ADMINISTRATIVE INFORMATION

Summary Plan Description

Additional Legal Notices

In addition to ERISA, there are other laws that affect your benefits, and for which certain legal notices are required. You can see these notices on the company intranet, IQ.

The federal law known as the Employee Retirement Income Security Act of 1974 (ERISA) governs certain employee benefit plans, including some of the plans described in this Benefits Handbook. This section discusses your legal rights under ERISA, as well as some important administrative information.

Which Benefits Are Subject to ERISA?

Some of the benefits described in this Benefits Handbook are subject to the Employee Retirement Income Security Act of 1974 (ERISA) and some are not. For those benefits that are subject to ERISA, this Benefits Handbook, including all its various sections, serves as your summary plan description (SPD), as required by Department of Labor regulations.

The following benefits are subject to ERISA:

- Medical (including prescription drug coverage and EAP)
- Dental
- Vision
- Flexible Spending Accounts
- Short-Term Disability
- Long-Term Disability
- Life Insurance
- Accidental Death and Dismemberment
- Business Travel Accident Insurance
- Adoption Plan
- Legal Assistance Plan
- 401(k) Savings

The following benefits are not subject to ERISA:

- Health Savings Account (HSA)
- Supplemental Medical Benefits (Accident Insurance, Critical Illness Insurance, and Hospital Indemnity Insurance)
- Time Off
- WorkLife (including Identity Theft Program, Pet Insurance, and Education Assistance)
- Commuter Benefits
- Statutory

IN THIS SECTION

SEE PAGE

PLAN DOCUMENTS

Every effort has been made to ensure that the information in this Benefits Handbook is complete and accurate. However, if there is an inconsistency between any of the terms of the official plan documents or any SPD within this Benefits Handbook with regard to plan benefits, or legal compliance requirements under the Employee Retirement Income Security Act of 1974 (ERISA) or any other federal law, the applicable plan will be enforced consistent with the official plan documents.

The terms of the plans will also be enforced consistent with the official plan documents in the event of a conflict between the plan documents and any oral representation concerning plan benefits or legal compliance requirements.

Copies of all plan documents are available for review upon written request to the plan administrator. A copy of any of these documents will be furnished to a plan participant or beneficiary (or an authorized representative) upon request. A reasonable fee may be charged for the copies as permitted under ERISA.

YOUR RIGHTS UNDER ERISA

As a participant in IQVIA's ERISA benefit plans you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants are entitled to each of the rights described here.

Receive Information About Your Plan and Benefits

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

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

You may receive a summary of the plan's annual financial report, if any is required to be prepared under ERISA. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

You may continue medical, dental, vision and health care spending account participation for yourself, your spouse or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA coverage rights. (For information about COBRA, see the *COBRA* section.)

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and don't receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials weren't sent because of reasons beyond the administrator's control. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have exhausted the claims procedures available to you under the plan, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you're discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you're successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

YOUR HIPAA PRIVACY RIGHTS

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

- Applies pre-existing condition exclusions, if any.
- 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, 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, visit the IQVIA company intranet, IQ, or call Employee Benefit Services at 800-526-7094.

CLAIMS REVIEW AND APPEALS PROCEDURES

The procedures for filing claims for benefits are summarized in the respective plan overviews. If you're not satisfied with the outcome of your claim, you can ask to have the claim reviewed.

Almost all of the benefit plans described in this Benefits Handbook have a specific amount of time, by law, to evaluate and respond to benefit claims. These time limits apply to plans subject to ERISA. The period of time the plans have to evaluate and respond to a claim begins on the date the claim is first filed. In addition, there are specific timelines and information requirements that you must comply with when filing a claim, or the claim may be denied and the rights you might otherwise have may be forfeited.

The plan administrator has the authority to control and manage the operation and administration of the plans described in this Benefits Handbook and is the agent for service of legal process. The person or entity responsible for specific operational or administrative duties (such as processing claims) may not be the official "plan administrator." Generally, an insurance company or carrier is the claim administrator, and has final responsibility and authority for responding to claims appeals.

For a list of the persons or entities responsible for processing claims and deciding claims and appeals for the benefit plans offered by IQVIA, see "Other Plan Details" on page 219.

CLAIM FILING AND REVIEWS

The plan administrator has delegated to some claims administrators, the exclusive right to interpret and administer the provisions of the plan and to determine benefit payments under the plan. Apart from the right to appeal claim decisions described in this summary plan description, the claims administrator's decisions are final and binding. In reviewing your claim, the claims administrator and/or recordkeeper will apply the plan terms and use its discretion in interpreting and applying plan terms. Benefits will be paid only if you've met the eligibility and participation requirements and the claims administrator determines that you're entitled to plan benefits.

The plan administrator has delegated claims administration authority for the plans as follows.

- For Self Insured Plans:
  - **Medical:** Aetna
  - **Prescription drugs:** Express Scripts
  - **Dental:** Delta Dental
  - **Short-Term Disability:** Lincoln
- For Fully Insured Plans:
  - **Long-Term Disability:** Lincoln
  - **Life Insurance and AD&D:** Lincoln
  - **Business Travel Accident:** CHUBB
  - **Vision:** EyeMed
- For Other Plans:
  - **401(k):** Fidelity
  - **FSAs:** Mercer Marketplace
  - **Legal Assistance:** MetLife Legal Plans

ADVERSE BENEFIT DETERMINATION

An "adverse benefit determination" is: (1) a denial, reduction or termination of a benefit; (2) a failure to provide or pay for a benefit (in whole or in part); (3) a denial of participation in the plan. For health coverage, an adverse benefit determination also includes a pre-service claim denial on the grounds that the treatment is experimental or investigational or not medically necessary and concurrent care determinations.

In the event of an adverse benefit determination, the claimant will receive notice of the determination. The notice will include the following:

- The specific reasons for the adverse determination.
- The specific plan provisions on which the determination is based.
- A request for any additional information needed to reconsider the claim and the reason this information is needed.
- If applicable, a description of the plan's review procedures and the time limits applicable to such procedures.
- A statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on review.
- If any internal rules, guidelines, protocols or similar criteria were used as a basis for the adverse determination by a group health plan or a plan providing disability benefits, 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.
- For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits under a group health plan or a plan providing disability benefits, 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.
- For adverse determinations involving urgent care, a description of the expedited review process for such claims. (This notice can be provided orally within the timeframe for the expedited process, as long as written notice is provided no later than three days after the oral notice.)

- For adverse determinations of benefits based on a determination of disability, an explanation of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.

Except as specifically provided otherwise, all determination notices may be provided in written or electronic form. Determination notices based on a determination of disability must be provided in a culturally and linguistically appropriate manner.

JUDICIAL REVIEW

You must pursue all the claim and appeal procedures referenced in "Claims Review and Appeals Procedures" on page 202 applicable to the plan from which you are seeking a benefit in a timely manner before you pursue any other legal recourse regarding claims for benefits. You may not bring any action at law or in equity to recover benefits unless and until the appeal rights referenced in "Claims Review and Appeals Procedures" have been exhausted and the benefits requested in the appeal have been denied in whole or in part (or there is some other adverse benefit determination). If you wish to seek judicial review of any adverse benefit determination, you must file a civil action under Section 502(a) of ERISA within one (1) year after the date on which all administrative remedies are exhausted—that is, by the later of the date on which an adverse determination on review is issued or the last day on which a final decision should have been issued—or you'll be forever prohibited from bringing such action.

HEALTH CARE PLANS

This Benefits Handbook describes the claims review and appeal procedures for the following IQVIA Health Care Plans: Aetna $400 Deductible PPO Plan, Aetna $900 Deductible PPO Plan, Aetna $1,850 Deductible Plan, Aetna $2,850 Deductible Plan, Delta Dental Standard Plan, Delta Dental Enhanced Plan, and the EyeMed Vision Plan. If you have a claim or questions regarding a claim, contact the claim administrator for additional information. If you participate in any other IQVIA Health Care Plan, you should consult the information provided to you by these plans to determine the applicable claims review and appeal procedures.

