WELCOME

Summary Plan Description

Online and Print

This Benefits Handbook is available in both print and online versions. If you are using the online version, you can use the search tool at the top of the web page to find the information you need.

IQVIA is committed to providing comprehensive benefits to its employees and their families. Your benefits are a valuable and substantial part of the total compensation you receive from IQVIA.

This IQVIA Benefits Handbook contains both high-level summaries and detailed information about the IQVIA benefit plans and programs. Understanding these benefits is the key to getting the most from them. You should use this Benefits Handbook as your primary reference source – the first place to turn when you have a question about your benefits or your rights as a plan participant.

How the Benefits Handbook Is Organized

The Benefits Handbook includes information about the IQVIA benefit plans and programs available to you. The Handbook contains numerous sections, which fall into two categories:

- **Benefit plan descriptions**, organized into the following sections:
  - *Health Care*, including medical, dental, vision and prescription drug coverage.
  - *Savings and Spending Accounts* including the Health Savings Account (HSA), Health Care FSA, and the Dependent Care FSA.
  - Supplemental Medical Plans including Accident Insurance, Critical Illness Insurance, and Hospital Indemnity Insurance.
  - *Disability* (short-term and long-term).
  - *Life & Accident Insurance*.
  - *401(k) Savings*.
  - *Other Benefits*.
- **Information common to most plans**, including the following sections:
  - *About This Handbook*.
  - *Life Events* (to help you make the best use of your benefits as you experience certain events, such as getting married or having children, that may affect your benefits).
  - *Administrative Information* (including details on your rights under ERISA, facts such as plan numbers, etc.).
  - *Contacts*.

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ABOUT THIS HANDBOOK

Summary Plan Description

This Handbook describes the benefit plans and programs available to eligible U.S. employees of IQVIA. For this purpose, you are a "U.S. employee" if you are paid through the U.S. payroll system of IQVIA or one of its U.S.-based subsidiaries.

For More Information

For details about eligibility for benefits, see the "Eligibility" subsections in each of the *Participating in the Health Care Plans*, *COBRA*, *Savings and Spending Accounts*, *Short-Term Disability*, *Long-Term Disability*, *Life Insurance*, *Accidental Death & Dismemberment*, *Business Travel Accident Insurance*, and *401(k)* sections.

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. The following benefits described in this Benefits Handbook 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

For those benefits that are subject to ERISA, this Benefit Handbook serves as your summary plan description (SPD), as required by Department of Labor regulations.

While the Severance Plan is also subject to ERISA, it is not included in this Benefits Handbook. You can access the Severance Plan SPD on the IQVIA company intranet, IQ.

For More Information

For more information about your legal rights under ERISA, see the *Administrative Information* section.

The following benefits described in this Benefits Handbook are not subject to ERISA:

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

This Benefits Handbook is intended to help you use each plan's benefits most effectively. The Benefits Handbook also alerts you to actions or situations that could limit the benefits you and your eligible family members might receive.

The descriptions in the IQVIA Benefits Handbook provide you with most of the information you'll need to know about the IQVIA employee benefits plan. However, these descriptions provide only a summary of these benefits and don't cover all the details. Additional details are provided in the official plan documents, including:

- Insurance contracts, policies or certificates of coverage; and
- The trust agreement pursuant to which the assets of the 401(k) plan are held.

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, or legal compliance requirements under the Employee Retirement Income Security Act of 1974 (ERISA) or any other federal law, the plan will be enforced consistent with the plan documents. In the event of a conflict between the plan documents and any oral representation concerning plan benefits or legal compliance requirements, the plan also will be enforced consistent with the plan documents.

Notwithstanding any other provision in this Benefits Handbook, IQVIA intends to operate the Plan in compliance with the transparency, surprise billing and other applicable requirements in the relevant provisions of the Consolidated Appropriations Act, 2021 ("CAA") and the Transparency-In-Coverage Regulations as they become effective, based on a good faith, reasonable interpretation of the statute, existing regulations and other official guidance. As additional, final guidance becomes available and applicable, IQVIA will modify this Benefits Handbook accordingly and/or provide a Summary of Material Modifications.

About the Benefit Plans

IQVIA reserves the right to amend, modify, suspend or terminate any 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. For more information, see the *Administrative Information* section of this Benefits Handbook.

Updated Information

This Benefits Handbook describes the benefits, terms and conditions of the plans effective January 1, 2022.

Because the benefits described in this summary may change, IQVIA will provide you with updated information as required by law.

About Your Employment

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 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 the IQVIA benefits does not give you a right to any benefit to which you are not eligible under the terms of the underlying plan document.

If You Have Questions

If you have any questions about this summary or any provision of your benefit plans, refer to the individual plan contact information located in the *Administrative Information* section.

LIFE EVENTS AND YOUR BENEFIT PLANS

Summary Plan Description

IQVIA's benefits are designed to be flexible and to help you adapt to the life changes you encounter. Certain events in your life can affect your eligibility for benefits and may offer you the opportunity to make changes to your coverage. This section can help you make the most of the benefits available to you when these changes occur.

Changes to your benefits can be made by logging on to the IQVIA Benefits Marketplace website. For planned events such as a marriage or a new baby, it's a good idea to review your benefit options ahead of time, so you can make informed decisions when the event occurs.

In addition, please note the following:

- Most benefit changes that result from life status changes (sometimes known as "qualified status changes" or "life events") must be made within 30 days of the event.
- Because the IQVIA disability plans (short-term and long-term) are company-paid plans, the life events described in this section do not apply to those plans. See the *Disability Coverage* section for more information.

For More Information

For details about eligibility for certain benefits, when you can change your coverage, and how you pay for coverage, see the individual plan sections of this Benefits Handbook. For information about your legal rights under ERISA, general information on claims review and appeal procedures, and other important administrative details, see the *Administrative Information* section.

IN THIS SECTION.....SEE PAGE

IF YOU GET MARRIED

Getting married is considered a life status change or life event, meaning that you can make certain adjustments to your benefits. If you don't enroll or make changes to certain benefits within 30 days of getting married, you must wait until the next annual enrollment period or until you have another life event to enroll or make changes.

If you move or change your name, remember to update your personal information in IQVIA Workday. If you change your name, you also need to notify the Social Security Administration.

The following table outlines how your coverage is affected if you get married.

Benefit Plans	How Coverage Is Affected	Things to Consider
Health Care Plans (including medical, dental, vision and prescription drug coverage)	■ You may add coverage for a spouse and, if applicable, dependent children. You must enroll your spouse and/or dependent children within 30 days of the event. ■ If you plan to enroll under your spouse's plan and drop your IQVIA coverage, you must do so within 30 days of the event. ■ Your coverage change must be consistent with your life status change, unless you qualify for certain special enrollment rights. See "Special Enrollment Rights" in the *Participating in the Health Care Plans* section for details.	■ Determine whether your spouse will be covered under the Health Care Plans, or if you will be covered under his/her plans. ■ Decide if you and your spouse will maintain separate coverage. ■ If you have children, decide who will cover the children.
Flexible Spending Accounts (FSAs)	■ If you get married, you can enroll or increase your Health Care FSA and Dependent Care FSA contributions within 30 days of the event. ■ Your coverage change must be consistent with your life status change, unless you qualify for certain special enrollment rights. See "Special Enrollment Rights" in the *Participating in the Health Care Plans* section for details.	■ Determine what expenses your spouse or dependent children may have that will not be covered by the Health Care Plans, and decide if you want to establish or change your Health Care FSA. ■ If you have children who will be in daycare, decide if you want to establish or change your Dependent Care FSA.
Life and Accident Plans	■ You can purchase or increase optional life or voluntary AD&D coverage for yourself, your spouse and dependent children. The 30-day limit does not apply. ■ You can add your new spouse or dependent children as beneficiaries. The 30-day limit does not apply.	■ You may be required to submit evidence of insurability if you are enrolling for the first time or want to increase optional life/voluntary AD&D coverage.
401(k) Plan	■ There is no 30-day limit; you can change your 401(k) Plan elections at any time. ■ Review your beneficiary designation. Your spouse will automatically become the beneficiary of your 401(k) Plan. If you want to choose someone other than your spouse as your beneficiary, he or she will be required to have the beneficiary designation form notarized for written consent.	■ If you're currently contributing less than the maximum, you might want to consider saving more. ■ If you're eligible and not currently participating, consider enrolling.

Benefit Plans	How Coverage Is Affected	Things to Consider
Other Benefits	■ Other benefits such as the Employee Assistance Program (EAP), Healthy You (employee well-being), Supplemental Medical Plans (Critical Illness, Accident and Hospital Indemnity insurance), Identity Theft, Legal Assistance, Adoption Assistance, and Education Assistance are always available to you. ■ If you are an eligible employee, you can make changes to your Commuter Benefits at any time. ■ If you are eligible to participate in a Health Savings Account (HSA), you can make changes at any time.	■ Let your spouse know that he/she can take advantage of the Employee Assistance Program (EAP). ■ For Commuter Benefits, if your commuting expenses will change, decide if you want to establish, drop, or change your coverage.

