the claimant has the right to obtain information about the voluntary appeals process, if any, and information as to how the claimant may obtain information about alternative dispute resolution options from the Department of Labor or state regulators;

G. if any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse benefit determination, either the specific rule, guideline, protocol, or other similar criteria or a statement that a copy of such information will be made available free of charge upon request; and

H. for adverse benefit determinations based on medical necessity, experimental treatment, or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request.

Upon request by the claimant, the Plan will provide for the identification of experts whose advice was obtained on behalf of Plan in connection with an adverse determination, without regard to whether the advice was relied on in making the determination.

In deciding an appeal of any adverse benefit determination based in whole or in part on a medical judgment, the Claim Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and such individual shall not have been consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual. In deciding an appeal, no deference shall be afforded to the initial adverse benefit determination and the review of the appeal shall be conducted by an appropriate named fiduciary of the Plan who is neither the

individual who made the adverse benefit determination that is the subject of the appeal nor the subordinate of such individual.

The decision shall be final and binding upon the claimant and all other persons or entities involved, except to the extent that the Plan provides for a voluntary appeals procedure subsequent to this appeals process, or the decision is subject to judicial review.

7.10 Legal Remedy

Before pursuing a legal remedy, a claimant shall first exhaust all claims, review, and appeals procedures required under the Plan.

7.11 Payment Procedures

A. Payment of Claim

Subject to Section 9.4 of the Cafeteria Plan, benefits shall be payable to the claimant upon establishment of the right thereto. Notwithstanding the foregoing, if a claimant is adjudicated bankrupt or purports to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge any benefit payable under the Plan, voluntarily or involuntarily, the Claim Administrator, in its sole discretion, may hold or cause to be held, or apply such payment of benefit, or any part thereof, to or for the benefit of such claimant as the Claim Administrator deems appropriate.

B. Facility of Payment

If a claimant dies before all amounts payable under the Plan have been paid, or if the Claim Administrator determines that the claimant is a minor or is incompetent or incapable of executing a valid receipt and no guardian or legal representative has been appointed, or if the claimant fails to provide the Plan with a forwarding address, the amount otherwise payable to the claimant may be paid to any other person or institution reasonably determined by the Claim Administrator to be entitled equitably thereto and without prejudice therefore. Any payment made in accordance with this provision shall discharge the obligation of the Plan hereunder to the extent of such payment.

C. Forfeiture

The Claim Administrator shall take reasonable steps to ascertain the whereabouts of a claimant so as to effect delivery of benefits payable under the Plan. If a claimant has not collected benefits payable to him or her within 15 months from the date the claim was filed, the Claim Administrator may, three months after sending by certified mail a written notice of benefits to the last known address of such claimant as shown on the records of the Administrator, deem the claimant's right to such benefit waived. Upon such waiver, the Plan shall have no liability for payment of the benefit otherwise payable.

ARTICLE VIII

HIPAA PRIVACY AND SECURITY

8.1 Definitions

For purposes of this Article VIII, the following terms have the following meanings:

A. "Business Associate" means a person or entity that performs a function or activity regulated by HIPAA on behalf of the group health plans provided under the Plan and involving individually identifiable health information. Examples of such functions or activities are claims processing, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation and financial services. A Business Associate may be a Covered Entity. However, Insurers and HMOs are not Business Associates of the plans they insure. A person or entity that transmits PHI to a covered entity (or its business associate) and routinely requires access to that PHI may also be a business associate. Examples of such entities include health information exchange organizations, regional health information organizations and e-prescribing gateways. Vendors that contract with covered entities offering certain personal health records to individuals may also be considered business associates, and vendors that contract with Business Associates ("subcontractors") and require or have access to PHI or ePHI on a routine basis may also be Business Associates with respect to the Plan.

B. "Covered Entity" means a group health plan (including an employer plan, Insurer, HMO and government coverage such as Medicare); a health care provider (such as a doctor, hospital or pharmacy) that electronically transmits any health information in connection with a transaction for which the U.S. Department of Health and Human Services has established an electronic data interchange standard; and a health care clearinghouse (an entity that translates electronic information between nonstandard and HIPAA standard transactions).