Either you or your authorized representative may file claims for benefits under the IQVIA Health Care Plans. An "authorized representative" means a person you authorize, in writing, to act on your behalf. The plans also will recognize a court order giving a person the authority to submit claims on your behalf. All communications from the plans will be directed to your authorized representative unless your written designation provides otherwise.

Medical and Dental Claim Procedures

In general, health services and benefits must be medically necessary to be covered under the medical and dental plans. The procedures for determining medical necessity vary according to the type of service or benefit requested and the type of health plan. Medical necessity determinations are made on either a pre-service, concurrent or post-service basis.

Certain services require prior authorization in order to be covered. This prior authorization is called a "pre-service medical necessity determination." This section describes who is responsible for obtaining this review. You or your authorized representative (typically, your health care provider) must request medical necessity determinations according to the procedures described in this section, and in your provider's network participation documents as applicable.

When services or benefits are determined to be not medically necessary, you or your representative will receive a written description of the adverse determination and may appeal the determination. Appeal procedures are described in this section, in your provider's network participation documents and in the determination notices.

Pre-Service Claims

Pre-service claims are for benefits that must be approved before receiving medical care, for example, requests to pre-certify a hospital stay or to obtain pre-approval under a utilization review program or for which a lesser coverage is provided in the absence of such approval.

For pre-service health claims, the claims administrator will notify you of the determination, whether adverse or not, within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim. This period may be extended by 15 days if the claims administrator:

- Determines that an extension is necessary because of matters beyond the claims administrator's control.
- Notifies you within the initial 15-day period of the circumstances requiring the extension and the date by which the claims administrator expects to render a decision, which will be no more than 30 days after receipt of the request.

If the determination periods above would seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim, the claims administrator will expedite the pre-service determination.

For expedited claims, the claims administrator will notify you of the determination, whether adverse or not, as soon as possible considering the medical exigencies, but no later than 72 hours after receipt of the claim. If you fail to provide sufficient information for the claims administrator to determine whether, or to what extent, benefits are covered or payable under the plan, the claims administrator will notify you as soon as possible of the specific information necessary to complete the claim, but not later than 24 hours after the claims administrator receives the claim. You'll be given a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information.

The claims administrator will notify you of its benefit determination as soon as possible, but no later than 48 hours after the plan's receipt of the specified information or the end of the period you were given to provide the specified additional information, whichever happens first. The claims administrator may provide notices of urgent benefit determinations orally; oral notice will be followed by written notice within three days.

If such an extension is necessary because you don't submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You'll be given at least 45 days from receipt of the notice within which to provide the specified information.

Improperly Filed Pre-Service Claims

If a pre-service claim isn't filed according to the plan's claim procedures, you may be notified as soon as possible, but no later than five days after the claim is received by the plan. If the claim is an urgent care case, you may be notified within 24 hours. Notice of an improperly filed pre-service claim may be provided orally, or in writing, if you request. The notice will identify the proper procedures to be followed in filing the claim.

Concurrent Care Claims

- Concurrent care claims are where the plan has previously approved an ongoing course of treatment over a period of time or a specific number of treatments, and you request to extend the course of treatment beyond the approved period of time or number of treatments.

If you request an extension of ongoing treatment, you'll be notified as soon as possible given the medical exigencies, but no later than 24 hours after the claims administrator receives your claim, as long as the request to extend treatment is submitted to the plan at least 24 hours before the end of the prescribed time period or number of treatments.

Post-Service Claims

Post-service claims involve the payment or reimbursement of costs for medical care that has already been provided.

For post-service health claims, the claims administrator will notify you of an adverse determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This period may be extended by 15 days if the claims administrator determines that an extension is necessary because of matters beyond the claims administrator's control and notifies you, within the initial 30-day period, of the circumstances requiring the extension and the date by which the claims administrator expects to render a decision.

If such an extension is necessary because you don't submit the information necessary to decide the claim, the notice of extension will specifically describe the required information. You'll be given at least 45 days from receipt of the notice within which to provide the specified information.

Vision Claim Procedures

All claims for services received from an out-of-network provider should be submitted within 180 days of the date of the service. The claims administrator may deny any claims filed more than 180 days after the date of the service.

The claims administrator will notify you of its decision within 30 days after receiving the claim, unless special circumstances require an extension of time (but no later than 120 days). If the claims administrator cannot reach a decision within 30 days, you will be notified in writing of the expected date of the decision.

Appeal Procedures

If you receive notice of an adverse benefit determination and you disagree with the decision, you're entitled to apply for a full and fair review of the claim and the adverse benefit determination.

Appeals for Medical and Dental Claims

If you have a concern regarding a person, a service, the quality of care or contractual benefits, you may call the number on your ID card, explanation of benefits, or claim form, and explain your concern to a Plan member services representative. You may also express that concern in writing. The claims administrator will work to address your concern within 30 days. If you are not satisfied with the results of a coverage decision, you may start the appeals process.

To initiate an appeal, you must submit a request for an appeal in writing to the claims administrator within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal should be approved and include any information supporting your appeal. If you are unable or choose not to write, you may ask the claims administrator to register your appeal by telephone. Call or write them at the toll-free number on your ID card, explanation of benefits, or claim form.

Your appeal will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity or clinical appropriateness will be considered by a health care professional.

The claims administrator will respond in writing with a decision within 30 calendar days after they receive an appeal for a required pre-service or concurrent care coverage determination or a post-service Medical Necessity determination. The claims administrator will respond within 60 calendar days after they receive an appeal for any other post-service coverage determination. If more time or information is needed to make the determination, you will be notified in writing about the request for an extension of up to 15 calendar days and to specify any additional information needed to complete the review.

In the event any new or additional information (evidence) is considered, relied upon or generated by the claims administrator in connection with the appeal, they will provide this information to you as soon as possible and sufficiently in advance of the decision, so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by the claims administrator, they will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond.

You may request that the appeal process be expedited if:

1. The time frames under this process would seriously jeopardize your life, health or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; or
2. Your appeal involves non-authorization of an admission or continuing inpatient Hospital stay.

If you request that your appeal be expedited based on (1.) above, you may also ask for an expedited external review at the same time, if the time to complete an expedited review would be detrimental to your medical condition.

When an appeal is expedited, the claims administrator will respond orally with a decision within 72 hours, followed up in writing.

External Review Procedure

If you are not fully satisfied with the decision of the claims administrator's internal appeal review and the appeal involves medical judgment or a rescission of coverage, you may request that your appeal be referred to an Independent Review Organization (IRO). The IRO is composed of persons who are not employed by the claims administrator, or any of its affiliates. A decision to request an external review to an IRO will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate an external review. The claims administrator and your benefit plan will abide by the decision of the IRO.

To request a review, you must notify the Aetna Appeals Coordinator within 4 months of your receipt of the claims administrator's appeal review denial. The claims administrator will then forward the file to a randomly selected IRO. The IRO will render an opinion within 45 days.

When requested, and if a delay would be detrimental to your medical condition, as determined by Aetna's Physician Reviewer, or if your appeal concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility, the external review shall be completed within 72 hours.

Appeals for Vision Claims

To initiate an appeal, you must submit a request for an appeal in writing to the claims administrator within 180 days of receipt of a denial notice.

Level-One Appeal

Your request should include your name (the covered employee), your date of birth, the name of the person enrolled (i.e., your dependent if applicable), your member ID number, the provider's name and the claim number.

You are allowed to review, during normal working hours, any documents held by the claims administrator pertinent to the denial. You also may request in writing for copies of these documents. You may submit written comments or supporting documentation regarding the claim to assist in the claims administrator's review.

The claims administrator will respond within 30 days after receiving an appeal.

Level-Two Appeal

If you are dissatisfied with our level-one appeal decision, you may request a second review within 60 calendar days after the claims administrator's response to the initial appeal. The claims administrator will notify you of its final determination including the specific reasons for the decision in compliance with all applicable state and federal laws and regulations.

Notices Following Appeal

For all ERISA claims, the claims administrator or other appropriate named fiduciary will provide you with written or electronic notification of the determination on appeal. This administrative appeal process must be completed before you begin any legal action regarding your claim.