IF YOU BECOME A PARENT

Becoming a parent through birth or adoption of a child is considered a life status change or life event, meaning that you can make certain adjustments to your benefits. If you don't enroll or make changes to certain benefits within 30 days of becoming a parent, you must wait until the next annual open enrollment or until you have another life event to enroll or make changes.

The following table outlines how your coverage is affected when you become a parent.

Benefit Plans	How Coverage Is Affected	Things to Consider
Health Care Plans (including medical, dental, vision and prescription drug coverage)	■ If you plan to add coverage, you must enroll your new child within 30 days of the birth, placement for adoption, or adoption for coverage to be effective. ■ Your coverage change must be consistent with your life status change, unless you qualify for certain special enrollment rights. See "Special Enrollment Rights" in the *Participating in the Health Care Plans* section for details.	■ Determine whether your child will be covered under your IQVIA Health Care Plans or your spouse's plans. ■ If you are adopting a child, consider enrolling him/her in coverage.
Flexible Spending Accounts (FSAs)	■ You can enroll or increase Health Care FSA, Combination FSA and/or Dependent Care FSA contributions within 30 days of the event. ■ Your coverage change must be consistent with your life status change, unless you qualify for certain special enrollment rights. See "Special Enrollment Rights" in the *Participating in the Health Care Plans* section for details.	■ Determine what expenses your child may have that will not be covered by the health plans, and decide if you want to enroll or increase your Health Care or Combination FSA. ■ If your child is under age 13 and will be in daycare, decide if you want to enroll or increase your Dependent Care FSA.
Life Insurance AD&D Plans	■ You can purchase or increase optional life/voluntary AD&D coverage for yourself, your spouse and dependent children. The 30-day limit does not apply. ■ You can add your new spouse or dependent children as beneficiaries. The 30-day limit does not apply.	■ You may be required to submit evidence of insurability if you want to purchase or increase optional life/voluntary AD&D coverage.

Benefit Plans	How Coverage Is Affected	Things to Consider
401(k) Plan	■ There is no 30-day limit – you can change your 401(k) Plan elections at any time. ■ Review your beneficiary designations. If you are married, your spouse is automatically the beneficiary of your 401(k) Plan. If you want to add your dependent child as primary beneficiary, your spouse will be required to have the beneficiary form notarized for written consent.	■ Evaluate whether you're taking full advantage of the 401(k) Plan – review your contributions and investment choices.
Other Benefits	■ Other benefits such as the Employee Assistance Program (EAP), Healthy You (employee well-being), Supplemental Medical Plans (Critical Illness, Accident and Hospital Indemnity insurance), Identity Theft, Legal Assistance, Adoption Assistance, and Education Assistance are always available to you. ■ If you are an eligible employee, you can make changes to your Commuter Benefits at any time. ■ If you are eligible to participate in a Health Savings Account (HSA), you can make changes at any time	■ Let your dependents know that they can take advantage of the Employee Assistance Program (EAP). ■ For Commuter Benefits, if your commuting expenses will change, decide if you want to establish, drop, or change your coverage.

IF YOU BECOME LEGALLY SEPARATED OR DIVORCED OR YOUR MARRIAGE IS ANNULLED

Legal separation, divorce, or annulment are all considered life status changes or life events, meaning that you can make certain adjustments to your benefits. If you don't enroll or make changes to certain benefits within 30 days of the event, you must wait until the next annual open enrollment or until you have another life event to enroll or make changes.

If you move or change your name, remember to update your personal information in IQVIA Workday. If you change your name, you also need to notify the Social Security Administration.

The following table outlines how your coverage is affected by legal separation, divorce, or annulment.

Benefit Plans	How Coverage Is Affected	Things to Consider
Health Care Plans (including medical, dental, vision and prescription drug coverage)	■ If you're not currently enrolled because you have other coverage, you can enroll yourself and/or your dependent children in the Health Care Plans as long as you do so within 30 days of the event. ■ If you're currently enrolled in the Health Care Plans, you can change your coverage level or cancel coverage for your former spouse. Your spouse's coverage ends on the day your divorce, separation or annulment is finalized. ■ Your coverage change must be consistent with your life status change, unless you qualify for certain special enrollment rights. See "Special Enrollment Rights" in the *Participating in the Health Care Plans* section for details.	■ Evaluate whether you need to change your coverage level – for example, from employee + spouse to employee only. ■ Decide if your spouse will continue coverage through COBRA. Information on COBRA will be mailed to you following the removal of your former spouse from coverage.

Benefit Plans	How Coverage Is Affected	Things to Consider
Flexible Spending Accounts (FSAs)	■ You can decrease or stop your Health Care FSA and/or Dependent Care FSA contributions within 30 days of the event. ■ You may use the Health Care FSA to reimburse yourself for the eligible expenses of a dependent even if they do not live with you, if you are legally required to pay their health care expenses. ■ Your coverage change must be consistent with your life status change, unless you qualify for certain special enrollment rights. See "Special Enrollment Rights" in the *Participating in the Health Care Plans* section for details. ■ You cannot reduce your Health Care or Dependent Care FSA election to less than the amount you have already had deducted from your check to date during the year.	■ Evaluate whether you should continue or drop your Health Care FSA contributions. ■ Evaluate whether you should continue or drop your Dependent Care FSA contributions. ■ Remember to submit health care expenses that were incurred while your former spouse was still eligible for coverage.
Life and Accident Plans	■ You may increase or decrease coverage for yourself. ■ You must cancel coverage for your former spouse. ■ You may want to reconsider your beneficiary designations. The 30-day limit does not apply.	■ You may be required to submit evidence of insurability if you want to increase your optional life/voluntary AD&D coverage. See the *Life Insurance* section for details. ■ Determine whether you need to change your coverage – for example, stop participating in optional life or voluntary AD&D coverage for certain dependents.
401(k) Plan	■ There is no 30-day limit – you can change your 401(k) Plan elections at any time. ■ Review your beneficiary designation.	■ You may be required to provide a benefit for your former spouse through a qualified domestic relations order (QDRO), if agreed to by both parties through the court. ■ If you're currently contributing less than the maximum, you might want to consider saving more. ■ If you're eligible and not currently participating, consider enrolling.
Other Benefits	■ Other benefits such as the Employee Assistance Program (EAP), Healthy You (employee well-being), Supplemental Medical Plans (Critical Illness, Accident and Hospital Indemnity insurance), Identity Theft, Legal Assistance, Adoption Assistance, and Education Assistance are always available to you. ■ If you are an eligible employee, you can make changes to your Commuter Benefits at any time. ■ If you are eligible to participate in a Health Savings Account (HSA), you can make changes at any time.	■ For Commuter Benefits, if your commuting expenses will change, decide if you want to establish, drop, or change your coverage.

IF YOU TAKE AN APPROVED LEAVE OF ABSENCE (LOA)

If you plan to take a non-disability leave of absence (LOA), speak with Employee Benefits regarding the types of leave available and the eligibility requirements for each.

The following table outlines how your coverage is affected by taking an LOA.

Benefit Plans	How Coverage Is Affected
Health Care Plans (including medical, dental, vision and prescription drug coverage)	■ If you are on a short-term unpaid LOA, your medical, prescription drug, dental and vision plan coverage will continue and your missed deductions will be recouped when you return to work. ■ If you are on a long-term unpaid LOA, you can continue your medical, prescription drug, dental and vision plan coverage by paying the full IQVIA non-subsidized monthly premiums. ■ If you are on an approved Leave, you can continue your medical, prescription drug, dental and vision plan coverage. ■ If you are on a paid leave, your premiums will continue to be deducted from your paycheck. ■ If you are on a short-term unpaid leave, IQVIA will pay the premiums for employee and/or family coverage during your leave. (You must be enrolled in family coverage at the time of your application to continue that coverage during your leave.) Your missed deductions will be recouped when you return to work. If you are on an unpaid leave for longer than four weeks, you will be required to pay the full IQVIA non-subsidized monthly premiums directly to Employee Benefits during the leave.
Flexible Spending Accounts (FSAs)	■ If you are on an approved paid LOA, contributions will continue to be deducted from your paycheck for the Health Care and Dependent Care FSA. ■ If you are on an approved unpaid LOA, all contributions will be recouped from your pay. ■ You may continue to submit claims to the Dependent Care FSA for expenses incurred during the remainder of the calendar year.
Life and Accident Plans	■ If you are on an approved LOA, your company-paid insurance (except business travel accident coverage) will continue. You may continue optional life/voluntary AD&D coverage for you and/or your dependents by paying the premium. If you do not maintain your coverage during your leave, or if you don't make the required payments, coverage will be canceled. Evidence of insurability may be required to reinstate benefits. ■ Your pre-leave coverage will be reinstated when you return to work.
401(k) Plan	■ Contributions to your 401(k) account will be discontinued while you are on LOA, and resume when you return to work. ■ You may continue to make investment fund changes, and your account balance will change based on investment performance. ■ If you are on an approved military leave of absence, you may continue contributions based on the actual pay received from the company according to the military leave policy in effect. ■ When you return from military leave, you may make up the missed contributions to your account up to the statutory limits. ■ If you have an outstanding loan, contact Fidelity at 800-835-5097 to discuss your payment options.
Other Benefits	■ Other benefits such as the Employee Assistance Program (EAP), Healthy You (employee well-being), Supplemental Medical Plans (Critical Illness, Accident and Hospital Indemnity insurance), Identity Theft, Legal Assistance, Adoption Assistance, and Education Assistance may continue depending on your type of leave. ▫ **If you are on a short-term LOA,** your other benefits will continue. ▫ **If you are on a long-term unpaid LOA,** your other benefits will be suspended until you return to work. (This does not apply to the EAP.)