C. "Protected Health Information or PHI" means individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. Information is "individually identifiable" if it names the individual person or there is a reasonable basis to believe components of the information could be used to identify the individual. "Health Information" means information, including genetic information, whether oral or recorded in any form or medium, that (i) is created by a health care provider, health care plan, employer, life insurer, public health authority, health care clearinghouse, or school or university; and (ii) relates to the past, present, or future physical or mental health or condition of a person, the provision of health care to a person; or the past, present or future payment for health care.

8.2 Uses and Disclosures of PHI

The Plan may disclose a Covered Employee's PHI or ePHI to the Plan Sponsor (or to the agent of the Plan Sponsor) for the plan administration functions under 45 CFR §164.504(a), to the extent not inconsistent with the HIPAA regulations. The Plan will not disclose PHI or ePHI to the Plan Sponsor except upon receipt of a certification by the Plan Sponsor that the Plan incorporates the agreements of Sections 8.3 and 8.4, except as otherwise permitted or required by law.

8.3 Privacy Agreements of the Plan Sponsor

As a condition for obtaining PHI from the Plan and its Business Associates, the Plan Sponsor agrees it will:

A. Not use or further disclose such PHI other than as permitted by Section 8.2, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

B. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

C. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

D. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware, including reporting any breach of unsecured PHI;

E. Make the PHI of a particular participant available for purposes of the participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;

F. Make the PHI of a particular participant available for purposes of required accounting of disclosures by the Plan Sponsor pursuant to the participant's request for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;

G. Make the Plan Sponsor's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

H. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

I. Ensure that there is adequate separation between the Plan and the Plan Sponsor by implementing the terms of subparagraphs (1) through (3), below:

   1. Employees With Access to PHI: The employees, classes of former employees or other individuals under the control of the Plan Sponsor listed on Schedule A are the only individuals that may access PHI received from the Plan.

   2. Use Limited to Plan Administration: The access to and use of PHI by the individuals described in (1), above, is limited to plan administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the Plan Sponsor for the Plan.

   3. Mechanism for Resolving Noncompliance: If the Plan Sponsor or the persons listed on Schedule A who are responsible for monitoring compliance determine that any person described in (1), above, has violated any of the restrictions of this Article VIII,

then such individual shall be disciplined in accordance with the policies of the Plan Sponsor established for purposes of privacy and security compliance, up to and including dismissal from employment. The Plan Sponsor shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

J. Notify participant(s) of an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information (a "Breach") without unreasonable delay in a report which includes the following information:

1. the circumstances surrounding the Breach;

2. the date of the Breach and the date of its discovery;

3. the information Breached;

4. any steps the impacted individuals should take to protect themselves;

5. the steps the Company is taking to investigate the Breach, mitigate losses, and protect against future Breaches; and

6. a contact person who can provide additional information about the Breach.

The Company will cooperate with participant(s) in the investigation of, and response to, the Breaches it reports to participant(s). For this purpose, the term "Breach" means an unauthorized acquisition, access, use or disclosure of PHI that compromises the security or privacy of the information.

Notwithstanding the foregoing, the terms of this Article VIII shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504(f)(1)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations.

8.4 Security Agreements of the Plan Sponsor

As a condition of obtaining e-PHI from the Plan, its Business Associates, Insurers and HMOs, the Employer agrees it will:

A. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

B. Ensure that the adequate separation between the Plan and the Plan Sponsor as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

C. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;

D. Report to the Plan any security incident of which it becomes aware. For purposes of this Amendment, security incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the e-PHI; and

E. Upon request from the Plan, the Plan Sponsor agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Plan Sponsor.

SCHEDULE A

EMPLOYEES APPROVED TO HAVE ACCESS TO PROTECTED HEALTH INFORMATION

Angela Farmer, Senior Director of Compensation & Benefits EME

Nancy Scicchitani, Benefits Manager, North America

Shayna Hedrick, Leave of Absence Analyst, North America

Jane Martiny, Benefits Consultant, North America

Thomas Gallant, Benefits Analyst, North America

Yasmin Portreal, Compensation & Benefits Associate

James Maddock, Senior Manager, HRIS

Nicki Walsh, Payroll Manager, North America

APPENDIX C

PAREXEL INTERNATIONAL CORPORATION COMBINATION LIMITED PURPOSE HEALTH CARE FLEXIBLE SPENDING ACCOUNT PLAN

ARTICLE I

PLAN ESTABLISHMENT

1.1 Effective Date

The PAREXEL International Corporation Combination Limited Purpose Health Care Flexible Spending Account Plan ("the Plan") is amended and restated as of the Effective Date as defined in Article I of the PAREXEL International Corporation Cafeteria Plan.