Legal Action

You also have the right to bring a civil action under Section 502(a) of ERISA if you are not satisfied with the decision on review of your medical, dental, or vision appeals. See "Judicial Review" on page 204.

You or your plan may have other voluntary alternative dispute resolution options such as mediation. Contact your plan administrator for more information or your local U.S. Department of Labor office and your state insurance regulatory agency.

HEALTH CARE AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

Initial Benefit Determination

When you file a claim for reimbursement from the Health Care or the Dependent Care Flexible Spending Account (FSA), the plan has up to 30 days to evaluate and respond to claims for benefits. The 30-day period begins on the date the claim is first filed. This period may be extended by 15 days, as long as the claim administrator or its delegate:

- Determines that an extension is necessary due to matters beyond the claim administrator's control.
- Notifies you within the initial period of the circumstances requiring the extension and the date by which the plan expects to render a decision.

In addition, the notice of extension must include the additional information needed to resolve the claim. (See "Claims Review and Appeals Procedures" on page 202 for information on the types of information included in the notice.) You'll be given at least 45 days from receipt of the notice within which to provide the specified information.

Appeal Procedures

You (or an authorized representative) will have at least 180 days after receiving the denial notice to file an appeal.

You must submit a written request for a review of the denial of the claim. You can submit written comments, documents, records or other information relating to the claim for benefits. All documents you submit will be considered upon review. In your request for a review, state the reasons that you believe your claim was improperly denied and include all additional information that you consider relevant in support of your claim.

After receiving a request for review, a final decision will be rendered within 60 days. The claims administrator will render the decision and will notify you (or your authorized representative).

Notices Following Appeal

The claims administrator will provide you with written notification of the determination on appeal. (See the "Claims Review and Appeals Procedures" section on page 202 for the types of information that will be included in the notice.) In deciding whether to appeal, you may obtain access to copies of (free of charge) relevant information in your claim file upon request.

Legal Action

This administrative appeal process must be completed before you begin any legal action regarding your claim. See "Judicial Review" on page 204.

SHORT-TERM DISABILITY (STD) PLAN

If you wish to file a claim for benefits, you should follow the claim procedures described in the section of this SPD that describes the STD benefits. To complete your claim filing, Lincoln must receive the claim information it requests from you (or your authorized representative), your attending physician and IQVIA. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Lincoln directly.

Claim Procedures

You will receive a written notice of an initial decision on your claim as soon as possible after the claims evaluator receives your completed claims forms (but generally within 45 days). This 45-day period may be extended for two additional 30-day periods provided that, prior to any extension period, the claims administrator or plan administrator notifies you in writing that an extension is necessary due to matters beyond the control of the plan. Extension notices will generally explain all of the following:

- The circumstances requiring the extension.
- The standards for eligibility.
- Any unresolved issues that prevent a decision.
- Any information needed to resolve those issues.
- The date by which the plan expects to render its decision.

If an initial decision on your claim is extended due to your failure to submit information necessary to decide your claim, you will be given at least 45 days to provide the necessary information and the time for decision shall be tolled from the date on which the notification of extension and request for additional information is sent to you.

If a claim for benefits is wholly or partly denied, the claims administrator or plan administrator will furnish you with written notification of the decision. This written notice will provide all of the following:

- The specific reason(s) for the decision.
- Specific references to the plan provision(s) on which the denial is based.
- A description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary.
- An explanation of the plan's review procedures and the steps to take if you wish to appeal the denial and applicable time limits for such an appeal.
- An explanation of your right to bring a civil action under Section 502(a) of ERISA if you appeal the plan's decision and still receive a final denial.
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol or similar criterion, or information on how to obtain a copy of the rule or protocol free of charge.

- If denial was based on medical judgment, either an explanation of the scientific or clinical judgment for the determination (applying the terms of the plan to your medical circumstances), or information on how an explanation can be obtained free of charge.
- An explanation of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.

  Except as specifically provided otherwise, all determination notices may be provided in written or electronic form. Determination notices based on a determination of disability must be provided in a culturally and linguistically appropriate manner.

Appeal Procedures

On any wholly or partially denied claim for benefits, you or your representative may appeal to the plan administrator for a full and fair review of the claim denial. You may do any or all of the following:

- Request a review upon written application within 180 days of the claim denial.
- Request, free of charge, copies of all documents, records and other information relevant to your claim.
- Submit written comments, records and other information relating to your claim.

Upon receipt of a request for review, your claim will be reviewed by the plan administrator without deference to the initial decision by the claims evaluator and a final written decision will be provided to you or your representative within 45 days after the request is received, unless special circumstances exist that require an extension of time to process the appeal. The plan administrator may receive one 45-day extension to provide you a final decision, if necessary, provided the plan administrator notifies you of the circumstances requiring such extension and the date a decision will be rendered before the expiration of the initial 45-day deadline.

Where an appeal is based on a medical judgment, the plan administrator must consult with a properly trained health care professional. Upon concluding its review on appeal, the plan administrator will provide a written notice of its final decision on appeal. If it is determined that additional benefits are due to you as a result of the final decision, proper benefit adjustments will be made and paid directly to you. If, however, the appeal has been denied, the notice of the final decision will provide you all of the following:

- The specific reason(s) for the denial.
- The plan provision(s) on which the denial is based.
- The extent to which an internal rule or protocol was relied on in making a determination and your right to receive a copy of such rule or protocol free of charge.
- If the decision was based on medical necessity, experimental treatment or a similar exclusion or limit, a statement explaining the scientific or clinical judgment supporting the decision or instructions on how the claimant can receive such information free of charge.
- An explanation of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

- The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.

Except as specifically provided otherwise, all determination notices may be provided in written or electronic form. Determination notices based on a determination of disability must be provided in a culturally and linguistically appropriate manner.

The plan cannot deny disability benefits on appeal based on new or additional evidence that was not included when the disability benefit was denied at the claims stage, without giving you notice and a fair opportunity to respond. Your claim on appeal will be reviewed without deference to the initial adverse decision by an appropriate fiduciary of the plan who is neither the individual who made the initial decision regarding your claim nor a subordinate of such individual. In addition, if the initial adverse benefits determination was based in whole or in part on a medical judgment (including a determination with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the fiduciary reviewing your claim on appeal will consult with a healthcare professional with appropriate training and experience in the field of medicine involving the medical judgment. Finally, the fiduciary reviewing your claim on appeal must identify the medical or vocational experts who were used in making the initial decision regarding your benefits, and the fiduciary reviewing your claim on appeal may not rely on such experts or their subordinates in making a decision on appeal.

When an appeal has been denied, you and the Plan Administrator may have other voluntary alternative dispute resolution options, such as mediation. Contact your local U.S. Department of Labor Office for details.

LONG-TERM DISABILITY (LTD) PLAN

If you wish to file a claim for benefits, you should follow the claim procedures described in the section of this SPD that describes the LTD benefits. To complete your claim filing, Lincoln must receive the claim information it requests from you (or your authorized representative), your attending physician and IQVIA. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Lincoln directly.

Claim Procedures

Lincoln will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Lincoln both determines that such an extension is necessary due to matters beyond the control of the plan and notifies you of the circumstances requiring the extension of time and the date by which Lincoln expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30 day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Lincoln may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the plan will include all of the following:

- The specific reason(s) for the determination.
- References specific plan provision(s) on which the determination is based.
- Descriptions of additional material or information necessary to complete the claim and why such information is necessary.
- Disclosure of plan procedures and time limits for appealing the determination. An explanation of your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Lincoln on appeal.
- Disclosure of any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Appeal Procedures

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made no later than 45 days following receipt of the written request for review. If Lincoln determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Lincoln will notify you in writing if an additional 45-day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45-day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Lincoln may decide your appeal without that information.

You will have the opportunity to submit written comments, documents or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The review will be conducted by Lincoln and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Lincoln will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the plan in connection with the denial of your claim, Lincoln will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain all of the following information:

- The specific reason(s) for the determination.
- References to the specific plan provision(s) on which the determination is based.
- Disclosure of any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request).
- An explanation of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.
- A statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision.
- The statement that you are entitled to receive upon request and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination.
- The statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements. Notices will be provided in a culturally and linguistically appropriate manner.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim. See "Judicial Review" on page 204.