IF YOU BECOME DISABLED

If you become disabled, notify your supervisor and call Lincoln immediately at 800-213-5608. In addition, you must notify the IQVIA Benefits Marketplace by calling 888-264-9180. If you are injured on the job, you must also call IQVIA Risk Management at 800-526-7094.

The following table outlines how your benefits coverage is affected by becoming disabled. See the *Disability Coverage* section for more information.

Benefit Plans	How Coverage Is Affected
Health Care Plans (including medical, dental, vision and prescription drug coverage)	■ If you are receiving short-term disability (STD) benefits, your health care coverage remains in effect. Your premium will be deducted from your STD payments. ■ If you are receiving long term disability (LTD) benefits, you may continue your health care coverage if you are still employed by IQVIA by paying your portion of the premium. If you separate from employment, you will be offered COBRA continuation coverage.
Flexible Spending Accounts (FSAs)	■ If you are receiving STD benefits, contributions will continue to be deducted for your Health Care FSA and/or Dependent Care FSA.
Life and Accident Plans	■ If you are receiving STD benefits, all current coverage remains in effect. Any applicable premiums for optional life/voluntary AD&D coverage will be deducted from your STD payments. Business travel accident coverage ends on the day you become disabled. ■ If you are receiving LTD benefits, your life insurance coverage may continue up to age 70 without any premium contribution as outlined in the continuation of coverage during disability provision. ■ You and/or your dependents may convert to an individual policy within 30 days of when your coverage ends.
401(k) Plan	■ If you are receiving STD or LTD benefits, your 401(k) contributions will not be deducted from your pay. ■ You may elect to roll over your account value at the LTD effective date or have the account paid to you. Lincoln must determine that you are disabled and you must be coded as "terminated" before any distribution may be processed. ■ If you have the account paid to you (not rolled over), you should consult a tax advisor for tax consequences on the distribution. ■ Check with Lincoln to evaluate the impact of a 401(k) payout on your LTD benefit, if any.
Other Benefits	■ The continuation of benefits such as the Employee Assistance Program (EAP), Healthy You (employee well-being), Supplemental Medical Plans (Critical Illness, Accident and Hospital Indemnity insurance), Identity Theft, Legal Assistance, Adoption Assistance, and Education Assistance depends on your type of disability leave. ▫ **If you are on STD,** your Education Assistance benefits are suspended until you return to work; your other benefits will continue ▫ **If you are on LTD,** your Adoption Assistance and Education Assistance will be suspended until you return to work. (This does not apply to the EAP, Healthy You, Identity Theft, or Legal Assistance.)

IF YOU BECOME TERMINALLY ILL

If you become terminally ill and need to take a leave of absence, notify your supervisor and call Lincoln immediately at 800-213-5608. In addition, you must notify the IQVIA Benefits Marketplace by calling 888-264-9180.

The following table outlines how your benefits coverage is affected by becoming terminally ill.

Benefit Plans	How Coverage Is Affected	Things to Consider
Health Care Plans (including medical, dental, vision and prescription drug coverage)	■ Your coverage will not be affected if you are able to continue to work. ■ If you are receiving short-term disability (STD) benefits, your health care coverage remains in effect. Your premium will be deducted from your STD payments.	■ Check to see if you are covered for hospice care.
Flexible Spending Accounts (FSAs)	■ Your coverage will not be affected if you are able to continue to work. ■ If you are receiving STD benefits, contributions will continue to be deducted for both accounts.	
Life and Accident Plans	■ Review your beneficiary designations, and make changes as necessary. The 30-day limit does not apply.	■ If you qualify, Lincoln allows you access to up to the lesser of 80% of your life insurance benefit or $250,000 (AD&D is not included). At your death, any remaining benefits will be paid to your beneficiary. There are no restrictions as to how you spend the money. You may want to consult with a tax advisor before choosing this option.
401(k) Plan	■ Review your beneficiary designations.	
Other Benefits	■ Other benefits such as the Employee Assistance Program (EAP), Healthy You (employee well-being), Supplemental Medical Plans (Critical Illness, Accident and Hospital Indemnity insurance), Identity Theft, Legal Assistance, Adoption Assistance, and Education Assistance are always available to you while you are actively at work or on STD. Education Assistance will be suspended until you return to work. If you are on LTD, Adoption Assistance will also be suspended while you are out. ■ If you are an eligible employee, you can make changes to your Commuter Benefits at any time.	■ The Employee Assistance Program (EAP) can provide resources and bereavement counseling for your eligible dependents. ■ For Commuter Benefits, if your commuting expenses will change, decide if you want to establish, drop, or change your coverage.

IF YOU DIE WHILE ACTIVELY EMPLOYED

If you die, your beneficiary should notify IQVIA as soon as possible. To receive benefits, your beneficiary will need to complete a claim form and submit a certified death certificate. IQVIA can help your beneficiary complete the necessary claim forms and any additional information required by the insurance company.

The following table outlines how benefits coverage for your dependents is affected.

Benefit Plans	How Coverage Is Affected
Health Care Plans (including medical, dental, vision and prescription drug coverage)	■ The company will provide medical, prescription drug, dental and vision coverage for your eligible dependents through COBRA at no cost to them until the end of the month in which your death occurs. After this, your eligible dependents will be offered COBRA continuation coverage.
Flexible Spending Accounts (FSAs)	■ Your eligible dependents may submit expenses incurred prior to your death.
Life and Accident Plans	■ Your beneficiary(ies) will be paid a life insurance benefit and, if applicable, an AD&D benefit. ■ Your dependents may convert their life and accident coverage to an individual policy within 30 days of your death.
401(k) Plan	■ Your 401(k) account will become fully vested. ■ Your beneficiary(ies) will receive information about their payout options. Among the options they may choose are: ▫ A lump sum as soon as practical after your death. ▫ A deferred lump sum distribution payable no later than the last day of the 5th calendar year immediately following your death. ▫ Annual or quarterly installment payments over a period not to exceed your beneficiary's life expectancy.
Other Benefits	■ The Employee Assistance Program (EAP) can provide resources and bereavement counseling for your eligible dependents. ■ Your dependents may submit Commuter Benefits expenses you incurred prior to your death (180 day limit).

IF A DEPENDENT DIES

A dependent dying is considered to be a life status change or life event, meaning that you can make certain adjustments to your benefits. If you don't enroll or make changes to certain benefits within 30 days, you must wait until the next annual open enrollment or until you have another life event to enroll or make changes.

If a dependent dies, notify IQVIA and make any necessary changes to your personal information on the IQVIA Benefits Marketplace website.

If you have optional life insurance coverage, you will need to complete a claim form and submit a certified death certificate. IQVIA can help you complete the necessary claim forms and any additional information required by the insurance company.

The following table outlines how your coverage is affected if a dependent dies.

Benefit Plans	How Coverage Is Affected	Things to Consider
Health Care Plans (including medical, dental, vision and prescription drug coverage)	■ If you're not currently enrolled and your spouse dies, you can enroll yourself and/or your dependent children as long as you do so within 30 days of the event. ■ If you're currently enrolled in IQVIA coverage, you can change your coverage level or cancel coverage for that dependent. ■ Your coverage change must be consistent with your life status change, unless you qualify for certain special enrollment rights. See "Special Enrollment Rights" in the *Participating in the Health Care Plans* section for details.	■ Evaluate whether you need to change your coverage level – for example, from employee + spouse to employee only.
Flexible Spending Accounts (FSAs)	■ You can enroll, increase or decrease your Health Care FSA and/or Dependent Care FSA contributions within 30 days of the event. ■ Your coverage change must be consistent with your life status change, unless you qualify for certain special enrollment rights. See "Special Enrollment Rights" in the *Participating in the Health Care Plans* section for details. ■ You cannot reduce your Health Care FSA election to less than the amount you have already been reimbursed.	■ Evaluate whether you should continue, drop, or change your Health Care FSA contributions. ■ Evaluate whether you should continue, drop, or change your Dependent Care FSA contributions. ■ Remember to submit health care expenses that were incurred by your dependent prior to his/her death.
Life and Accident Plans	■ You can change your coverage. The 30-day limit does not apply. ■ You may want to reconsider your beneficiary designations. The 30-day limit does not apply.	■ Determine whether you need to change your coverage – for example, stop participating in the optional life/voluntary AD&D coverage. ■ You may be required to submit evidence of insurability if you want to increase your coverage.
401(k) Plan	■ There is no 30-day limit – you can change your 401(k) Plan elections at any time. ■ Review your beneficiary designation.	
Other Benefits	■ Other benefits such as the Employee Assistance Program (EAP), Healthy You (employee well-being), Supplemental Medical Plans (Critical Illness, Accident and Hospital Indemnity insurance), Identity Theft, Legal Assistance, Adoption Assistance, and Education Assistance are always available to you. ■ If you are an eligible employee, you can make changes to your Commuter Benefits at any time.	■ The Employee Assistance Program (EAP) can provide resources and bereavement counseling for you and your eligible dependents. ■ For Commuter Benefits, if your commuting expenses will change, decide if you want to establish, drop, or change your coverage.

