PARTICIPATING IN THE HEALTH CARE PLANS

Summary Plan Description

Health Care Plan Only

The information about eligibility and changing your coverage in this section applies to the IQVIA Health Care Plan only. The IQVIA Health Care Plan includes the Medical, Prescription Drug, Dental and Vision Plans.

For eligibility and participation information regarding other IQVIA benefits, see the separate descriptions of each benefit in the appropriate section.

For More Information

For information about your legal rights under ERISA, general information on claims review and appeal procedures, and other important administrative details, see the *Administrative Information* section. To contact the plan administrator, use the information listed in the *Contacts* section.

This section explains who is eligible to participate in the IQVIA Health Care Plan (Medical, Prescription Drug, Dental and Vision Plans) and includes details on how and when to enroll.

IN THIS SECTION ..... SEE PAGE

ELIGIBILITY

If you are a U.S. employee, regularly scheduled to work 30 hours or more per week, you are eligible to participate in the IQVIA Health Care Plan. Coverage begins on the date of hire, unless otherwise noted.

You are not eligible to participate in the IQVIA Health Care Plan if you are:

- Regularly scheduled to work fewer than 30 hours per week.
- A resident of Puerto Rico. (Please note that residents of Puerto Rico are eligible for different health care options than what is described in this Benefits Handbook. Separate information about these plans is available to eligible employees. Puerto Rico residents are also not eligible to participate in the 401(k) Plan or the Flexible Spending Accounts.)
- A temporary or seasonal employee.
- An employee of a recently acquired company that has not yet transitioned to IQVIA's payroll and benefits. Please refer to your local Human Resources group for information about the benefit options available to you.

Your Regularly Scheduled Work Week

For benefits eligibility purposes, your regularly scheduled work week is based on your regular work schedule, not the actual hours you work. If your regularly scheduled work week changes, your eligibility to participate in the Health Care Plan may change.

ELIGIBLE DEPENDENTS

Keep in Mind When Enrolling...

You are responsible for understanding and following the dependent eligibility rules. IQVIA reserves the right to conduct dependent eligibility audits at any time. You may be asked to validate the eligibility of any dependents you have enrolled.

If you're an eligible employee, you may enroll certain dependents for coverage under the Health Care Plan.

You may cover:

- Your legal spouse.
- Your dependent children up to age 26.
- Your unmarried dependent children of any age who live with you, are unable to support themselves and who became physically or mentally incapacitated prior to age 26 and remain physically or mentally incapacitated. See "Dependent Children" below for more information.

Dependent Coverage

When enrolling eligible dependents, you must enroll them in the same coverage you choose for yourself.

DEPENDENT CHILDREN

Eligible dependent children include your:

- Natural children.
- Adopted children (including those children whose adoption proceedings are pending).
- Stepchildren.
- Grandchildren with court awarded custody.
- Children for whom you are the court appointed legal guardian.

Disabled Dependent Children

To cover disabled dependent children, you must verify that the disability occurred before age 26. You have up to 30 days after the date he or she reaches age 26 to provide this verification, and the claims administrator may require you to provide medical documentation substantiating continued permanent disability on an annual basis.

COVERAGE CATEGORIES

When you enroll in the Health Care Plans, your coverage level is based on the dependents you enroll and includes the following coverage categories:

- Employee Only.
- Employee + Spouse.
- Employee + Child(ren).
- Employee + Family (Spouse + 1 or More Children).

You can elect to waive coverage if you have coverage through another source.

COST OF COVERAGE

You and IQVIA share in the cost of coverage under the Medical, Dental and Vision Plans. While IQVIA pays a portion of the cost, you are required to contribute to the cost of health care coverage for you and your covered dependents. Your contributions depend on the option and coverage category you select. Your contributions are made with pre-tax dollars. Each year, your open enrollment materials will show the required contributions for each option offered and each coverage category.

Your contributions for coverage start when your coverage begins or the first pay cycle following your enrollment, if later. (Please see "When Coverage Begins" on page 28 for more information.) Your contributions are automatically deducted from your pay in equal installments.

If you are enrolled for coverage but are away from work because of an unpaid leave of absence, you will continue to be responsible for your contribution payments. If you are on a short-term unpaid leave, your contributions will be recouped from your pay when you return to work. If you are on a long-term leave of absence, you will be required to pay your contributions monthly on a post-tax basis.