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT

If you wish to file a claim for benefits, you should follow the claim procedures described in the section of this SPD that describes these insurance benefits. To complete your claim filing, Lincoln must receive the claim information it requests from you (or your authorized representative), your attending physician and IQVIA. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact Lincoln directly.

Claim Procedures

Death Claims, Non-Disability Claims and Education Benefit Claims

In the event that your claim is denied, either in full or in part, Lincoln will notify you in writing within 90 days after your claim was filed. Under special circumstances, Lincoln is allowed an additional period of no more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from Lincoln indicating the reason for the delay and the date you may expect a final decision. Lincoln's notice of denial shall include all of the following:

- The specific reason(s) for denial with reference to those plan provisions on which the denial is based.
- A description of any additional material or information necessary to complete the claim and why that material or information is necessary.
- A description of the plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Lincoln on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Disability Claims

Lincoln will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if Lincoln both determines that such an extension is necessary due to matters beyond the control of the plan and notifies you of the circumstances requiring the extension of time and the date by which Lincoln expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30-day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Lincoln may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the plan will include all of the following:

- The specific reason(s) for the determination.
- References to the specific plan provision(s) on which the determination is based.
- Descriptions of additional material or information necessary to complete the claim and why such information is necessary.
- Disclosure of any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).
- For adverse determinations of benefits based on a determination of disability, an explanation of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and

- A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.
- Descriptions of plan procedures and time limits for appealing the determination and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from Lincoln on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements. Notices will be provided in a culturally and linguistically appropriate manner.

Appeal Procedures

Death Appeals, Non-Disability Appeals and Education Benefit Appeals

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive Lincoln's notice of denial. You have the right to all of the following:

- Submit a request for review, in writing, to Lincoln.
- Upon request and free of charge, reasonable access to and copies of all relevant documents as defined by applicable U.S. Department of Labor regulations.
- Submit written comments, documents, records and other information relating to the claim to Lincoln.

Lincoln will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review.

A final decision on the review shall be made no later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those summary of benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim. See "Judicial Review" on page 204.

Disability Appeals

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made no later than 45 days following receipt of the written request for review. If Lincoln determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). Lincoln will notify you in writing if an additional 45-day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45-day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, Lincoln may decide your appeal without that information.

You will have the opportunity to submit written comments, documents or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The plan cannot deny disability benefits on appeal based on new or additional evidence that was not included when the disability benefit was denied at the claims stage, without giving you notice and a fair opportunity to respond. The review will be conducted by Lincoln and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Lincoln will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the plan in connection with the denial of your claim, Lincoln will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain all of the following information:

- The specific reason(s) for the determination.
- References to the specific plan provisions on which the determination is based.
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request).
- For adverse determinations of benefits based on a determination of disability, an explanation of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.
- The statement that you are entitled to receive upon request and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination.
- A statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision.
- The statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements. Notices will be provided in a culturally and linguistically appropriate manner.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim. See "Judicial Review" on page 204.

BUSINESS TRAVEL ACCIDENT INSURANCE

If you wish to file a claim for benefits, you should follow the claim procedures described in the section of this SPD that describes the BTA benefits. To complete your claim filing, CHUBB must receive the claim information it requests from you (or your authorized representative), your attending physician and IQVIA. If you or your authorized representative has any questions about what to do, you or your authorized representative should contact CHUBB directly.

Claim Procedures

Death and Non-Disability Claims

In the event that your claim is denied, either in full or in part, CHUBB will notify you in writing within 90 days after your claim was filed. Under special circumstances, CHUBB is allowed an additional period of no more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from CHUBB indicating the reason for the delay and the date you may expect a final decision. CHUBB's notice of denial shall include all of the following:

- The specific reason(s) for denial with reference to those plan provisions on which the denial is based.
- A description of any additional material or information necessary to complete the claim and why that material or information is necessary.

- A description of the plan's procedures and applicable time limits for appealing the determination, including a statement of your right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from CHUBB on appeal.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Disability Claims

CHUBB will give you notice of the decision no later than 45 days after the claim is filed. This time period may be extended twice by 30 days if CHUBB both determines that such an extension is necessary due to matters beyond the control of the plan and notifies you of the circumstances requiring the extension of time and the date by which CHUBB expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days within which to provide the specified information. If you deliver the requested information within the time specified, any 30-day extension period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, CHUBB may decide your claim without that information.

If your claim for benefits is wholly or partially denied, the notice of adverse benefit determination under the plan will include all of the following:

- The specific reason(s) for the determination.
- References to the specific plan provision(s) on which the determination is based.
- Descriptions of additional material or information necessary to complete the claim and why such information is necessary.
- Descriptions of plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to bring a lawsuit under Section 502(a) of ERISA following an adverse determination from CHUBB on appeal.
- Disclosure of any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request).
- For adverse determinations of benefits based on a determination of disability, an explanation of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;
  - The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
  - A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements. Notices will be provided in a culturally and linguistically appropriate manner.

Appeal Procedures

Death Appeals and Non-Disability Appeals

If you or your authorized representative appeal a denied claim, it must be submitted within 90 days after you receive CHUBB's notice of denial. You have the right to all of the following:

- Submit a request for review, in writing, to CHUBB.
- Upon request and free of charge, reasonable access to and copies of all relevant documents as defined by applicable U.S. Department of Labor regulations.
- Submit written comments, documents, records and other information relating to the claim to CHUBB.

CHUBB will make a full and fair review of the claim and all new information submitted whether or not presented or available at the initial determination, and may require additional documents as it deems necessary or desirable in making such a review.

A final decision on the review shall be made no later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension and the date by which the plan expects to make a decision. If an extension is required due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the necessary information and the date by which you need to provide it to us. The 60-day extension of the appeal review period will begin after you have provided that information.

The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those summary of benefits' provisions upon which the final decision is based. It will also include a statement describing your access to documents and describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the determination.

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim. See "Judicial Review" on page 204.

Disability Appeals

You have 180 days from the receipt of notice of an adverse benefit determination to file an appeal. Requests for appeals should be sent to the address specified in the claim denial. A decision on review will be made no later than 45 days following receipt of the written request for review. If CHUBB determines that special circumstances require an extension of time for a decision on review, the review period may be extended by an additional 45 days (90 days in total). CHUBB will notify you in writing if an additional 45-day extension is needed.

If an extension is necessary due to your failure to submit the information necessary to decide the appeal, the notice of extension will specifically describe the required information and you will be afforded at least 45 days to provide the specified information. If you deliver the requested information within the time specified, the 45-day extension of the appeal period will begin after you have provided that information. If you fail to deliver the requested information within the time specified, CHUBB may decide your appeal without that information.

You will have the opportunity to submit written comments, documents or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The plan cannot deny disability benefits on appeal based on new or additional evidence that was not included when the disability benefit was denied at the claims stage, without giving you notice and a fair opportunity to respond. The review will be conducted by CHUBB and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, CHUBB will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the plan in connection with the denial of your claim, CHUBB will provide you with the names of each such expert, regardless of whether the advice was relied upon.

A notice that your request on appeal is denied will contain all of the following information:

- The specific reason(s) for the determination.
- References to the specific plan provisions on which the determination is based.
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request).
- For adverse determinations of benefits based on a determination of disability, an explanation of the decision, including an explanation of the basis for disagreeing with or not following:
  - The views presented by the claimant to the plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant;

- The views of medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination; and
- A disability determination regarding the claimant presented by the claimant to the plan made by the Social Security Administration.

- The statement that you are entitled to receive upon request and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination.
- A statement describing your right to bring a lawsuit under Section 502(a) of ERISA if you disagree with the decision.
- The statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements. Notices will be provided in a culturally and linguistically appropriate manner.

Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim. See "Judicial Review" on page 204.