IF YOU LEAVE IQVIA

The following table outlines what happens to your benefits coverage when you leave IQVIA.

Benefit Plans	How Coverage Is Affected	Things to Consider
Health Care Plans (including medical, dental, vision and prescription drug coverage)	■ Coverage ends on the last day of the month in which you leave IQVIA.* ■ You can continue coverage for 18 months through COBRA. You will be required to pay the full cost of coverage plus a 2% administrative fee.	
Flexible Spending Accounts	■ Participation ends on the day you leave IQVIA.* ■ You can elect to continue participation in the Health Care FSA through the end of the year on an after-tax basis through COBRA. You will be required to pay the full cost of coverage plus a 2% administrative fee. ■ You may not continue your Dependent Care FSA when you leave IQVIA. ■ You may submit dependent care expenses incurred through the remainder of the calendar year.	■ Remember to submit health care expenses incurred prior to your termination date within 90 days of your separation.
Life and Accident Plans	■ Coverage ends on the last day of your employment with IQVIA.* ■ You can elect to continue coverage by converting to an individual policy. You must purchase this coverage within 30 days after your company-sponsored coverage ends.	

Benefit Plans	How Coverage Is Affected	Things to Consider
401(k) Plan	■ If your 401(k) account balance is less than $1,000, it will be paid out as a lump sum. You may roll it over to an Individual Retirement Account (IRA) or another tax-qualified employer plan without taxes being withheld. If you do not roll it over, there may be tax liabilities for which you will be responsible. ■ If your account balance is greater than $1,000, you may choose to receive the full value of your account balance in a lump sum, or you may keep your account in the Plan until age 70-1/2. ■ Outstanding loans must be paid back after you leave IQVIA, unless you set-up ACH repayments directly with Fidelity within 30 days of termination to continue loan payments. If payments are not continued, the loan will automatically be defaulted and become taxable income in the year of default. ■ You may roll your balance over to an Individual Retirement Account (IRA) or another tax-qualified employer plan without taxes being withheld. If you do not roll it over, there may be tax liabilities for which you will be responsible. ■ You will not be able to make any further contributions, but you may continue to change investment funds within the Plan. ■ Review your beneficiary designation. If you are married, your spouse is always your beneficiary. If you want to choose another beneficiary, your spouse will be required to provide notarized written consent. Call Fidelity at 1-800-835-5097 for beneficiary forms or log on to their website at http://www.401k.com.	■ If you are "Early Retirement" eligible, i.e., at least age 55 with 5 or more years of service, you may keep your account in the Plan until age 70-1/2. ■ If you are "Early Retirement" eligible, i.e., at least age 55 with 5 or more years of service, you may elect installment payments directly from the Plan to be paid over a specific time period or over your lifetime or joint lifetimes with your spouse, if married. This is provided you have terminated employment with IQVIA.
Other Benefits	■ All other benefits will end on your last day of work.	■ Remember to submit any Commuter Benefits expenses you incurred before your last day of work (180 day limit).

* If you receive a severance package upon termination, the date your benefits end may differ depending on the terms of your separation.

IF YOU RETIRE

Remember to notify IQVIA at least two months before you plan to retire. COBRA will be offered at retirement for medical, dental and vision coverage.

The following table outlines what happens to your benefits coverage when you retire.

Benefit Plans	How Coverage Is Affected	Things to Consider
Health Care Plans (including medical, dental, vision and prescription drug coverage)	■ Coverage ends on the last day of the month in which you retire.* ■ You can continue coverage through COBRA. You will be required to pay the full cost of coverage plus a 2% administrative fee. ■ You can apply for Medicare if you are age 65 or older.	
Flexible Spending Accounts	■ Participation ends on the day you leave IQVIA.* ■ You can elect to continue participation in the Health Care FSA through the end of the year on an after-tax basis through COBRA. You will be required to pay the full cost of coverage plus a 2% administrative fee. ■ You may not continue your Dependent Care FSA when you retire.	■ Remember to submit health care expenses incurred prior to your retirement date within 90 days of your last day of work. ■ You may submit dependent care expenses incurred through the remainder of the calendar year.
Life and Accident Plans	■ Coverage ends on the last day of your employment with IQVIA*. ■ You can elect to continue coverage by converting to an individual policy. You must purchase coverage within 30 days after coverage ends.	

Benefit Plans	How Coverage Is Affected	Things to Consider
401(k) Plan	■ If your 401(k) account balance is less than $1,000, it will be paid out as a lump sum. You may roll it over to an Individual Retirement Account (IRA) or another tax-qualified employer plan without taxes being withheld. If you do not roll it over, there may be tax liabilities for which you will be responsible. ■ If your account balance is greater than $1,000, you may choose to receive the full value of your account balance in a lump sum, or you may keep your account in the Plan until age 65. ■ Outstanding loans must be paid back after you retire from IQVIA, unless you set-up ACH repayments directly with Fidelity within 30 days of termination in order to continue loan payments. If payments are not continued, the loan will automatically be defaulted and become taxable income in the year of default. ■ You may roll your balance over to an Individual Retirement Account (IRA) or another tax-qualified employer plan without taxes being withheld. If you do not roll it over, there may be tax liabilities for which you will be responsible. ■ You will not be able to make any further contributions, but you may continue to change investment funds within the Plan. ■ Review your beneficiary designation. If you are married, your spouse is always your beneficiary. If you want to choose another beneficiary, your spouse will be required to provide notarized written consent. Call Fidelity at 800-835-5097 for beneficiary forms or log on to their website at http://www.401k.com.	■ If you are "Early Retirement" eligible, i.e., at least age 55 with 5 or more years of service, you may keep your account in the Plan until age 70-1/2. ■ If you are "Early Retirement" eligible, i.e., at least age 55 with 5 or more years of service, you may elect installment payments directly from the Plan to be paid over a specific time period or over your lifetime or joint lifetimes with your spouse, if married. This is provided you have terminated employment with IQVIA.
Other Benefits	■ All other benefits will end on your last day of work.	■ Consider accessing the Employee Assistance Program (EAP) to help you prepare for retirement. ■ Remember to submit any Commuter Benefits expenses you incurred before your last day of work (180 day limit).

* If you receive a severance package upon termination, the date your benefits end may differ depending on the terms of your separation.

IF A DEPENDENT CHILD IS NO LONGER ELIGIBLE FOR COVERAGE

A dependent child losing eligibility for coverage is considered a life status change or life event, meaning that you can make certain adjustments to your benefits. If you don't make changes to certain benefits within 30 days, you must wait until the next annual open enrollment or until you have another life event to make changes.

The following table outlines how coverage is affected when a dependent child is no longer eligible for coverage.

Benefit Plans	How Coverage Is Affected	Things to Consider
Health Care Plans (including medical, dental, vision and prescription drug coverage)	■ If you're currently enrolled in IQVIA coverage, you can change your coverage level or cancel coverage for that dependent. Your child can continue coverage through COBRA. You will be required to pay the full cost of coverage plus a 2% administrative fee. ■ Your coverage change must be consistent with your life status change, unless you qualify for certain special enrollment rights. See "Special Enrollment Rights" in the *Participating in the Health Care Plans* section for details.	■ Evaluate whether you need to change your coverage level – for example, from employee + spouse to employee only.
Flexible Spending Accounts	■ You can decrease or stop your Health Care FSA and/or Dependent Care FSA contributions within 30 days of the event. ■ Your coverage change must be consistent with your life status change, unless you qualify for certain special enrollment rights. See "Special Enrollment Rights" in the *Participating in the Health Care Plans* section for details. ■ You cannot reduce your Health Care FSA election to less than the amount you have already been reimbursed.	■ Evaluate whether you should continue, drop, or change your Health Care FSA contributions. ■ Evaluate whether you should continue, drop, or change your Dependent Care FSA contributions. ■ Remember to submit health care expenses that were incurred by your dependent prior to his/her losing coverage.
Life and Accident Plans	■ You can change your coverage as long as you do so within 30 days of the event. ■ You may want to reconsider your beneficiary designations. The 30-day limit does not apply.	■ Determine whether you need to change your coverage – for example, stop participating in optional life/voluntary AD&D coverage. ■ You may be required to submit evidence of insurability if you want to increase your coverage.

IF YOUR SPOUSE HAS A CHANGE IN EMPLOYMENT

A spouse's change in employment resulting in you or your dependents gaining or losing coverage under another plan is considered a life status change or life event, meaning that you can make certain adjustments to your benefits. If you don't enroll or make changes to certain benefits within 30 days, you must wait until the next annual open enrollment or until you have another life event to enroll or make changes.

The following table outlines what happens to benefits coverage if your spouse has a change in employment.