1.2 Purpose

The Plan is created exclusively for Employees, as defined in Article II of the Cafeteria Plan. The Plan's purpose is to reimburse Covered Employees, as defined in Article II of this Appendix, for Qualifying Medical Expenses, as defined in Article II of this Appendix.

1.3 Qualification

A. ERISA

The Plan is an *employee welfare benefit plan*, as defined in the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This document is intended to satisfy the written plan document requirement of ERISA Section 402.

B. Internal Revenue Code

The Plan is intended to qualify as a health plan under Section 105(e) of the Internal Revenue Code of 1986, as amended ("the Code"). The Plan's Qualifying Medical Expense reimbursements are intended to be eligible for exclusion from Covered Employees' gross income under Code Section 105(b). This document is intended to satisfy the written plan document requirement of Treasury regulations Section 1.105-11(b)(1)(i).

1.4 Incorporation by Reference

The term Cafeteria Plan as used in this Appendix means the PAREXEL International Corporation Cafeteria Plan. The terms of the Cafeteria Plan are incorporated by reference wherever they apply to this Plan's operation, to the extent such provisions do not conflict with the provisions of this Plan.

1.5 Duration

The Plan is established with the intention of being maintained for an indefinite period of time; however, Company, as defined in Article II of the Cafeteria Plan, in its sole discretion and in accordance with the provisions of Article VIII of the Cafeteria Plan may amend or terminate the Plan or any provision of the Plan.

ARTICLE II

DEFINITIONS

In this Appendix, references to an Article or Section refer to an Article or Section of this Appendix unless otherwise specified. When capitalized in this document, these words and phrases have the following meanings:

2.1 Covered Employee

Covered Employee means an Employee who satisfies the participation requirements of Article III.

2.2 Dependent

Dependent means a Covered Employee's:

A. Spouse, and

B. dependent(s) as defined in Code Section 152 (without regard to (b)(1), (b)(2), and (d)(1)(B)), and

C. the Covered Employee's child as defined in Code Section 152(f)(1) who has not attained age 27 as of the end of the taxable year.

2.3 Effective Date

Effective Date means the date this Plan becomes operative, which is the effective date identified in Article I of the PAREXEL International Corporation Cafeteria Plan.

2.4 Exclusions

Exclusions means the exclusions in Article V.

2.5 Combination Limited Purpose Health Care Flexible Spending Account

Combination Limited Purpose Health Care Flexible Spending Account means the notational account established on behalf of each Covered Employee who elects the Combination Limited Purpose Health Care Flexible Spending Account premium payment benefit under the Cafeteria Plan to which the Covered Employee allocates Salary Reduction Contributions for the reimbursement of Qualifying Medical Expenses.

2.6 Maximum Annual Benefit

Maximum Annual Benefit means the total Salary Reduction Contributions a Covered Employee authorizes to his or her Health Care Flexible Spending Account, according to the election procedures of Section 7.1, for Qualifying Medical Expense reimbursement, which amount must be not more than an amount communicated annually by the Plan Administrator, which amount shall not exceed maximum amount allowed under Section 125 of the Code.

2.7 Plan

Plan means the PAREXEL International Corporation Combination Limited Purpose Health Care Flexible Spending Account Plan as herein set forth and as amended from time to time.

2.8 Qualifying Medical Expenses

Qualifying Medical Expenses means a Covered Employee's and a Dependent's expenses *incurred* during the Plan Year for medical care, as defined in Code Section 213(d)(1)(A) and (B). The Plan will allow a grace period of two and one half months following the end of the Plan Year in which Covered Employees and Dependents may incur Qualifying Medical Expenses to be reimbursed under the current Plan Year's election.