401(K) PLAN

Benefits will be paid to you and your beneficiaries without the necessity of formal claims. However, a participant or beneficiary has a right to file a claim, ask if he or she has a right to any benefits or appeal the denial of a claim. A claim request can be made in writing to the plan administrator. If you make a claim and it is denied, a notice will be given to you that will indicate the specific reason for denial, the plan provisions that apply, a description of any additional information needed to perfect or review the claim further and will explain the plan's claim appeal procedure and steps to be taken if you or your beneficiary want to submit your claim for further review. You may appeal the denial of a claim in writing no more than 60 days after you receive notice of denial or, if no written denial of your claim was provided, no later than 60 days after the deemed denial of your claim. The decision of the plan administrator will be given to you in writing no later than 60 days following receipt of appeal.

NON-ASSIGNMENT OF BENEFITS

Except as explicitly set forth in the official plan documents and certificates for coverages offered by IQVIA Inc. or as described in the QMCSO and QDRO paragraphs below, your benefits and rights under the IQVIA plans (including the right to request documents and bring a lawsuit under ERISA) are personal to you and cannot be transferred or assigned to any other person or entity. Nothing in this Handbook or the plan documents shall be construed to make the IQVIA Plans or IQVIA Inc. liable for medical care, treatment, or services. Direct payments to a provider will not constitute a waiver of this non-assignability of rights provision.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

A qualified medical child support order, also known as a QMCSO, is any judgment, decree or order, including a court-approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a participant or beneficiary is eligible, and that the plan administrator determines is qualified under the terms of ERISA and applicable state law. Children who may be covered under a QMCSO include children born out of wedlock, those not claimed as dependents on your federal income tax return and children who don't reside with you. Keep in mind that a medical child support order cannot require the plan to provide coverage it doesn't otherwise offer—for example, children who are no longer eligible due to their age can't be added under a QMCSO.

If a QMCSO affects you, you should notify Mercer Marketplace so that the order can be handled properly. You and your dependents may obtain a copy of the procedures governing the QMCSO without charge by calling Mercer Marketplace at 888-264-9180. If IQVIA receives a QMCSO affecting you, you'll be notified. The plan will comply with all valid QMCSOs.

QUALIFIED DOMESTIC RELATIONS ORDER (QDRO)

A domestic relations order is a state court order, decree or judgment that directs a plan administrator to pay all or a portion of your 401(k) Plan benefits to a former spouse or a dependent. The Fidelity QDRO Center provides a website dedicated to handling QDROs. Fidelity reviews the domestic relations order and determines whether or not it is qualified (i.e., a qualified domestic relations order (QDRO)).The terms of the plan control all questions of benefit entitlement and calculation. For example, a QDRO cannot provide for a form of payment not available under the plan. If the order is a QDRO, the plan must follow the order.

If a QDRO affects you, please contact Fidelity at 1-800-835-5097 or link to the Fidelity QDRO Center website (https://qdro.fidelity.com) for handling your QDRO. The plan will comply with all valid QDROs. You and your dependents may obtain a copy of the procedures governing the QDROs without charge by calling Fidelity at 1-800-835-5097.

DETERMINING PAYMENT OF BENEFITS

The plan administrator has generally delegated to the claims administrators the discretionary authority to:

- Make decisions regarding the interpretation or application of plan provisions.
- Make determinations, including factual determinations, as to the rights and benefits of employees and participants under a plan.
- Make claims determinations under a plan.
- Decide appeals of denied claims.

Plan benefits will be paid only if the plan administrator, or its delegate, decides in its discretion that the claimant is entitled to them. The decision of the plan administrator or its delegate, as applicable, is final and binding.

CORRECTING MISTAKES IN PAYMENTS

If you are mistakenly paid a benefit, or if you receive more than you're entitled to, the claims administrator for that plan will do one of two things:

- Require that you return the overpayment.
- Reduce any future payment (for you or a dependent) by the amount of the overpayment.

CHANGE OR TERMINATION OF THE PLAN

IQVIA reserves the right to amend, modify, suspend or terminate the Health Care Plans, Flexible Spending Accounts, Short-Term and Long-Term Disability Plans, Life Insurance Plan, AD&D Plan, Business Travel Accident Plan, Adoption Plan, Legal Assistance Program, 401(k) Plan, in whole or in part, subject to applicable legal and contractual agreements, at any time and for any reason, regardless of your status at the time of the change.

A decision to terminate, amend or replace these plans may be due to changes in federal law or state laws governing benefits, the requirements of the Internal Revenue Service or ERISA or for any other reason. This may include elimination of or decreases in benefits, changes in plan networks and/or increases in your required contributions for coverage.

The Benefits Committee also may adopt written plan amendments that are necessary to meet the requirements of the Internal Revenue Code, ERISA or any other law, provided these amendments don't significantly change cost or benefit levels.

No plan changes can cause any part of the 401(k) Plan trust fund to be used for purposes other than the benefit of participants or their beneficiaries. Plan changes also cannot deny a participant any right or benefit that the participant is entitled to under the Internal Revenue Code.

Benefits under the Health Care Plans, Flexible Spending Accounts, Short-Term and Long-Term Disability Plans, Life Insurance Plan, AD&D Plan, Adoption Plan, Legal Assistance Program, and Business Travel Accident Plan aren't vested. However, if a plan is terminated or changed, you'll still be paid any benefits you were entitled to receive under the terms of that plan, up to the cancellation date or date of the change. Special rules apply to the 401(k) Plan.

For some of the plans, if the plan is terminated, you may be able to convert or port your coverage to an individual insurance policy. Refer to the description of the specific plan for these privileges.

If the Flexible Spending Accounts are terminated, no further contributions will be made to employee accounts. However, you may continue to submit and be reimbursed for claims for eligible expenses through March 31 following the year in which the plan terminates. For the Health Care FSA, eligible expenses include only those expenses incurred prior to the date the spending account terminated. For the Dependent Care FSA, eligible dependent care expenses incurred through the end of the year in which the Flexible Spending Account terminated can be reimbursed.

401(K) PLAN

In the event that the 401(k) Plan is terminated, your benefit earned up to the date of termination will become fully vested to the extent of the funds in the respective plan.

If the 401(k) Plan continues, but the plan and the trust agreement discontinue additional contributions, all necessary plan provisions (other than those related to contributions) will remain in effect. In addition, the trust provisions will remain in existence. The trustee and the plan administrator will hold, administer, and distribute all plan funds according to the terms of the plan and trust agreement.

If the 401(k) Plan is terminated, or if there's a complete discontinuance of contributions, all affected participants will be 100% vested in Company-matching contributions and any other unvested accounts, regardless of their years of service. Each participant will be entitled to receive the amount credited to his/her account. At its discretion, the plan administrator may authorize payment of this amount in cash.

No part of the principal or income of the fund will be used for, or diverted to, purposes other than for the exclusive benefit of participants or their beneficiaries. The trust may continue for such time as may be necessary to accomplish this objective. Plan changes also may not alter any participant's vested rights.

As the 401(k) Plan is a defined contribution plan, benefits are related to the contributions credited to your account and the fund's investment performance.

EMPLOYMENT RIGHTS NOT IMPLIED

This Benefits Handbook is for your information only; it is not a binding contract, nor does it impose any legal obligation upon IQVIA. The plans and the benefits described in this Benefits Handbook do not imply or create a contract or guarantee of continued employment between IQVIA and any individual. Employment with IQVIA or a subsidiary is "at will" and may be terminated by either party at any time, with or without cause or notice, except as provided by the terms of any applicable collective bargaining agreement. This provision applies to all employees regardless of their hire date.

Participation in IQVIA benefits doesn't give you a right to any benefit to which you're not eligible under the terms of the underlying plan document.

OTHER PLAN DETAILS

IQVIA is required to provide certain information about each ERISA benefit plan, including the official plan name and number, sources of funding, type of administration, and the claims administrator. Following is information specific to each plan.

Wrap Approach

As you review the plan details below, you may notice that several of the plans share the same formal name and plan number.

IQVIA uses this wrap plan approach to manage the plans more efficiently.