Benefit Plans	How Coverage Is Affected	Things to Consider
Health Care Plans (including medical, dental, vision and prescription drug coverage)	■ If you plan to add coverage for a spouse and, if applicable, dependent children, you must enroll your spouse, and/or children within 30 days of the event. ■ If you plan to enroll under your spouse's plan and drop your IQVIA coverage, you must do so within 30 days of the event. ■ Your coverage change must be consistent with your life status change, unless you qualify for certain special enrollment rights. See "Special Enrollment Rights" in the *Participating in the Health Care Plans* section for details.	■ Determine whether your spouse will be covered under the Health Care Plans, or if you will be covered under his/her plans. ■ Decide if you and your spouse will maintain separate coverage. ■ If you have children, decide who will cover the children.
Flexible Spending Accounts	■ You can enroll, increase, decrease or stop your Health Care FSA and Dependent Care FSA contributions within 30 days of the event. ■ Your coverage change must be consistent with your life status change, unless you qualify for certain special enrollment rights. See "Special Enrollment Rights" in the *Participating in the Health Care Plans* section for details. ■ You cannot reduce your Health Care FSA election to less than the amount you have already been reimbursed.	■ Determine what expenses your spouse or children may have that will not be covered by the health plans, and decide if you want to establish, drop, or change your Health Care FSA. ■ If you have children who will be in daycare, decide if you want to establish, drop, or change your Dependent Care FSA.
Life and Accident Plans	■ You can purchase or increase optional life and/or voluntary AD&D coverage for yourself, your spouse and eligible dependent children, if any, as long as you do so within 30 days of the event. ■ You can add your spouse or children as beneficiaries. The 30-day limit does not apply.	■ You or your spouse may be required to submit evidence of insurability if you want to increase your coverage.
401(k) Plan	■ There is no 30-day limit – you can change your 401(k) Plan elections at any time. ■ Review your beneficiary designation.	■ If you're currently contributing less than the maximum, you might want to consider saving more. ■ If you're eligible and not currently participating, consider enrolling.
Other Benefits	■ Other benefits such as the Employee Assistance Program (EAP), Healthy You (employee well-being), Supplemental Medical Plans (Critical Illness, Accident and Hospital Indemnity insurance), Identity Theft, Legal Assistance, Adoption Assistance, and Education Assistance are always available to you. ■ If you are an eligible employee, you can make changes to your Commuter Benefits at any time.	■ Let your dependents know that they can take advantage of the Employee Assistance Program (EAP). ■ For Commuter Benefits, if your commuting expenses will change, decide if you want to establish, drop, or change your coverage.

HEALTH CARE

Summary Plan Description

Your overall wellness is important to both you and IQVIA. To help support your wellness needs, IQVIA offers a wide range of quality benefits including a health care plan that consists of medical, prescription drug, dental and vision programs.

When you enroll in the IQVIA Medical Plan, your prescription drug coverage is included. You may also elect dental and vision coverage, if you choose.

These programs offer flexibility and, in some instances, choice, so that you can enroll in the programs that best meet your needs. IQVIA provides the resources to help you get the most out of your benefits. It's your responsibility to stay informed and use these resources to invest in your future and choose good health.

Residents of Hawaii and Puerto Rico

Please note that employees in Hawaii and Puerto Rico have different health care options from what's in this Benefits Handbook. If you live in Hawaii or Puerto Rico, you will receive separate summaries of the plans available to you, and you will have access to the plan websites describing their coverage. You can also contact IQVIA Employee Benefits for details on the plan offerings.

For More Information

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

IN THIS SECTION.....SEE PAGE

PARTICIPATING IN THE HEALTH CARE PLANS

Summary Plan Description

Health Care Plan Only

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

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

For More Information

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

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

IN THIS SECTION ..... SEE PAGE

ELIGIBILITY

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

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

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

Your Regularly Scheduled Work Week

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

ELIGIBLE DEPENDENTS

Keep in Mind When Enrolling...

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

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

You may cover:

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

Dependent Coverage

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

DEPENDENT CHILDREN

Eligible dependent children include your:

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

Disabled Dependent Children

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

COVERAGE CATEGORIES

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

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

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

COST OF COVERAGE

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

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

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

SPOUSAL SURCHARGE

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

TOBACCO SURCHARGE

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

PAYING FOR BENEFITS WITH PRE-TAX DOLLARS

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

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

LIMITS FOR CERTAIN EMPLOYEES

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

HOW TO ENROLL

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

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

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

ENROLLING WHEN FIRST ELIGIBLE

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

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

Enrolling for Coverage

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

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

ENROLLING DURING OPEN ENROLLMENT

FSA Enrollment

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

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

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

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

MAKING MID-YEAR ENROLLMENT CHANGES

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

Life Status Change

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

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

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

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

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

Network Provider Changes Are Not Life Status Changes

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

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

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

Special Enrollment Rights

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

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

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

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

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

Children's Health Insurance Program (CHIP) or Medicaid

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

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

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

Judgments, Decrees and Orders

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

Medicare or Medicaid Entitlement

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

Family and Medical Leave Act (FMLA)

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

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

Significant Cost or Coverage Changes

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

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

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

How to Make Changes

Changes Must Be Consistent with Your Life Status Change

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

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

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

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

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

IF YOU DO NOT ENROLL

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

WHEN COVERAGE BEGINS

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

ID Cards

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

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

WHEN COVERAGE BEGINS FOR YOUR COVERED DEPENDENTS

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

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

WHEN COVERAGE ENDS

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

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

WHEN COVERAGE ENDS FOR YOUR COVERED DEPENDENTS

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

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

IF YOU GO OUT ON LEAVE

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

MEDICAL LEAVE/FMLA

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

The following reasons qualify for family medical leave:

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

Going on Leave

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

While on Leave

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

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

When You Return to Work

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

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

If You Do Not Return to Work

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

See the *COBRA* section for details.

MILITARY LEAVE OF ABSENCE

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

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

IF YOU ARE COVERED BY MORE THAN ONE PLAN

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

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

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

WHICH PLAN PAYS FIRST

Court-Ordered Benefit Responsibility

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

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

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

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

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

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

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

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

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

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

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

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

HOW MUCH THE PLAN PAYS

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

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

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

SUBROGATION AND REIMBURSEMENT

Required Notification

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

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

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

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

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

Consequences of Subrogation and Reimbursement

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

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

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

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

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

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

MEDICAL COVERAGE

Summary Plan Description

Self-Insured

The IQVIA Medical Plan administered by Aetna is not an insured plan. The benefits under the plan are self-insured by IQVIA which is responsible for their payment.

The IQVIA Medical Plan combines traditional medical, preventive, surgical, hospitalization and major medical coverage into one plan. Under the plan, you retain all of the valuable benefits available under managed care programs, (e.g., pre-certification of all inpatient hospital admissions and certain outpatient procedures). And, you maintain the flexibility and convenience of self-management, (e.g., choice of doctors, no primary care physician and no referrals). There are four medical plan options administered by Aetna—the $400 Deductible PPO Plan, $900 Deductible PPO Plan, $1,850 Deductible Plan with Health Savings Account (HSA) and $2,850 Deductible Plan with Health Savings Account (HSA). Employees in California and Georgia can choose between Kaiser and Aetna.

If you are eligible to participate in the IQVIA Medical Plan, you may choose the plan option that best meets your individual needs. The quality, covered services and provider networks are the same under all four plans, but the amount you pay for care depends on which plan you choose.

For More Information

For details about eligibility for benefits, when you can change your coverage and how you pay for coverage, see the *Participating in the Health Care Plans* section. For information about your legal rights under ERISA, general information on claims review and appeal procedures and other important administrative details, see the *Administrative Information* section. To contact the plan administrator, use the information listed in the *Contacts* section.

IN THIS SECTION ..... SEE PAGE

AT A GLANCE

Questions?

If you have questions about your medical benefits, call Aetna at 800-726-4366 or Kaiser at 800-464-4000, or log on to their websites at www.aetna.com or https://healthy.kaiserpermanente.org.

The Aetna Medical Plan options are network-based, meaning the benefits will be richer if you use a preferred network physician or hospital. However, you are welcome to see out-of-network providers if you choose, and benefits will be paid at the out-of-network rate.

If you choose Kaiser, coverage is in-network only. There is no coverage out of the network (except emergency care).

Here is a quick look at what each of the plan options cover.