SPOUSAL SURCHARGE

If you choose to enroll a spouse who has access to their own employer-subsidized health coverage, you will be charged a spousal surcharge of $50 per month to cover them under a IQVIA medical plan. This surcharge does not apply if your spouse works for IQVIA, is unemployed or self-employed.

TOBACCO SURCHARGE

If you or a covered dependent attest to using tobacco, you will be charged a tobacco surcharge of $50 per month for coverage under the IQVIA medical plan. If you or a covered dependent use tobacco, be sure to complete the Tobacco Cessation Program, provided at no cost to you, by November 1 if you would like to have the tobacco surcharge removed.

PAYING FOR BENEFITS WITH PRE-TAX DOLLARS

Pre-tax benefit deductions are withheld from your pay before federal income taxes, Social Security taxes and (in most states) state income taxes are deducted. This provides you with a tax advantage—that is, when your taxable pay is less, so are your overall taxes.

Paying for benefits with pre-tax dollars means your future Social Security benefits will be slightly reduced. Generally, the tax advantages of pre-tax plans will outweigh the reduced Social Security benefits later, but if you have any questions or concerns, you should consult your tax advisor.

LIMITS FOR CERTAIN EMPLOYEES

All benefits and elections under the plans are subject to all applicable non-discrimination rules and other applicable law (such as, the non-discrimination rules of Code Sections 105(h), 125, 129 and 79, the Code Sections 125 key employee 25% concentration rules, Americans with Disabilities Act rules, etc.) and IQVIA shall test the plan for compliance with such rules and may take any actions it considers advisable for the purpose of ensuring the plan's compliance with such rules, including limiting benefits for certain employees.

HOW TO ENROLL

Generally, you have two opportunities to enroll in the Health Care Plan:

- When you're first eligible.
- During open enrollment.

In some instances, you may be able to make mid-year enrollment changes if you experience certain life status changes. See "Making Mid-Year Enrollment Changes" beginning on page 25.

ENROLLING WHEN FIRST ELIGIBLE

You will have 30 days from the date you become eligible to participate in the Health Care Plans. If you don't enroll and make choices about your Health Care Plan options and coverage levels within this 30-day period, you will not have medical, prescription drug, dental, vision or flexible spending account coverage.

You will not be able to change your coverage until the next open enrollment period. However, you may have an additional enrollment opportunity if you have a life status change.

Enrolling for Coverage

You can enroll in the IQVIA Health Care Plans online at the IQVIA Benefits Marketplace website from any computer that has internet access.

Generally, your elections remain in effect for the entire plan year (January 1 through December 31), unless you experience a life status change.

ENROLLING DURING OPEN ENROLLMENT

FSA Enrollment

You need to enroll each year if you want to participate in a flexible spending account (FSA). If you don't enroll, participation in the FSA will end. See the Flexible Spending Accounts (FSAs) section for more information.

Each year during the fall, IQVIA holds open enrollment. During this period, you can change your options and/or level of coverage for the coming plan year. Elections made during open enrollment take effect on the following January 1 and remain in effect through December 31 of that same year.

Generally, with the exception of the flexible spending accounts, health savings account (HSA) and commuter benefits your current elections automatically renew if you don't change them during open enrollment unless IQVIA holds a mandatory open enrollment period. You should always review any open enrollment communications you receive to ensure your coverage will continue or if enrollment is required.

It is important that you review the options available to you along with any changes that may have been made to the plans so that you can choose the option that best meets your needs. After you enroll, you'll have the option to save or print your confirmation statement to ensure it accurately shows the elections you made. You may not change your elections during the year unless you experience a life status change.

MAKING MID-YEAR ENROLLMENT CHANGES

The coverage you elect under the IQVIA Health Care Plan will remain in effect from January 1 (or the date you began participation) through December 31. Generally, you can make changes only during the open enrollment period. However, because your needs may change when you experience certain life events, you may be allowed to make mid-year enrollment changes in certain situations in accordance with the Internal Revenue Code and as permitted by the plan administrator.