Notwithstanding any other Plan provision, medical expenses that are not dental, vision or preventive care expenses, except to the extent that they exceed the minimum deductible for a high deductible health plan in Code Section 223(c)(2)(A), as indexed, are not considered Qualifying Medical Expenses under this Plan. To be a Qualifying Medical Expense, the medical care must be essential to diagnose, cure, mitigate, treat, or prevent a disease or disorder or to affect an unsound structure or function of the mind or body. *Incurred* refers to the date the medical care is provided — not to the date charged, billed, or paid.

ARTICLE III

PARTICIPATION

3.1 Participation

An Employee is a Covered Employee and participates in the Plan during those periods in which the Employee:

A. participates in the Cafeteria Plan, and

B. has allocated an amount to his or her Combination Limited Purpose Health Care Flexible Spending Account.

Except for Qualifying Medical Expenses incurred before Plan coverage ceases and subject to satisfying the procedural requirements of Article VII, no Plan benefits are payable after coverage terminates.

3.2 Termination of Participation

A Covered Employee shall cease to participate in the Plan when he or she is no longer eligible to participate in the Cafeteria Plan, when the Covered Employee revokes his or her election to participate in the Plan, or when the Covered Employee terminates employment, retires or dies.

ARTICLE IV

MEDICAL EXPENSE REIMBURSEMENT BENEFIT

4.1 Right to Benefit

Subject to the following terms and limits and the Exclusions, Covered Employees are entitled to reimbursement for Qualifying Medical Expenses.

4.2 Maintenance of Accounts

The Plan Administrator shall maintain a Combination Limited Purpose Health Care Flexible Spending Account for each Employee who elects the health care spending account premium payment benefit. The Combination Limited Purpose health care spending account premium payment benefit elected by the Employee shall be credited to his or her Combination Limited Purpose Health Care Flexible Spending Account as of the first day that the Employee's election is effective.

4.3 Amount Payable

Subject to the procedural requirements of Article VII, payable Qualifying Medical Expenses may not exceed the health care spending account premium payment benefit the Covered Employee elected to be credited to his or her Health Care Flexible Spending Account for the Plan Year, less any payments previously made during the Plan Year — up to the Maximum Annual Benefit.

4.4 Qualifying Medical Expenses

Qualifying Medical Expenses, as defined by Article II, must be dental, vision, or preventive care expenses. The following are examples of Qualifying Medical Expenses to the extent they are not covered by any other health plan and meet the limitations described below:

A. Vision Expenses

1. Eyeglasses
2. Contact lenses
3. Ophthalmologist fees
4. The cost of a guide dog for the blind and special education devices for the blind (such as an interpreter)

B. Dental Expenses

1. Anesthesia

2. Cleaning

3. Charges in excess of Usual and Prevailing Fee Limits

4. Drugs and their administration

5. Experimental procedures

6. Extra sets of dentures or other Dental appliances

7. Medically Necessary orthodontia expenses for adults or dependents

8. Myofunctional therapy

9. Replacement of dentures or bridgework

10. Replacement of lost, stolen, or missing dentures or orthodontic devices

C. Preventive Care Expenses

D. Post-Deductible Expenses

Qualifying Medical Expenses, as defined in Article II of this Appendix, that are not covered by any other health plan, may also include expenses such as the following, but only to the extent they exceed the deductible for a high deductible health plan in Code Section 223(c)(2)(A) as indexed:

1. abortion, if legal where performed

2. acupuncture

3. ambulance service

4. birth control pills

5. breast pumps and supplies that assist lactation

6. capital expenses for home improvements and special equipment installed in the car or home, if the main reason for the improvement or equipment is for medical care, but only to the extent the expenditure exceeds any increase in the improved property's value

7. Christian Science practitioners

8. crutches

9. dental treatment

10. doctor's fees including, but not limited to: anesthesiologists, gynecologists, chiropodists, chiropractors, dermatologists, neurologists, obstetricians, ophthalmologists, osteopaths, podiatrists, pediatricians, psychiatrists, and psychologists