Medical Options	$400 Deductible PPO Plan		$900 Deductible PPO Plan		$1,850 Deductible Plan with HSA		$2,850 Deductible Plan with HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible								
■ Individual	■ $400	■ $2,500	■ $900	■ $3,000	■ $1,850	■ $3,700	■ $2,850	■ $5,700
■ Family	■ $800	■ $5,000	■ $1,800	■ $6,000	■ $3,700	■ $7,400	■ $5,700	■ $11,400
Coinsurance for most covered services	80%	60%	80%	60%	80%	60%	70%	50%
Annual Medical Out-of-Pocket Maximum								
■ Individual	■ $2,200	■ $4,400	■ $3,000	■ $6,000	■ $3,500	■ $7,000	■ $5,500	■ $11,000
■ Family	■ $4,400	■ $8,800	■ $6,000	■ $12,000	■ $6,500	■ $13,000	■ $11,000	■ $22,000
Lifetime Maximum								
Preventive Care	100%	60%, after deductible	100%	60%, after deductible	100%	60%, after deductible	100%	50%, after deductible
Physician Office Visits	Primary Care Physician: $20 copay Specialists: $40 copay Deductible doesn't apply	60%, after deductible	Primary Care Physician: $40 copay Specialists: $80 copay Deductible doesn't apply	60%, after deductible	80%, after deductible	40%, after deductible	70%, after deductible	50%, after deductible

Medical Options	$400 Deductible PPO Plan		$900 Deductible PPO Plan		$1,850 Deductible Plan with HSA		$2,850 Deductible Plan with HSA	
	In-Network	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Telehealth* (Teladoc) (online video or phone appointments for treatment of non-emergency medical issues)	$20 copay; deductible doesn't apply		$20 copay; deductible doesn't apply		$49 copay until deductible is met; then 80% coinsurance		$49 copay until deductible is met; then 40% coinsurance	
Inpatient Hospital Services	80% after deductible	60%, after deductible	80% after deductible	60% after deductible	80% after deductible	60% after deductible	70%, after deductible	50%, after deductible

*Available with the Aetna plans only.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

What does the annual medical out-of-pocket maximum include?

The annual out-of-pocket maximum includes the calendar year deductible, office visit copays and coinsurance. It does not include any costs not covered by the plan—like costs above Maximum Reimbursable Charges (MRC).

How does the family deductible and out-of-pocket maximum work in the $1,850 and $2,850 Deductible Plans with HSA?

In the $1,850 Deductible Plan with HSA administered by Aetna, if you cover dependents, you and your covered family members must meet the family deductible before the plan pays benefits for any family member. Medical and prescription drug expenses for one family member or for all family members can add up to the deductible.

The same rule applies to the out-of-pocket maximum before the plan pays 100% of covered expenses for any family member.

If you enroll in the $1,850 Deductible Plan with HSA administered by Kaiser or $2,850 Deductible Plan with HSA administered by Aetna or Kaiser, each individual only needs to meet the individual deductible before the plan pays benefits for that individual member. The same rule applies to the out-of-pocket maximum before the plan pays 100% of covered expenses for that individual member.

What happens if my doctor drops out of the network?

You will need to choose another doctor from the Aetna provider directory to receive network benefits. Keep in mind that you can go to any doctor in the network, and you do not have to choose a primary care physician. You can continue to see a doctor who has dropped out of the network, but you will receive lower benefits for out-of-network care. If you choose Kaiser, you will need to find another doctor from the Kaiser network.

When do I receive my health plan ID card after I enroll as a new hire?

You should receive ID cards (depending on your elections) within 2-3 weeks to your home address:

- Aetna: Each family will be issued two (2) ID cards. If you wish to print additional cards, please sign into your Aetna account at www.aetna.com, or download the Aetna app to your mobile device, where you can also view an electronic ID card.
- Kaiser: Each covered member will receive an ID card, which will serve as a combined medical and prescription card. If you wish to print additional cards, you can do so at https://healthy.kaiserpermanente.org.

How can I view my claims status?

You can view the status of your claims:

- At www.aetna.com. Log in and click, "Manage Claims" at the top of the Welcome page.
- At https://healthy.kaiserpermanente.org. Log in and click "Coverage and Costs."

If you're not registered to use the Aetna or Kaiser websites, use these instructions below:

- Aetna: Go to www.aetna.com and click "Log In/Register." You will need to enter your member ID, which is located on your ID card, first and last name, date of birth, zip code and an email address. Then, click "Continue" and follow the prompts to set up your account.
- Kaiser: Go to https://healthy.kaiserpermanente.org and click "Register." Then click "I have a Kaiser Permanente plan and want to use online services." You will need to enter your first and last name, date of birth, preferred language, region and medical record number (MRN) from your ID card. Note: Northern CA employees do not need to include the "11" prefix in the MRN.

HOW THE MEDICAL PLAN WORKS

There are four levels of medical coverage:

- **$400 Deductible PPO Plan:** Offers the lowest deductibles and out-of-pocket costs when you need medical services. However, the monthly contributions for coverage are the highest.
- **$900 Deductible PPO Plan:** Higher deductibles and out-of-pocket costs than the $400 Deductible PPO Plan, but lower monthly contributions.
- **$1,850 Deductible Plan with HSA**: Offers a higher deductible and out-of-pocket costs with the lower monthly contributions for coverage than the $900 Deductible PPO Plan.
- **$2,850 Deductible Plan with HSA**: Offers the highest deductible and out-of-pocket costs with the lowest monthly contributions for coverage.

With all four options:

- Each time you receive care with Aetna, you can choose to receive care from in-network or out-of-network providers. If you choose Kaiser, coverage is in-network only (except for emergency care).
- Aetna offers a network of providers who have agreed to charge lower, fixed fees for services. You save money by using in-network providers.
- With Aetna, out-of-network care is generally subject to a higher annual deductible, and expenses are covered at a lower percentage than in-network services.
- When you enroll in any Medical Plan option, you are automatically enrolled in the Prescription Drug Program administered by Express Scripts (Aetna) or Kaiser.

IN-NETWORK BENEFITS

Aetna has selected a group of health care professionals and facilities for the Choice POS II network. All providers in the network must meet certain quality criteria established by Aetna. The network monitors the quality of service patients receive through regular practice reviews, site visits, chart reviews and numerous other measures.

When you receive in-network care, the following benefit features apply:

- You are covered at 100% for eligible preventive care.
- Physician office visits are subject to a copay in the $400 Deductible PPO Plan and $900 Deductible PPO Plan; the deductible doesn't apply. In the $1,850 Deductible Plan with HSA and $2,850 Deductible Plan with HSA you pay coinsurance after the deductible is met.
- Pre-certification for inpatient hospitalizations and certain outpatient services are managed by the doctors for you.
- The doctors have agreed to accept negotiated fees that are generally lower than what you would pay out-of-network; as a result, Maximum Reimbursable Charges (MRC) do not apply.

Kaiser's exclusive network of providers allows members to access all services under one roof, including primary and specialty care, lab, X-ray and pharmacy. All providers in the network must meet certain quality criteria established by Kaiser. The network monitors the quality of service patients receive through regular practice reviews, site visits, chart reviews and numerous other measures.

When you receive in-network care, the following benefit features apply:

- You are covered at 100% for eligible preventive care.
- Physician office visits are subject to a copay in the $400 Deductible PPO Plan and $900 Deductible PPO Plan; the deductible doesn't apply. In the $1,850 Deductible Plan with HSA and $2,850 Deductible Plan with HSA you pay coinsurance after the deductible is met.

- Pre-certification for inpatient hospitalizations and certain outpatient services are managed by the network doctors for you. If you are using out-of-network providers, you are responsible for the pre-certification and you will incur a financial penalty if you do not obtain the pre-certification.

To find a doctor in the network:

- Aetna: Go to www.aetna.com/docfind. (If you're not registered to use www.aetna.com, click "Log In/Register." You will need to enter your member ID, which is located on your ID card, first and last name, date of birth, zip code and an email address. Then, click "Continue" and follow the prompts to set up your account.) Once you're logged in, click "Find Care," on the welcome page.
- Kaiser: Go to https://healthy.kaiserpermanente.org. (If you're not registered to use https://healthy.kaiserpermanente.org, click "Register." Then click "I have a Kaiser Permanente plan and want to use online services." You will need to enter your first and last name, date of birth, preferred language, region and medical record number (MRN) from your ID card. Note: Northern CA employees do not need to include the "11" prefix in the MRN.) Once you're logged in, click "Coverage and Costs."

If you need any assistance locating a provider in the network, call Aetna at 800-726-4366 or Kaiser at 800-464-4000.

OUT-OF-NETWORK BENEFITS

In the Aetna plans, you can choose to visit an out-of-network physician, hospital or other provider at any time. If you receive covered services on an out-of-network basis:

- Services performed by providers not participating in the network will be reimbursed at the out-of-network level of benefits, based on Maximum Reimbursable Charge (MRC) limits for covered services. You are responsible for any amounts above the MRC limits.
- For out-of-network care, you are responsible for filing any required claim forms, obtaining authorizations for hospital admissions and obtaining any required pre-certification for services.

Maximum Reimbursable Charges (MRC)

For most services, Maximum Reimbursable Charge (MRC) limits are based on a fee schedule (developed using a Medicare-based methodology). For some services, MRC limits are based on what providers with similar professional backgrounds, education and experience charge for a specific service within a given area. The plans cover costs up to MRC limits and you are responsible for paying any portion of the bill over the limits. Charges above MRC amounts will not apply toward your deductible, coinsurance or annual out-of-pocket maximum.

IF YOU LIVE OUTSIDE THE NETWORK AREA

In the Aetna plans, if you are unable to locate an in-network provider in your area who can provide you with a service or supply that is covered under the Medical Plan, call the number on the back of your ID card to request authorization for out-of-network provider coverage. If you get authorization for services provided by an out-of-network provider, benefits for those services will be covered at the in-network benefit level. You will still be responsible for paying any portion of the bill over the in-network benefit level.

In the Kaiser plans, if you move outside of your network area, you can continue to use the Kaiser providers or switch to an Aetna plan. If you move out of California or Georgia, you would have the option to elect an Aetna plan.