Life Status Change

A life status change (also known as a "qualified status change") is an event that may allow you to make certain mid-year changes to your health care coverage. Changes to your health care coverage must be consistent with the change in status. Generally, the event must affect your eligibility, your eligible spouse's eligibility or your eligible dependent child's eligibility for coverage under an employer plan (including plans of other employers). Under the IQVIA Health Care Plan, life status changes include:

- Marriage or divorce.
- Birth or adoption of a child.
- A child ceases to be an eligible dependent.
- You or your spouse gains or loses group coverage.
- A change in your employment status (including a reduction in hours), or the employment status of your spouse or dependent, which affects plan eligibility.
- Death of your spouse or child.
- You or your spouse takes an unpaid leave of absence pursuant to the Family and Medical Leave Act.
- Reduction in hours of service—you and your dependents may drop your group health plan coverage, even if you remain eligible for such coverage, if:
  - You were reasonably expected to work 30 hours per week and you experience a change in employment, after which you are reasonably expected to work less than 30 hours per week

- You intend to enroll yourself and any dependents dropping coverage in another health plan (satisfying the Affordable Care Act's definition of minimum essential coverage) effective no later than the first day of the second month after you drop IQVIA Health Care Plan coverage.

- Enrollment in a health plan offered through the public Marketplace—If you are eligible for a special enrollment period to enroll in public Marketplace coverage, or you want to enroll in public Marketplace coverage during the public Marketplace's annual open enrollment period, you may drop group healthcare coverage under the IQVIA Health Care Plan, even if you remain eligible for coverage under this Plan. You (and any dependents whose coverage is dropped at this time) must intend to enroll in Marketplace coverage that is effective no later than the day immediately following the last day your coverage under the IQVIA Health Care Plan is dropped.

All changes must be consistent with the life status change. For example, if you have a change due to the birth of a child, you may add that child to your coverage, but you cannot remove another family member.

Network Provider Changes Are Not Life Status Changes

The enrollment choices you make are in effect for the entire calendar year in which you enroll. Changes in your plan's network coverage are not considered to be a life status change. For example, if your doctor is no longer available through the network, you cannot change your coverage until the next open enrollment period as this wouldn't be considered a life status change.

You also may be able to change your benefit elections because of certain other events:

- A special enrollment right under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
- A judgment, decree or qualified medical child support order (QMCSO) requiring coverage for a child.
- Eligibility for Medicare or Medicaid.
- Certain leaves under the Family and Medical Leave Act (FMLA).
- Significant cost or coverage changes.

Special Enrollment Rights

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have special enrollment rights under certain circumstances. If you're declining enrollment for yourself or your eligible dependents (including your spouse) because of other health insurance coverage and that coverage ends, you may enroll yourself or your eligible dependents in the IQVIA Health Care Plan provided that you request enrollment within 30 days after your other coverage ends.

If you or your eligible dependents were eligible for IQVIA health care coverage but declined because you had other health insurance coverage, you may enroll in the IQVIA plan if you lose coverage under the other plan because:

- Your eligibility ends.
- Your COBRA coverage is exhausted.
- Employer contributions to the other coverage end.

In addition, if you have a new dependent as the result of a marriage, birth, adoption or placement for adoption, you may enroll your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. Coverage for the new dependent child will be effective from the date of birth, adoption or placement for adoption. **However, if you miss the 30-day deadline, you'll have to wait until the next open enrollment period (or for a life status change or another special enrollment right) to enroll.**

Please Note: Newborns aren't automatically covered by the plan; you must enroll all dependents for coverage.

Children's Health Insurance Program (CHIP) or Medicaid

You have a special enrollment opportunity if you or your eligible dependents either:

- Lose Medicaid or Children's Health Insurance Program (CHIP) coverage because you are no longer eligible.
- Become eligible for your state's premium assistance program under Medicaid or Children's Health Insurance Program (CHIP).

For these enrollment opportunities, you will have 60 days (instead of 30 days) from the date of the Medicaid/CHIP eligibility change to request enrollment in the IQVIA Health Care Plan. This two-month notice deadline does not apply to enrollment opportunities other than the Medicaid/CHIP eligibility change.

Judgments, Decrees and Orders

You may make a change that corresponds to any judgment, decree or order requiring the Medical Plan to provide medical coverage to your dependent child. In the case of a child whom you're required to cover pursuant to a qualified medical child support order (QMCSO), coverage will begin on the date specified in the order, or if none is specified, the date the order is received. You may decrease your coverage for that child if the court order requires the child's other parent to provide coverage and your spouse's or former spouse's plan actually provides that coverage. (For more information on what you should do if you or IQVIA receives a QMCSO, call the IQVIA Benefits Marketplace at 888-264-9180.)