11. hearing examinations and hearing aids
12. hospital services
13. laboratory fees and diagnostic testing
14. mental health treatment
15. nursing home services, including meals and lodging
16. nursing services
17. organ transplant expenses
18. over-the-counter drugs or items only as permitted under applicable law or regulation
19. oxygen and oxygen equipment
20. prescription drugs
21. prostheses
22. smoking cessation products
23. special schooling and equipment for the mentally or physically handicapped
24. sterilization
25. substance abuse treatment
26. surgery
27. therapy
28. transportation for medical reasons
29. wheelchairs
30. X-ray fees

4.5 Limits

The Plan reimburses Qualifying Medical Expenses only to the extent the charge is not compensated for by any prepaid health coverage, group health plan, medical insurance, or otherwise. Qualifying Medical Expenses may include certain deductibles and co-payments if not reimbursed through coordination of benefits with a secondary payor.

ARTICLE V

EXCLUSIONS

5.1 General Rules

A. The Plan pays only those Qualifying Medical Expenses incurred by an Employee or the Employee's Dependent:

1. during the current Plan Year, except that, the Plan will allow a grace period of two and one half months following the end of the Plan Year in which Covered Employees may incur Qualifying Medical Expenses for reimbursement from amounts remaining unused at the end of the immediately preceding Plan Year. This reimbursement will be treated as if the expenses had been incurred in the prior year**;** and

2. while the Employee is a Covered Employee.

B. The Plan does not reimburse amounts paid for services or supplies that merely improve health or morale generally.

5.2 Specific Exclusions

The Plan does not reimburse amounts that are not paid for dental, vision, or preventive services except to the extent that the amounts exceed the deductible for a high deductible health plan as specified in Code Section 223(c)(2)(A), as indexed. Certain expenses will not be reimbursed, under any circumstances, including:

A. cosmetic surgery or similar procedure unless the surgery or procedure is necessary to ameliorate a deformity arising from or directly related to a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease

B. custodial or domiciliary care

C. diaper service

D. funeral and burial expenses

E. health club membership fees and dues

F. household and domestic help

G. illegal services and supplies

H. insurance premiums of any kind including those for health maintenance organizations, life insurance, long term care, loss of earnings, accidental death or dismemberment, automobile insurance, and group medical or other health insurance

I. meals and lodging at a non-medical facility

J. maternity clothes or uniform

K. nursing services for a normal, healthy newborn baby, except for breast pumps and supplies that assist lactation

L. over-the-counter or nonprescription drugs or items unless specifically permitted under applicable law or regulation

M. personal use items like cosmetics, toiletries, and items for personal hygiene or beautification

N. schooling or tuition for scholastic improvement or discipline

O. social activities like dancing or swimming lessons

P. special foods or dietary supplements like vitamins, minerals, bottled water, and diet foods

Q. transportation for non-medical reasons

R. trips or vacations

S. long term care expenses

ARTICLE VI

COBRA CONTINUATION COVERAGE

6.1 Eligibility for Continuation Coverage

Certain Employees and Dependents shall have the right to purchase continuation coverage under this Plan in accordance with the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272, Title X (COBRA), provided such individuals were Covered Persons under the Plan on the date immediately preceding the date of a Qualifying Event or become Covered Persons during the continuation period because such Dependent is born to or placed for adoption with the Employee.

COBRA rights are explained in detail in the PAREXEL International Corporation Health and Welfare Plan Wrap Around Summary Plan Description and applicable Incorporated Documents.

ARTICLE VII

PROCEDURES

7.1 Procedures

The provisions of Article VII of Appendix B of the PAREXEL International Corporation Cafeteria Plan apply in their entirety to the Plan, as defined in Article II.

ARTICLE VIII

HIPAA PRIVACY AND SECURITY

8.1 HIPAA Privacy and Security

The provisions of Article VIII of Appendix B of the PAREXEL International Corporation Cafeteria Plan apply in their entirety to the Plan, as defined in Article II.

APPENDIX D

PAREXEL INTERNATIONAL CORPORATION HEALTH SAVINGS ACCOUNT

ARTICLE I

PLAN ESTABLISHMENT

1.1 Trustee/Custodial Agreement

Health Savings Account benefits under the Cafeteria Plan consist solely of the ability to make contributions to the Health Savings Account pursuant to the Salary Reduction Agreement. Terms and conditions of coverage and benefits (e.g., eligible medical expenses, claims procedures, etc.) will be provided by the applicable trustee/custodian for the Health Savings Account, not this Cafeteria Plan. The terms and conditions of each Covered Employee's Health Savings Account trust or custodial account are described in the Health Savings Account trust or custodial agreement provided by the applicable trustee/custodian to each electing Covered Employee and are not a part of this Plan.