PAYING FOR YOUR CARE

In-network preventive care is covered at 100%. For all other services, you pay a copay and/or you must meet the annual deductible before you and IQVIA begin to share the cost of services.

DEDUCTIBLE

Deductible

The deductible is the amount you pay each year for eligible medical expenses before the plan begins to pay for certain benefits.

The deductible is the amount of covered charges you pay each year before the plan begins paying benefits. Exceptions include in-network preventive care and in-network physician office visits ($400 Deductible PPO Plan and $900 Deductible PPO Plan).

Only covered services count toward the deductible. This includes Maximum Reimbursable Charges (MRC) for medically necessary services out-of-network. Amounts above MRC limits are not covered services and do not count toward your deductible.

The annual deductible for each option is shown below:

Coverage Type	$400 Deductible PPO Plan		$900 Deductible PPO Plan		$1,850 Deductible Plan with HSA		$2,850 Deductible Plan with HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual	$400	$2,500	$900	$3,000	$1,850	$3,700	$2,850	$5,700
Family	$800	$5,000	$1,800	$6,000	$3,700	$7,400	$5,700	$11,400

- In the $1,850 Deductible Plan with HSA administered by Aetna, if you cover dependents, you and your covered family members must meet the family deductible before the plan pays benefits for any family member. Medical and prescription drug expenses for one family member or for all family members can add up to the deductible.
- If you enroll in the $1,850 Deductible Plan with HSA administered by Kaiser or $2,850 Deductible Plan with HSA administered by Aetna or Kaiser, each individual only needs to meet the individual deductible before the plan pays benefits for that individual member.

COINSURANCE

For most services, after you meet the deductible, you and IQVIA each pay for a percentage of the cost. The percentages are based on if you choose in- or out-of-network care.

COPAY

For certain services, like physician office visits (e.g., in the $400 Deductible PPO Plan and $900 Deductible PPO Plan), you pay a copay each time you receive care. In some instances, like emergency room care under the $400 Deductible PPO Plan, you pay a copay in addition to the coinsurance.

ANNUAL MEDICAL OUT-OF-POCKET MAXIMUM

Your annual medical out-of-pocket maximum is the most you must pay in a calendar year (including your annual deductible, office visit copays and coinsurance) toward covered eligible expenses.

Prescription copays under the $1,850 and $2,850 Deductible Plans with HSA also apply toward your medical deductible and out-of-pocket maximum. If you enroll in the $400 or $900 Deductible PPO Plan, prescription drug costs do not count toward the medical plan deductible; however, they do accumulate toward the out-of-pocket maximum.

In the Aetna plans, if you use an out-of-network provider, only Maximum Reimbursable Charges (MRC) for medically necessary services will count toward the annual out-of-pocket maximum. Amounts above MRC limits are not covered expenses and do not count toward your annual out-of-pocket maximum. The out-of-pocket maximum for each option is shown below:

Coverage Type	$400 Deductible PPO Plan		$900 Deductible PPO Plan		$1,850 Deductible Plan with HSA		$2,850 Deductible Plan with HSA	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
■ Individual	■ $2,200	■ $4,400	■ $3,000	■ $6,000	■ $3,500	■ $7,000	■ $5,500	■ $11,000
■ Family	■ $4,400	■ $8,800	■ $6,000	■ $12,000	■ $6,500	■ $13,000	■ $11,000	■ $22,000

- In the $1,850 Deductible Plan with HSA administered by Aetna, if you cover dependents, you and your covered family members must meet the family out-of-pocket maximum before the plan pays 100% of covered expenses for any family member. Medical and prescription drug expenses for one family member or for all family members can add up to the out-of-pocket maximum.
- If you enroll in the $1,850 Deductible Plan with HSA administered by Kaiser or $2,850 Deductible Plan with HSA administered by Aetna or Kaiser, each individual needs to meet the out-of-pocket maximum before the plan pays 100% of covered expenses for that individual family member.

A Quick Note about Deductibles and Out-of-Pocket Maximums

Deductibles and out-of-pocket maximums for in-network and out-of-network services are combined, which means that covered expenses cross accumulate between in and out-of-network deductibles and maximums. All other plan maximums and service-specific maximums also cross accumulate between in- and out-of-network, unless otherwise noted.

MAXIMUM LIFETIME BENEFIT

The maximum lifetime benefit limit for in-network or out-of-network care for each covered individual is unlimited for covered expenses for the length of the time the individual is covered by the IQVIA Medical Plan. Some services and treatments have specific lifetime and/or calendar year limits. See "Benefits Covered by the Medical Plan" beginning on page 45 for details on special limits for specific covered services.

OTHER PLAN FEATURES

This section describes features of the Medical Plan, including in- and out-of-network pre-certification, what to do if you need emergency care, case management, wellness tools and resources, benefits for hospital stays for mothers and newborns, and coverage for surgery following a mastectomy.

PRE-CERTIFICATION

Hospital Notification

To contact Aetna or Kaiser regarding a hospital stay, call the telephone number listed on your ID card.

In-Network

Certain in-network services, such as hospital admissions and select outpatient services require pre-certification. You must obtain pre-certification from Aetna or Kaiser before you receive care for these services. Your network provider will obtain the necessary pre-certifications for you. If you are using out-of-network providers, you are responsible for the pre-certification, and you will incur a financial penalty if you do not obtain the pre-certification.

You may call Aetna or Kaiser for a detailed list of services. The list may change periodically.

Your network provider will also contact Aetna or Kaiser if a maternity stay will exceed 48 hours for the mother and newborn child following a vaginal delivery, or 96 hours for the mother and newborn child following a cesarean section delivery.

Out-of-Network

Certain out-of-network services, such as hospital admissions and select outpatient services require pre-certification. To have your treatment pre-certified, you must call Aetna or Kaiser prior to receiving treatment. If you don't, your benefits may be reduced or denied.

If you have to be admitted to a hospital due to an emergency, you must call Aetna or Kaiser before you're admitted or as soon as reasonably possible.

Services Requiring Pre-Certification

Inpatient Settings

- All inpatient admissions and non-obstetric observations stays such as:
  - Acute hospitals
  - Hospice care
  - Long-term care facilities
  - Rehabilitation facilities
  - Skilled nursing facilities
  - Transfers between inpatient facilities
- Cochlear device and/or implantation.
- Cosmetic procedures.
- Experimental and investigational procedures.
- Gender reassignment surgery.
- Interventional pain management (e.g., implantable infusion pumps, spinal and peripheral nerve stimulators, spine injections)
- Major joint surgeries (hip, knee, shoulder)
- Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (Cesarean section).
- Musculoskeletal services, including major joint surgeries (hip, knee, shoulder) and interventional pain management (e.g., implantable infusion pumps, spinal and peripheral nerve stimulators, spine injections).
- Observation stays more than 24 hours.
- Power morcellation with uterine myomectomy, with hysterectomy or for removal of uterine fibroids.

Outpatient Settings

- Behavioral health services requiring precertification/authorization including:
  - Applied behavior analysis (ABA)
  - Inpatient admissions
  - Intensive outpatient programs (IOPs)
  - Neuropsychological testing
  - Outpatient detoxification
  - Partial hospitalization programs (PHPs)
  - Psychological testing
  - Residential treatment center (RTC) admissions
  - Transcranial magnetic stimulation (TMS)
- Certain imaging services.
- Certain outpatient surgical procedures.
- Certain prescription and injectable drugs (specific listing of codes).
- Chemotherapy for cancer diagnosis.
- Chiropractic care.
- Cosmetic or reconstructive procedures.
- Diagnostic cardiology.
- Dialysis (when request is initiated by a participating provider, and dialysis to be performed at a non-participating facility).
- Durable medical equipment (specific listing of codes).
- External prosthetic appliances, (specific listing of codes).
- Genetic testing.
- High-tech radiology (MRI, CAT scans, PET scans).
- Home health care/home infusion therapy.
- Hyperbaric oxygen therapy.
- Infertility program.
- Infertility treatment.
- Mental health or substance abuse services.
- Musculoskeletal services, including major joint surgeries (hip, knee, shoulder) and interventional pain management (e.g., implantable infusion pumps, spinal and peripheral nerve stimulators, spine injections).
- National Medical Excellence Program®.
- Occupational therapy.
- Pain management.
- Physical therapy.
- Private duty nursing.
- Radiation therapy.
- Requests for services provided by a non-participating provider to be covered at in-network level.
- Sleep studies.
- Speech therapy.
- Ventricular assist devices.
- Video electroencephalograph (EEG).

Additional Services

- Transportation by fixed-wing aircraft (plane).

IF YOU NEED EMERGENCY CARE

If you have a medical emergency, you should call 911 or go to the nearest physician, hospital emergency room or other urgent care facility. Your emergency care will be covered based on the deductible and coinsurance provisions of your option.

CASE MANAGEMENT

Case management is a service provided through a review organization, which assists individuals with treatment needs that extend beyond the acute care setting. The goal of case management is to ensure that you receive appropriate care in the most effective setting possible whether at home, as an outpatient, or an inpatient in a hospital or specialized facility. Should the need for case management arise, a case management professional will work closely with you and your family and your physician to determine appropriate treatment options which will best meet your needs and keep costs manageable. The case manager will help coordinate the treatment program and arrange for necessary resources. Case managers are also available to answer questions and provide ongoing support for your family in times of medical crisis.