Medicare or Medicaid Entitlement

You may change an election for medical coverage mid-year if you, your spouse or your eligible dependent becomes entitled to (or loses entitlement to) coverage under Part A or Part B of Medicare, or under Medicaid. However, you're limited to reducing your medical coverage only for the person who becomes entitled to Medicare or Medicaid, and you're limited to adding medical coverage only for the person who loses eligibility for Medicare or Medicaid.

Family and Medical Leave Act (FMLA)

You may drop medical coverage mid-year when you begin an approved unpaid leave that satisfies the provisions of the Family and Medical Leave Act (FMLA).

When you return from an FMLA leave, you will be immediately reinstated in the same elections you made before taking your FMLA leave. See "If You Go Out on Leave" beginning on page 29 for more information.

Significant Cost or Coverage Changes

If the cost of benefits increases or decreases during a benefit period, IQVIA may, in accordance with plan terms, automatically change your elective contribution. When the change in cost is significant, you may either increase your contribution or elect less-costly coverage.

In addition, you may make changes to your elections if:

- There is a significant overall reduction to your benefit option.
- Your coverage option ceases.
- A new coverage option is added.

How to Make Changes

Changes Must Be Consistent with Your Life Status Change

Keep in mind that most of the changes you make to your coverage must be consistent with the change in your status.

You have 30 days from the date of the following events to enroll in or make a coverage change:

- Life status change.
- Judgment, decree or order.
- Change in Medicare or Medicaid entitlement.
- Significant cost or coverage changes.

If you don't make changes within this 30-day period, you can't enroll for coverage until the next open enrollment period.

You have 30 days from the date you experience an event under the HIPAA special enrollment rights provision to enroll in or change your coverage. If you don't make changes within the 30-day period, you can't enroll for coverage until the next open enrollment period. You can make a change to your coverage at the IQVIA Benefits Marketplace website.

IF YOU DO NOT ENROLL

If you:	And you do not enroll:
Are a current participant in the Health Care Plan	Your current coverage and elections will continue unless IQVIA holds a mandatory open enrollment period. You should always review any open enrollment communications you receive to ensure your coverage will continue or if enrollment is required.
Are a newly-hired or newly-eligible employee	You will not have coverage if you're a new hire or newly eligible employee and do not enroll within the designated 30-day period, See "Enrolling When First Eligible" on page 24 for more information.
Have a life status change	You will have to wait until the next open enrollment period if you have a qualified status change that allows you to make a change mid-year and you do not enroll within the designated 30-day eligibility period. Please see "Making Mid-Year Enrollment Changes" on page 25 for more information.

WHEN COVERAGE BEGINS

If you:	Your coverage begins:
Are a current participant in the Health Care Plan and make changes during open enrollment	At the beginning of the following plan year (January 1).
Are a newly-hired or newly-eligible employee	On your date of hire.
Have a change in work status or experience a life status change	Coverage begins as of the day of the life event, if you have already met the plan's eligibility requirements and if you make your eligible benefit changes through the IQVIA Benefits Marketplace website within 30 days. If you miss the 30-day deadline, you will have to wait until the next open enrollment period to make any changes.

ID Cards

All medical, dental and vision plan participants receive a separate medical, prescriptions drug, dental and vision ID card from the plan carriers. The ID cards include information on your medical, dental prescription drug, and vision plans.

If you need care before you receive your card(s), call the carrier to request a temporary ID card. If you lose your card(s), call the carrier for information about your coverage before you receive treatment, so you can be sure the option you have enrolled in covers the treatment you're about to receive. (See the *Contacts* section for contact information.)

WHEN COVERAGE BEGINS FOR YOUR COVERED DEPENDENTS

If you enroll your eligible dependents at the same time you enroll, their coverage begins when your coverage begins. If you enroll your eligible dependents at a later time, the date when their coverage begins depends on when you enroll them:

- If you enroll an eligible dependent for coverage during the open enrollment period, coverage begins the following January 1.
- If you enroll an eligible dependent for coverage within 30 days from the date of the following events, coverage begins as follows:
  - Life status change—as of the date of the qualifying event.
  - Judgment, decree or order—on the date designated on the legal document.
  - Change in Medicare or Medicaid entitlement—the first of the month following the date Medicare or Medicaid entitlement is lost.
  - Significant cost or coverage changes—the first of the month following the date of the event.
- If you enroll an eligible dependent for coverage within 30 days from the date you experience an event under the HIPAA special enrollment rights provision, coverage begins the first of the month following the date of the event.