1.2 Health Savings Account Not Intended to be an ERISA Plan

The Health Savings Account is not an employer-sponsored employee benefits plan. It is a savings account that is established and maintained by a Health Savings Account trustee/custodian outside this Plan to be used primarily for reimbursement of "qualified medical expenses" as set forth in Code Section 223(d)(2). The Employer has no authority or control over the funds deposited in a Health Savings Account. Even though this Cafeteria Plan may allow contributions to a Health Savings Account through salary reductions, the Health Savings Account is not intended to be an ERISA benefit plan sponsored or maintained by the Employer.

1.3 Incorporation By Reference

The term Cafeteria Plan as used in this Appendix means the Cafeteria Plan as defined in Section 1.3 of the PAREXEL International Corporation Cafeteria Plan. The terms of the Cafeteria Plan are incorporated by reference wherever they apply to this Plan's operation, to the extent such provisions do not conflict with the provisions of this Plan.

ARTICLE II

DEFINITIONS

In this Appendix, references to an Article or Section refer to an Article or Section of this Appendix, unless otherwise specified. When capitalized in this document, these words and phrases have the following meanings:

2.1 Covered Employee

Covered Employee means an Employee who satisfies the participation requirements of Article III.

2.2 Health Savings Account (HSA)

An individual trust or custodial account established under Code Section 223 by a Covered Employee with a trustee/custodian that has contracted with the Company to receive pre-tax salary reduction contributions. Although funded by Salary Reduction Contributions under the Cafeteria Plan, the Health Savings Account is not part of or intended to be part of an ERISA-covered benefit plan.

ARTICLE III

PARTICIPATION

3.1 Participation

An Employee is a Covered Employee and participates in the Health Savings Account during those periods in which the Employee:

A. participates in the Cafeteria Plan and an Employer-sponsored high deductible health plan that meets the requirements of Section 223; and

B. has elected the Health Savings Account Premium Payment Benefit as described in Article IV of the Cafeteria Plan.

ARTICLE IV

HEALTH SAVINGS ACCOUNT BENEFIT

4.1 Contributions for Cost of Coverage for HSA/Maximum Limits

The annual contribution for a Covered Employee's Health Savings Account is equal to the annual benefit amount elected by the Health Savings Account, but in no event shall the amount elected exceed the statutory maximum amount for HSA contributions applicable to the Covered Employee's high-deductible health plan coverage option (i.e., single or family) for the calendar year in which the contribution is made. An additional catch-up contribution of up to $1,000 may be made for Covered Employees who are age 55 or older as of the end of the taxable year.

In addition, the maximum annual contribution shall be:

A. reduced by any Employer contribution made on the Covered Employee's behalf; and

B. prorated for the number of months in which the Covered Employee is an HSA-eligible individual, unless the Covered Employee chooses to use the full-year contribution rule described in Section 223(b)(8).

Because HSAs are individual accounts, complying with the maximum annual contribution is the responsibility of the Covered Employee.

4.2 Recording Contributions for HSA

As described in Article I, the HSA is not an employer-sponsored employee benefit plan—it is an individual trust or custodial account separately established and maintained by a trustee/custodian outside the Plan. Consequently, the HSA trustee/custodian, not the Employer, will establish and maintain the HSA. The HSA trustee/custodian will be chosen by the Participant, not by the Employer. The Employer may, however, limit the HSA provider to whom it will forward Employer contributions and contributions that the Participant makes via Salary Reduction Agreement.

The Plan Administrator will maintain records to track HSA contributions a Covered Employee makes pursuant to the Salary Reduction Agreement, but it will not create a separate fund or otherwise segregate assets for this purpose. The Employer has no authority or control over the funds deposited in an HSA.

4.3 Tax Treatment of HSA Contributions and Distributions

The federal income tax treatment of the HSA (including contributions and distributions) is governed by Code Section 223.