There are four plans as follows:

- #501 IQVIA Inc. Health Plan (including Medical, Prescription Drug, EAP, Dental, Vision, and the Flexible Benefits Plan)
- #502 IQVIA Inc. Life, Disability and Accident Plan (including Life, AD&D, STD, LTD, and BTA)
- #505 IQVIA Inc. Adoption and Legal Assistance Plan (including the Adoption Plan and the Legal Assistance Plan)
- #004 IQVIA 401(k) Plan

HEALTH CARE PLANS

Formal Plan Name	IQVIA Inc. Health Plan
Common Plan Name	IQVIA Inc. Medical Plan
Plan Type	Self Insured group health plan, including medical, prescription drug, and EAP.
Plan Year	January 1 to December 31
Plan Number	501
Plan Sponsor	The plan sponsor and principal employer for the IQVIA benefit plans is: IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 Employer Identification Number: 06-1506026 The plan sponsor retains all fiduciary responsibility with respect to these plans, except to the extent the plan sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities and to the extent the plan sponsor is not held responsible with respect to a plan by law.
Plan Administrator and Agent for Service of Legal Process	The plan administrator has sole and absolute authority to make all decisions regarding eligibility and/or entitlement to participation or benefits. The plan administrator can be reached at: Benefits Committee c/o IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 The plan's agent for service of legal process is its General Counsel, care of IQVIA Inc. at the address above.
Type of Administration	This plan is administered by the IQVIA Benefits Committee. Certain administrative duties concerning COBRA are delegated by contract to Mercer Marketplace. Other administrative duties are performed by either administrative service companies who have entered into contracts with IQVIA or individual insurance companies. (See Claims Administrators below.)
Plan Funding	Benefits under the plan are funded by a combination of employer and employee contributions. Employees contribute at a fixed rate per month toward the cost of the plan through payroll deductions. Benefits are provided under a self-funded administrative services arrangement. For self-funded plans, insurance companies or other companies act as administrators. These administrators do not collect premiums or insure benefits, but rely on the company or the plan to provide them with money to pay claims. The company or the plan pays each of these administrators a fee to administer the plan and make benefit payments.
COBRA Administration	The COBRA administrator is: Mercer Marketplace 888-264-9180

Claims Administrators	The administrative services provided by insurance companies providing benefits and/or administrative services for the group health plan include, where applicable: network establishment, maintenance and management, pre-certification and other utilization review determinations and the review of all utilization review appeals, claims services, in particular claims processing and determination, pre-determinations, review of certain appeals and payment of benefit claims, and the handling of grievances and various other customer services. IQVIA has engaged the services of the following third-party administrators who are responsible for processing claims for these self-insured plans. The claims administrator for the medical plans is: Aetna P.O. Box 981106 El Paso, TX 79998-1106 **For Southern California Member:** Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004 **For Northern California Members:** Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 12923 Oakland, CA 94604-2923 **For Georgia Members:** Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 370010 Denver, CO 80237-9998 **Claims services number:** 1-800-390-3510

DENTAL PLAN

Formal Plan Name	IQVIA Inc. Health Plan
Common Plan Name	IQVIA Inc. Dental Plan
Plan Type	Group health plan providing dental benefits.
Plan Year	January 1 to December 31
Plan Number	501
Plan Sponsor	The plan sponsor and principal employer for the IQVIA benefit plans is: IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 Employer Identification Number:06-1506026 The plan sponsor retains all fiduciary responsibility with respect to these plans, except to the extent the plan sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities and to the extent the plan sponsor is not held responsible with respect to a plan by law.

Plan Administrator and Agent for Service of Legal Process	The plan administrator has sole and absolute authority to make all decisions regarding eligibility and/or entitlement to participation or benefits. The plan administrator can be reached at: Benefits Committee c/o IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 The plan's agent for service of legal process is its General Counsel, care of IQVIA Inc. at the address above.
Type of Administration	This plan is administered by the IQVIA Benefits Committee. Certain administrative duties concerning COBRA are delegated by contract to Mercer Marketplace. Other administrative duties are performed by either administrative service companies who have entered into contracts with IQVIA or individual insurance companies.
Plan Funding	Benefits under the plan are funded by a combination of employer and employee contributions. Employees contribute at a fixed rate per month toward the cost of the plan through payroll deductions. Benefits are provided under a self-funded administrative service arrangement. For self-funded plans, insurance companies or other companies act as administrators. These administrators do not collect premiums or insure benefits, but rely on the company or the plan to provide them with money to pay claims. The company or the plan pays each of these administrators a fee to administer the plan and make benefit payments.
COBRA Administration	The COBRA administrator is: Mercer Marketplace 888-264-9180
Claims Administrators	The administrative services provided by insurance companies providing benefits and/or administrative services for the group health plan include, where applicable: network establishment, maintenance and management, pre-certification and other utilization review determinations and the review of all utilization review appeals, claims services, in particular claims processing and determination, pre-determinations, review of certain appeals and payment of benefit claims, and the handling of grievances and various other customer services. IQVIA has engaged the services of the following third-party administrators who are responsible for processing claims for these self-insured plans. The claims administrator for the dental plans is: Delta Dental P.O. Box 2105 Mechanicsburg, PA 17065

PRESCRIPTION DRUG PROGRAM

Formal Plan Name	IQVIA Inc. Health Plan
Common Plan Name	IQVIA Inc. Medical Plan
Plan Type	Group health plan providing prescription drug benefits.
Plan Year	January 1 to December 31
Plan Number	501
Plan Sponsor	The plan sponsor and principal employer for the IQVIA benefit plans is: IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 Employer Identification Number: 06-1506026 The plan sponsor retains all fiduciary responsibility with respect to these plans, except to the extent the plan sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities and to the extent the plan sponsor is not held responsible with respect to a plan by law.

<table>
<tr><td>Plan Administrator and Agent for Service of Legal Process</td><td>The plan administrator has sole and absolute authority to make all decisions regarding eligibility and/or entitlement to participation or benefits. The plan administrator can be reached at:
Benefits Committee
c/o IQVIA Inc.
4820 Emperor Blvd.
Durham, NC 27703
919-998-2000
The plan’s agent for service of legal process is its General Counsel, care of IQVIA Inc. at the address above.</td></tr>
<tr><td>Type of Administration</td><td>This plan is administered by the IQVIA Benefits Committee. Certain administrative duties concerning COBRA are delegated by contract to Express Scripts. Other administrative duties are performed by either administrative service companies who have entered into contracts with IQVIA or individual insurance companies.</td></tr>
<tr><td>Plan Funding</td><td>Benefits under the plan are funded by a combination of employer and employee contributions. Employees contribute at a fixed rate per month toward the cost of the plan through payroll deductions. Benefits are provided under a self-funded administrative service arrangement.
For self-funded plans, insurance companies or other companies act as administrators. These administrators do not collect premiums or insure benefits, but rely on the company or the plan to provide them with money to pay claims. The company or the plan pays each of these administrators a fee to administer the plan and make benefit payments.</td></tr>
<tr><td>COBRA Administration</td><td>The COBRA administrator is:
Mercer Marketplace
888-264-9180</td></tr>
<tr><td>Claims Administrators</td><td>The administrative services provided by insurance companies providing benefits and/or administrative services for the group health plan include, where applicable: network establishment, maintenance and management, pre-certification and other utilization review determinations and the review of all utilization review appeals, claims services, in particular claims processing and determination, pre-determinations, review of certain appeals and payment of benefit claims, and the handling of grievances and various other customer services.
IQVIA has engaged the services of the following third-party administrators who are responsible for processing claims for these self-insured plans.
The claims administrator for the Prescription Drug program is:
Express Scripts
<table>
<tr><td>Claims Administration
Express Scripts
Express Scripts, Inc.
P.O. Box 52132
Phoenix, AZ 85072-2132
For Southern California Member:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7004
Downey, CA 90242-7004
For Northern California Members:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923
For Georgia Members:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 370010
Denver, CO 80237-9998
Claims services number:
1-800-390-3510</td><td>Appeals
Express Scripts
Express Scripts, Inc.
PO Box 60903
Phoenix, AZ 85082-0903
For Southern California Member:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7004
Downey, CA 90242-7004
For Northern California Members:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923
For Georgia Members:
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 370010
Denver, CO 80237-9998
Claims services number:
1-800-390-3510</td></tr>
</table></td></tr>
</table>