WHEN COVERAGE ENDS

Generally, your health care coverage as an employee ends on the earliest of:

- The last day of the calendar month in which your employment ends (whether voluntarily or involuntarily).
- The last day of the calendar month you otherwise no longer meet the eligibility requirements for coverage.
- The last day of the calendar month for which you have required contributions, if the plan receives notice that you've stopped making the necessary contributions toward the cost of coverage.
- The last day of the calendar month you choose to stop coverage due to a family/employment status change.
- The last day of the current calendar year if you do not elect to continue coverage for the next year during the open enrollment period.
- The day you die.
- The day IQVIA discontinues the plan.

WHEN COVERAGE ENDS FOR YOUR COVERED DEPENDENTS

Your covered dependents' health care coverage ends on the earliest of:

- The day your coverage ends.
- The last day of the calendar month in which your covered dependent child reaches age 26.
- The last day of the calendar month in which your covered dependent no longer meets the eligibility requirements for coverage.
- The last day of the calendar month following the date you choose to stop coverage due to a life status change.
- The last day of the calendar month for which you last made the required contributions toward the cost of your covered dependent's coverage. There is an exception for a divorce or legal separation—coverage ends as of the date of the divorce or legal separation decree.
- The day IQVIA discontinues coverage under the plan.

IF YOU GO OUT ON LEAVE

If you go out on leave, your coverage may be impacted depending on the reason for your leave and the length of time you are away from work.

MEDICAL LEAVE/FMLA

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid, job- and benefits-protected leave during a 12-month period for specific medical and/or family reasons. In addition, you may be eligible for up to 26 weeks of unpaid leave in a 12-month period to care for a family member wounded in military service.

The following reasons qualify for family medical leave:

- Birth of your child, or the placement of a child for adoption or foster care in your home.
- Care for an immediate family member (your spouse, child or parent) with a serious health condition.
- Your inability to work because of a serious health condition.
- Qualifying exigencies arising from a family member's call to active military service.
- Care for a family member wounded in active military service.

Going on Leave

You must give 30 days advance notice to IQVIA if your leave is foreseeable. If you cannot give 30 days notice, you should provide as much notice as possible.

While on Leave

If you are on leave because of a family member's or your own health condition, you may be asked to provide medical proof of that condition periodically.

Your Health Care Plan coverage will continue as long as you make any required contributions.

When You Return to Work

When you return from an FMLA leave, you will be restored to your original or an equivalent position, with equivalent pay, benefits and other employment terms as if you had not taken the leave.

If you are on Family Medical leave for your own health, IQVIA will require a medical release from your doctor before you can return to work.

If You Do Not Return to Work

If you do not come back to work when your leave ends, you will be eligible to continue health care coverage through the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). The date you should have returned to work will be the date your coverage is considered to end for determining COBRA coverage.

See the *COBRA* section for details.

MILITARY LEAVE OF ABSENCE

If you take a military leave, whether for active duty or for training, you are entitled to extend your medical coverage for up to 16 weeks as long as you give IQVIA advance notice of the leave (with certain exceptions). If IQVIA does not receive notice to extend your coverage, benefits will end on the 30th day of military leave. Your total leave, when added to any prior periods of military leave, cannot exceed five years (with certain exceptions).

If the entire length of the leave is 30 days or less, you will not be required to pay any more for coverage than the amount you paid before the leave. If the entire length of the leave is 31 days or longer, you may be required to pay up to 102% of the full coverage amount (as required under COBRA). If you take a military leave but your coverage under the plan is terminated (for instance, because you do not elect the extended coverage), you will be treated as if you had not taken a military leave upon re-employment when determining whether exclusions or waiting periods apply.

IF YOU ARE COVERED BY MORE THAN ONE PLAN

If you or a covered dependent has coverage under the IQVIA Health Care Plan and coverage under another Health Care Plan (like your spouse's/partner's plan), benefits under the IQVIA plan are coordinated with those provided by the other plan so that your combined coverage doesn't exceed the provider's fees for eligible expenses. An eligible expense is any expense covered in full or in part under any one of your plans. If an expense is not a covered expense in either of the plans, the plan will not pay benefits.

Coordination of benefits (COB) rules under the IQVIA plan are designed to determine how much each plan pays when you or your covered dependents are covered under more than one Health Care Plan. The rules involve two steps:

- Determining which plan pays first (the plan that pays first is your "primary coverage").
- Determining how much the IQVIA plan will pay.

WHICH PLAN PAYS FIRST

Court-Ordered Benefit Responsibility

Sometimes a court assigns responsibility to one parent for paying a child's health care expenses—for example, if there's a divorce. This order is called a qualified medical child support order (QMCSO). QMCSOs take precedence over all other rules, as long as the claims administrator of the plan covering that parent has knowledge of the QMCSO before benefits are paid in the plan year.

If you or a covered dependent has coverage under more than one plan, first submit your expenses to the primary plan, then submit them to the secondary plan. To determine which plan is primary:

- **For you:** The IQVIA coverage is primary. Submit your health care expenses to the IQVIA plan first, then to the other plan.
- **For your spouse:** Your spouse's employer-sponsored plan is primary, if he/she is enrolled. Submit your spouse's health care bills to his/her plan first, then to the IQVIA plan.
- **For your children:** When a child is covered under both parents' plans, the plan of the parent whose birthday falls earlier in the calendar year pays benefits first. If you and your spouse have the same birthday, the plan that has been covering your child longer pays benefits first. If the other plan has not adopted this "birthday rule," that plan's order of determination rules determines which plan is primary.
- If you're divorced, legally separated or remarried, the plans pay benefits in the following order:
  - First, if a court decree states that one parent is responsible for the child's healthcare expenses or health coverage and the plan for that parent has actual knowledge of the terms of the order, but only from the time of actual knowledge;
  - Then, the plan of the parent with custody.
  - Then, the plan of the spouse of the parent with custody.
  - Then, the plan of the parent without custody.
  - Finally, the Plan of the spouse of the parent not having custody of the child.

- **If you're covered under Medicare:** If you or your dependent is covered by Medicare because of age, disability or end-stage renal disease, IQVIA coverage may be primary to Medicare coverage. Generally, if you're still working for IQVIA and you have Medicare coverage, the medical coverage you have through IQVIA is primary, so submit your medical bills to the IQVIA plan first. Then, submit any medical expenses not covered by the IQVIA plan to Medicare for payment. However, once your employment ends, Medicare becomes your primary plan in most cases.
- Note that:
  - If one of the Plans that covers you is issued out of the state whose laws govern the IQVIA Policy, and determines the order of benefits based upon the gender of a parent, and as a result, the Plans do not agree on the order of benefit determination, the Plan with the gender rules shall determine the order of benefits.
  - If none of the above rules determines the order of benefits, the Plan that has covered you for the longer period of time shall be primary.
  - If you have been covered for the same amount of time by more than one IQVIA policy, the IQVIA self-funded plan shall be primary.
- When coordinating benefits with Medicare, this Plan will be the Secondary Plan and determine benefits after Medicare, where permitted by the Social Security Act of 1965, as amended for the following:

  (a) a former employee who is eligible for Medicare and whose insurance is continued for any reason as provided in this Plan;

  (b) a former employee's dependent, or a former dependent spouse, who is eligible for Medicare and whose insurance is continued for any reason as provided in this Plan;

  (c) an employee whose employer and each other employer participating in the employer's plan have fewer than 100 employees and that employee is eligible for Medicare due to disability;

  (d) the dependent of an employee whose employer and each other employer participating in the employer's plan have fewer than 100 employees and that dependent is eligible for Medicare due to disability;

  (e) an employee or a dependent of an employee of an employer who has fewer than 20 employees, if that person is eligible for Medicare due to age;

  (f) an employee, retired employee, employee's dependent or retired employee's dependent who is eligible for Medicare due to End Stage Renal Disease after that person has been eligible for Medicare for 30 months;

  - Aetna will assume the amount payable under:
    - Part A of Medicare for a person who is eligible for that Part without premium payment, but has not applied, to be the amount he would receive if he had applied.
    - Part B of Medicare for a person who is entitled to be enrolled in that Part, but is not, to be the amount he would receive if he were enrolled.
    - Part B of Medicare for a person who has entered into a private contract with a provider, to be the amount he would receive in the absence of such private contract.
  - A person is considered eligible for Medicare on the earliest date any coverage under Medicare could become effective for him.
  - This reduction will not apply to any Employee and his Dependent or any former Employee and his Dependent unless he is listed under (a) through (f) above.