VISION PLAN

Formal Plan Name	IQVIA Inc. Health Plan	
Common Plan Name	IQVIA Inc. Vision Plan	
Plan Type	Group health plan providing vision benefits.	
Plan Year	January 1 to December 31	
Plan Number	501	
Plan Sponsor	The plan sponsor and principal employer for the IQVIA benefit plans is: IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 Employer Identification Number: 06-1506026 The plan sponsor retains all fiduciary responsibility with respect to these plans, except to the extent the plan sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities and to the extent the plan sponsor is not held responsible with respect to a plan by law.	
Plan Administrator and Agent for Service of Legal Process	The plan administrator has sole and absolute authority to make all decisions regarding eligibility and/or entitlement to participation or benefits. The plan administrator can be reached at: Benefits Committee c/o IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 The plan's agent for service of legal process is its General Counsel, care of IQVIA Inc. at the address above.	
Type of Administration	Insurer-administered under Group Policy #12062458. Certain administrative duties concerning COBRA are delegated by contract to Mercer Marketplace. Other administrative duties are performed by either administrative service companies who have entered into contracts with IQVIA or individual insurance companies. (See Claims Administrators below.)	
Plan Funding	Benefits are provided under a group insurance contract with EyeMed. EyeMed is responsible for investing the premiums and paying benefit claims. EyeMed guarantees the payment of claims incurred before the group insurance contract terminates. The premiums are set every year by EyeMed. Premium contributions for vision come from a combination of employer and employee contributions. Employees contribute at a fixed rate per month toward the cost of the plan through payroll deductions.	
COBRA Administration	The COBRA administrator is: Mercer Marketplace 888-264-9180	
Claims Administrators	The claims administrator contracted to review and approve vision claims for this insured plan is EyeMed.	
	Claims Administration First American Administrators Attn: OON Claims P.O. Box 8504 Mason, Ohio 45040-7111 Fax: 866.293.7373.	**Appeals** FAA/EyeMed Vision Care Attn: Quality Assurance Dept. 4000 Luxottica Place Mason, OH 45040 Fax: 1-513-492-3259

HEALTH CARE AND DEPENDENT CARE FLEXIBLE SPENDING ACCOUNTS

Formal Plan Name	IQVIA Inc. Health Plan
Common Plan Name	IQVIA Inc. Health Care FSA IQVIA Inc. Dependent Care FSA
Plan Type	The Health Care FSA is a program providing tax-qualified reimbursement benefits for eligible health care expenses. The Dependent Care FSA is a program providing tax-qualified reimbursement benefits for eligible dependent day care expenses.
Plan Year	January 1 – December 31
Plan Number	501
Plan Sponsor	The plan sponsor and principal employer for the IQVIA benefit plans is: IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 Employer Identification Number: 06-1506026 The plan sponsor retains all fiduciary responsibility with respect to these plans, except to the extent the plan sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities and to the extent the plan sponsor is not held responsible with respect to a plan by law.
Plan Administrator and Agent for Service of Legal Process	The plan administrator has sole and absolute authority to make all decisions regarding eligibility and/or entitlement to participation or benefits. The plan administrator can be reached at: Benefits Committee c/o IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 The plan's agent for service of legal process is its General Counsel, care of IQVIA Inc. at the address above.
Type of Administration	Administrative Services Only Agreement with Mercer Marketplace
Plan Funding	Employees contribute at a fixed rate per month toward the cost of the spending account through payroll deductions. All reimbursements are paid from the general assets of the Company.
COBRA Administration	The COBRA administrator is: Mercer Marketplace 888-264-9180
Claims Administrators	The claims administrator for the Health Care and Dependent Care Flexible Spending Accounts is: Mercer Marketplace 888-264-9180

SHORT-TERM DISABILITY (STD) PLAN

Formal Plan Name	IQVIA Inc. Life, Disability and Accident Plan	
Common Plan Name	IQVIA Inc. Short-Term Disability Plan	
Plan Type	The STD Plan is a welfare benefit plan designed to pay disability benefits to eligible plan participants.	
Plan Year	January 1 – December 31	
Plan Number	502	
Plan Sponsor	The plan sponsor and principal employer for the IQVIA benefit plans is: IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 Employer Identification Number: 06-1506026 The plan sponsor retains all fiduciary responsibility with respect to these plans, except to the extent the plan sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities and to the extent the plan sponsor is not held responsible with respect to a plan by law.	
Plan Administrator and Agent for Service of Legal Process	The plan administrator has sole and absolute authority to make all decisions regarding eligibility and/or entitlement to participation or benefits. The plan administrator can be reached at: Benefits Committee c/o IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 The plan's agent for service of legal process is its General Counsel, care of IQVIA Inc. at the address above.	
Type of Administration	The Short-Term Disability Plan is administered on a day-to-day basis by a third-party contracted administrator.	
Plan Funding	Payments made under the STD Plan come from the general assets of IQVIA, which pays the full cost of the plan through its payroll system. No contributions are made to any fund, insurance program or trust.	
Claims Administrator	The third-party administrator contracted to review and approve disability diagnoses and benefit duration for this insured plan is Lincoln National Life Insurance Company.	
	Claims Administration Lincoln National Life Insurance Company 100 Liberty Way Dover, NH 03820	**Appeals** Lincoln National Life Insurance Company 100 Liberty Way Dover, NH 03820

LONG-TERM DISABILITY (LTD) INSURANCE PLAN

Formal Plan Name	IQVIA Inc. Life, Disability and Accident Plan	
Common Plan Name	IQVIA Inc. LTD Plan	
Plan Type	The LTD Plan is a fully-insured welfare benefit plan designed to pay disability benefits to eligible plan participants.	
Plan Year	January 1 – December 31	
Plan Number	502	
Plan Sponsor	The plan sponsor and principal employer for the IQVIA benefit plans is: IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 Employer Identification Number: 06-1506026 The plan sponsor retains all fiduciary responsibility with respect to these plans, except to the extent the plan sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities and to the extent the plan sponsor is not held responsible with respect to a plan by law.	
Plan Administrator and Agent for Service of Legal Process	The plan administrator has sole and absolute authority to make all decisions regarding eligibility and/or entitlement to participation or benefits. The plan administrator can be reached at: Benefits Committee c/o IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 The plan's agent for service of legal process is its General Counsel, care of IQVIA Inc. at the address above.	
Type of Administration	Insurer-administered under Group Policy No. 116963 001 with Lincoln National Life Insurance Company.	
Plan Funding	Benefits are provided under a group insurance contract with the Lincoln National Life Insurance Company. Lincoln is responsible for investing the premiums and paying benefit claims. Lincoln guarantees the payment of claims incurred before the group insurance contract terminates. The premiums are set every year by Lincoln. Premium contributions for LTD come from IQVIA, which pays the full cost of the plan.	
Claims Administrator	The claims administrator contracted to review and approve disability diagnoses and benefit duration for this insured plan is Lincoln National Life Insurance Company.	
	Claims Administration Lincoln National Life Insurance Company 100 Liberty Way Dover, NH 03820	**Appeals** Lincoln National Life Insurance Company 100 Liberty Way Dover, NH 03820