  However, when more than one Plan is secondary to Medicare, the benefit determination rules identified above, will be used to determine how benefits will be coordinated.

HOW MUCH THE PLAN PAYS

If the IQVIA plan is primary, then IQVIA plan's benefits are paid according to the regular plan provisions, and the other plan pays benefits according to its own Coordination of Benefits (COB) provisions.

If the IQVIA plan is secondary, then the primary plan pays benefits first. After the primary plan pays benefits, IQVIA applies a methodology for coordinating benefits called Standard Coordination of Benefits (COB) with a benefit credit.

The IQVIA plan will pay the portion of expenses not covered by the primary plan up to the plan's normal liability. The remaining portion of the payment the IQVIA plan does not have to pay is credited to the member (in the primary plan) and can be applied toward future claims within the calendar year.

SUBROGATION AND REIMBURSEMENT

Required Notification

You must notify the plan administrator within 45 days of the date of the injury or the date you gave notice of your intent to pursue or investigate a claim to recover damages. Examples of reimbursements include uninsured motorist coverage, personal umbrella coverage, no-fault automobile coverage and homeowner's insurance.

The IQVIA Health Care Plan provides benefits in case of accidental injury or illness such as coverage for medical treatment of your illness or injury. Under this plan, if you receive benefits from other sources because of the accidental injury or illness, the IQVIA plan may be entitled to some or all of the amounts you receive because of the accident, under two legal rights—subrogation and reimbursement.

- **Subrogation** is a legal right the plan can assert to recover the benefits it pays for accidental injuries or illnesses. The plan can recover these benefits from the parties who caused the accident or from their insurers and/or other insurers that provide coverage for the accidental injury or illness.
- **Reimbursement** is a legal right the plan can assert to recover its benefit payments from you or your family members. There is a duty to reimburse the plan when a settlement or payment arising out of an accidental injury or illness has been made without providing for payment back to the plan.

For example, assume that John is in an auto accident and receives medical treatment for his injuries. John participates in one of the IQVIA medical options, so his treatment is covered by that option and he receives benefits from the option. If John later receives a settlement from the driver of the other car involved in the accident, the IQVIA Medical Plan is entitled to be repaid for the benefits it provided.

If you're involved in an accident and receive any benefits from the IQVIA Health Care Plan, be sure to ask the claims administrator whether you need to be aware of any subrogation or reimbursement issues.

Consequences of Subrogation and Reimbursement

Because the rights of subrogation and reimbursement can affect any recovery you may receive from a third party for your injury or illness, you should be aware that the plan has the following rights:

- The plan has the right to receive payment on any claim against a third party, up to 100% of any services and benefits paid for your benefit, before you receive payment from that third party.
- The plan's subrogation and reimbursement rights apply to full and partial settlements, judgments or other recoveries from the incident paid or payable to you or your representative, no matter how those proceeds are captioned or characterized.
- The plan may enforce its subrogation and reimbursement rights even if you haven't been fully compensated for your injuries or damages, and the plan's rights will not be reduced because of your own negligence.
- If the plan incurs attorneys' fees and costs in order to collect third-party settlement funds held by you or by your representative, the plan has the right to recover those fees and costs from you.
- You may be required to provide information about your accident to help the plan determine who could be held liable for the injury or illness, and you must cooperate with the plan to protect its legal and equitable rights of subrogation and reimbursement.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

The privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulate how an employer group health plan:

- Provides documentation of coverage for former employees and dependents to use when they apply for other group coverage.
- Permits special enrollment periods and prohibits discrimination based on health status.
- Maintains the privacy of your health information.

HIPAA requires IQVIA to provide you with a notice of the plan's legal duties and privacy practices with respect to your protected health information (PHI). The plan creates, receives, uses, maintains and discloses health information about you and your covered dependents in the course of providing these benefits: medical, dental, vision, long-term care, health flexible spending accounts, and the employee assistance program. The privacy notice describes how the plan may use or disclose your health information, and under what circumstances it may share this information without your authorization (generally, to carry out treatment, payment or health care operations).

IQVIA distributes the notice via mail or in electronic form. You should retain this notice with your personal records. To receive a copy of the plan's Privacy Notice, it can be found in the employee handbook on the IQ intranet site.