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE

Plan Name	IQVIA Inc. Life, Disability and Accident Plan	
Common Plan Name	IQVIA Inc. Life and AD&D Plan	
Plan Type	The life and AD&D insurance plans are welfare plans designed to pay life and AD&D insurance benefits to plan participants.	
Plan Year	January 1 – December 31	
Plan Number	502	
Plan Sponsor	The plan sponsor and principal employer for the IQVIA benefit plans is: IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 Employer Identification Number: 06-1506026 The plan sponsor retains all fiduciary responsibility with respect to these plans, except to the extent the plan sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities and to the extent the plan sponsor is not held responsible with respect to a plan by law.	
Plan Administrator and Agent for Service of Legal Process	The plan administrator has sole and absolute authority to make all decisions regarding eligibility and/or entitlement to participation or benefits. The plan administrator can be reached at: Benefits Committee c/o IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 The plan's agent for service of legal process is its General Counsel, care of IQVIA Inc. at the address above.	
Type of Administration	Insurer-administered under the following Group Policy Numbers with Lincoln National Life Insurance Company: ■ 116963 002 (Basic life insurance and basic AD&D coverage). ■ 117059 001 (Optional life insurance coverage). ■ GSR 37864 (Voluntary AD&D coverage).	
Plan Funding	Benefits are provided under a group insurance contract with the Lincoln National Life Insurance Company. Lincoln is responsible for investing the premiums and paying benefit claims. Lincoln guarantees the payment of claims incurred before the group insurance contract terminates. The premiums are set every year by Lincoln. Premium contributions for basic life insurance and basic AD&D coverage come from IQVIA, which pays the full cost. Employees pay the cost of contributions for optional life insurance and voluntary AD&D coverage.	
Claims Administrators	The claims administrator contracted to review and approve claims for these insured life and AD&D plans is Lincoln National Life Insurance Company.	
	Claims Administration Lincoln National Life Insurance Company 100 Liberty Way Dover, NH 03820	**Appeals** Lincoln National Life Insurance Company 100 Liberty Way Dover, NH 03820

BUSINESS TRAVEL ACCIDENT (BTA) INSURANCE

Formal Plan Name	IQVIA Inc. Life, Disability and Accident Plan
Common Plan Name	IQVIA Inc. Business Travel Accident Plan
Plan Type	The BTA Plan is a welfare plan designed to pay accident and death benefits to plan participants.
Plan Year	June 1 – May 31
Plan Number	502
Plan Sponsor	The plan sponsor and principal employer for the IQVIA benefit plans is: IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 Employer Identification Number: 06-1506026 The plan sponsor retains all fiduciary responsibility with respect to these plans, except to the extent the plan sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities and to the extent the plan sponsor is not held responsible with respect to a plan by law.
Plan Administrator and Agent for Service of Legal Process	The plan administrator has sole and absolute authority to make all decisions regarding eligibility and/or entitlement to participation or benefits. The plan administrator can be reached at: Benefits Committee c/o IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 The plan's agent for service of legal process is its General Counsel, c/o IQVIA Inc. at the address above.
Type of Administration	Insurer-administered under the following Group Policy No. ADD N04965693 with CHUBB.
Plan Funding	Benefits are provided under a group insurance contract with CHUBB. The premiums are set every year by CHUBB. Premium contributions for coverage come from IQVIA, which pays the full cost.
Claims Administrators	The claims administrator contracted to review and approve claims for the BTA Plan is: CHUBB P.O. Box 5124 Scranton, PA 18505-0556

ADOPTION PLAN

Formal Plan Name	IQVIA Inc. Adoption and Legal Assistance Plan
Common Plan Name	IQVIA Inc. Adoption Plan
Plan Type	Program providing tax-qualified adoption assistance benefits.
Plan Year	January 1 – December 31
Plan Number	505
Plan Sponsor	The plan sponsor and principal employer for the IQVIA benefit plans is: IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 Employer Identification Number: 06-1506026 The plan sponsor retains all fiduciary responsibility with respect to these plans, except to the extent the plan sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities and to the extent the plan sponsor is not held responsible with respect to a plan by law.

Plan Administrator and Agent for Service of Legal Process	The plan administrator has sole and absolute authority to make all decisions regarding eligibility and/or entitlement to participation or benefits. The plan administrator can be reached at: Benefits Committee c/o IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 The plan's agent for service of legal process is its General Counsel, care of IQVIA Inc. at the address above.
Type of Administration	Self-administered
Plan Funding	Payments made under the Adoption Plan come from the general assets of IQVIA, which pays the full cost of the Plan. No contributions are made to any fund insurance program or trust.
Claims Administrators	Benefits Committee c/o IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000

LEGAL ASSISTANCE PLAN

Formal Plan Name	IQVIA Inc. Adoption and Legal Assistance Plan
Common Plan Name	IQVIA Inc. Legal Assistance Plan
Plan Type	Welfare benefit plan providing pre-paid legal assistance.
Plan Year	January 1 – December 31
Plan Number	505
Plan Sponsor	The plan sponsor and principal employer for the IQVIA benefit plans is: IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 **Employer Identification Number:** 06-1506026 The plan sponsor retains all fiduciary responsibility with respect to these plans, except to the extent the plan sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities and to the extent the plan sponsor is not held responsible with respect to a plan by law.
Plan Administrator and Agent for Service of Legal Process	The plan administrator has sole and absolute authority to make all decisions regarding eligibility and/or entitlement to participation or benefits. The plan administrator can be reached at: Benefits Committee c/o IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 The plan's agent for service of legal process is its General Counsel, care of IQVIA Inc. at the address above.
Type of Administration	The Plan is administered by the IQVIA Benefits Committee, with assistance of the contracted third party, MetLife Legal Plans.
Plan Funding	Employee contributions
Claims Administrators	MetLife Legal Plans, Inc. 1215 Superior Avenue Cleveland, OH 44114 1-800-821-6400 info.legalplans.com

401(K) PLAN

Plan Name	IQVIA 401(k) Plan
Plan Type	Defined Contribution Plan with 401(k), Roth 401(k), 401(m), after-tax, catch-up and Profit Sharing Plan features, intended to satisfy ERISA section 404(c).
Plan Year	January 1 to December 31
Plan Number	004
Plan Sponsor	The plan sponsor and principal employer for the IQVIA benefit plans is: IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 Employer Identification Number:06-1506026 The plan sponsor retains all fiduciary responsibility with respect to these plans, except to the extent the plan sponsor has delegated or allocated to other persons or entities one or more fiduciary responsibilities and to the extent the plan sponsor is not held responsible with respect to a plan by law.
Plan Administrator, Named Fiduciary and Agent for Service of Legal Process	The plan administrator has sole and absolute authority to make all decisions regarding eligibility and/or entitlement to participation or benefits. The plan administrator can be reached at: Benefits Committee c/o IQVIA Inc. 4820 Emperor Blvd. Durham, NC 27703 919-998-2000 The plan's agent for service of legal process is its General Counsel, care of IQVIA Inc. at the address above. Service of process may also be made on the plan trustee.
Type of Administration	The plan is administered by the IQVIA Benefits Committee, with the assistance of a third-party contracted recordkeeper and a trustee.
Plan Funding	Contributions for the 401(k) Plan come from IQVIA and its employees. Employees contribute to the plan, and IQVIA provides discretionary matching contributions, if applicable. Participant and Company contributions are held in a trust fund administered by a trustee appointed by IQVIA. The trustee is responsible for the management, investment and payment of plan assets, unless the 401(k) Plan Committee either assumes that responsibility or appoints an investment manager to manage plan assets.
Participation and Plan Deferrals	For individuals first hired prior to 2015, participation in the 401(k) plan is generally voluntary and begins as soon as administratively possible after you become eligible for and enroll in the 401(k) plan. Individuals first hired on or after January 1, 2015 will be automatically enrolled in the 401(k) plan within sixty (60) days of satisfying the 401(k) plan eligibility requirements unless the individual affirmatively declines participation within the 60-day period. Participants who are automatically enrolled will have their deferral percentage election automatically set at three percent (3%) effective January 1, 2018, but may change their future deferral percentage at any time once enrolled, including reducing their deferral percentage to zero.
Plan Trustee	Fidelity is the trustee for the 401(k) Plan. You can reach the trustee at: Fidelity Management Trust Company 82 Devonshire Street, L10A Boston, MA 02109
No PBGC Guarantee	Benefits under this Plan are based solely on the amounts in the individual accounts. The amounts in individual accounts are not insured by the Pension Benefit Guaranty Corporation ("PBGC") because the insurance provisions under the Employee Retirement Income Security Act of 1974 ("ERISA") are not applicable to this type of plan.