Case managers are registered nurses (RNs) and other credentialed health care professionals, each trained in a clinical specialty area such as trauma, high risk pregnancy and neonates, oncology, mental health, rehabilitation or general medicine and surgery. A case manager trained in the appropriate clinical specialty area will be assigned to you (or your dependent). In addition, case managers are supported by a panel of physician advisors who offer guidance on up-to-date treatment programs and medical technology. While the case manager recommends alternate treatment programs and helps coordinate needed resources, your physician remains responsible for the actual medical care.

You (or your dependent) or your doctor can request case management services by calling the number on your ID card. In addition, you may be referred directly through Aetna or Kaiser.

While participation in case management is strictly voluntary, case management professionals can offer quality, cost-effective treatment alternatives, as well as provide assistance in obtaining needed medical resources and ongoing family support in a time of need.

WELLNESS TOOLS AND RESOURCES

Aetna Navigator®

Register for Aetna Navigator® at www.aetna.com, Aetna's secure internet access to reliable health information, tools and resources. Aetna Navigator® online tools will make it easier for you to make informed decisions about your health care, view claims, research care and treatment options, and access information on health and wellness.

Aetna Navigator® Estimate the Cost of Care

Get the most value out of your benefits. Use the "Estimate the Cost of Care" tool on Aetna Navigator® to help decide whether to get care in network or out-of-network. Aetna's secure member website at www.aetna.com may contain additional information which may help you determine the cost of a service or supply. Log on to Aetna Navigator® to access the "Estimate the Cost of Care" feature. Within this feature, view our "Cost of Care" and "Member Payment Estimator" tools.

Kaiser Permanente Online Resources

Register to use https://healthy.kaiserpermanente.org. On the site, you can access:

- A directory of plan facilities and plan physicians.
- Tools you can use to email your doctor's office, view test results, refill prescriptions, and schedule routine appointments.
- Health education resources.
- Appointments and advice phone numbers.

You can also access tools and resources using the KP app on your smartphone or other mobile device.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

In accordance with the Newborns' and Mothers' Health Protection Act, group medical plans and health insurance issuers may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother to less than 48 hours following a normal vaginal delivery, or to less than 96 hours following a cesarean section. Further, the plan cannot require that any medical provider obtain authorization from the plan or any insurance issuer for prescribing a length of stay not in excess of the above periods.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Solely to the extent required under the Women's Health and Cancer Rights Act (WHCRA), the Medical Plan will provide certain benefits in connection with a mastectomy. The Medical Plan will include coverage for reconstructive surgery following a mastectomy.

If you or your eligible dependent(s) (including your spouse or domestic partner) are receiving benefits under the Medical Plan in connection with a mastectomy and elect breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and you or your eligible dependent(s) (including your spouse or domestic partner) for reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. See the *Participating in the Health Care Plans* section for a definition of eligible dependents.

Reconstructive benefits are subject to annual plan deductibles and coinsurance provisions like other medical and surgical benefits covered under the Medical Plan.

BENEFITS COVERED BY THE MEDICAL PLAN

All four medical options cover a variety of services, as long as the services are medically necessary. The level at which benefits are paid depends on which plan option you choose and whether you receive your care in-network or out-of-network. The following charts (one for each option) show the major provisions of each medical option. If you choose Kaiser, coverage is in-network only. There is no coverage out of the network (except emergency care). Differences in the plan's coverage for Kaiser are noted below.

To see details of these services, see "Covered Service Descriptions" beginning on page 58.

$400 DEDUCTIBLE PPO PLAN

	In-Network	Out-of-Network*
Annual Deductible		
■ Individual	■ $400	■ $2,500
■ Family	■ $800	■ $5,000
Coinsurance for most covered services	80%, after deductible	60%, after deductible
Annual Out-of-Pocket Maximum**		
■ Individual	■ $2,200	■ $4,400
■ Family	■ $4,400	■ $8,800
Lifetime Maximum	None	
Preventive Care		
Routine care and office visits (includes X-ray and lab work when billed as preventive care)	100%	60%, after deductible
Immunizations: (including travel immunizations and flu shots)		
■ Children through age 2	100%	60%, after deductible
■ Children age 3 and over and adults	100%	60%, after deductible
Mammograms***	100%	60%, after deductible
Pap smears	100%	60%, after deductible
Other routine cancer screenings	100%	60%, after deductible
Skin cancer screenings when provider bills as preventive	100%	60%, after deductible

	In-Network	Out-of-Network*
Obesity or health diet counseling	100%	60%, after deductible
Screening and counseling services for misuse of alcohol or drugs	100%	60%, after deductible
Screening and counseling services to stop using tobacco products	100%	60%, after deductible
Sexually transmitted infection counseling	100%	60%, after deductible
Physician Services		
Office visits ■ Primary care physician (PCP) ■ Specialty care physician (Includes X-ray and lab work when performed and billed by the physician's office) Nurse practitioners (NP) and Physicians Assistants (PA) to be billed based on provider office type	■ PCP: $20 copay; deductible doesn't apply ■ Specialists: $40 copay; deductible doesn't apply	60%, after deductible
Telemedicine (Teladoc) – Available with the Aetna plans only	$20 copay; deductible doesn't apply	
Surgery (physician's office)	80%, after deductible	60%, after deductible
Allergy injections/antigens/serum Note: Covers the injections/serum when there is no office visit charged. Standard is to waive the copay and apply the plan deductible and plan coinsurance.	Aetna: 80%, after deductible; no copay Kaiser: $15 copay	60%, after deductible
Allergy testing and treatment (dispensed by physician's office) Note: Covers both testing and treatment, including injections/serum when billed with an office visit. Standard is to cover same as the PCP or specialist office visit.	Aetna: 100% after applicable PCP or specialist copay; deductible doesn't apply Kaiser: Applicable specialist copay applies	60%, after deductible
Hospital Services		
Inpatient hospital care (semi-private room)	80%, after deductible	60%, after deductible
Inpatient physician's visits/consultations	80%, after deductible	60%, after deductible
Inpatient professional services (surgeon, radiologist, etc.)	80%, after deductible	60%, after deductible
Outpatient physician's visits/consultations	80%, after deductible	60%, after deductible
Outpatient facility services Office/ambulatory surgery center PCP and specialist copay will apply based on provider status	80%, after deductible	60%, after deductible
Outpatient professional services (surgeon, radiologist, etc.)	80%, after deductible	60%, after deductible
Other inpatient health care facilities (e.g., skilled nursing facility, rehab hospital, sub-acute facility)	80%, after deductible	60%, after deductible

	In-Network	Out-of-Network*
Maternity Care (Employee and dependent daughters)		
Physician's office (initial visit)	Aetna: $40 copay; deductible doesn't apply Kaiser: 100%	60%, after deductible
Physician's office (visits)	100%	60%, after deductible
Physician services (pre- and post-natal visits, delivery)	80%, after deductible	60%, after deductible
Mental Health and Substance Abuse		
Inpatient services (facility, professional and other inpatient services)	80%, after deductible	60%, after deductible
Outpatient (individual or group therapy office visit)	$20 copay; deductible doesn't apply	60%, after deductible
Outpatient services (facility, professional and other outpatient services)	80% after deductible	60% after deductible
Emergency Services		
Ambulance	80% after deductible	80% after deductible
Emergency room (waived if admitted)	Aetna: $150 per visit copay, then 80% after deductible Kaiser: 80% after deductible	Aetna: $150 per visit copay, then 80% after deductible Kaiser: 80% after deductible
Urgent care	Aetna: $50 copay; deductible doesn't apply Kaiser: $20 copay; deductible doesn't apply	Aetna: 60%, after deductible Kaiser: $20 copay; deductible doesn't apply
Other Services		
Abortion/Voluntary Sterilization (dependents covered)	80%, after deductible; subject to office visit copays	60%, after deductible
Acupuncture (Aetna: 12 visits per calendar year/Kaiser: 30 visits per calendar year)	■ Office visit: $40 copay; deductible doesn't apply ■ Other covered services: 80%, after deductible	60%, after deductible
Autism and ABA Therapy	$20 copay; deductible doesn't apply	60%, after deductible
Bariatric surgery (One per lifetime; no dollar limit)	80%, after deductible	60%, after deductible
Chiropractic care (60 visits per calendar year)	$40 copay; deductible doesn't apply	60%, after deductible
Clinical trials (routine patient care services incurred as a participant in an approved clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Dental treatment (due to accidental injury to sound natural teeth provided dental treatment is started within 12 months of an accident, TMJ medical treatment and appliances)	80%, after deductible; subject to office visit copays	60%, after deductible

	In-Network	Out-of-Network*
Diagnostic X-ray & lab	Aetna: 80%, after deductible Kaiser: $15 copay; deductible doesn't apply	60%, after deductible
Durable medical equipment	Aetna: 80%, after deductible Kaiser: 80%; deductible doesn't apply	60%, after deductible
Genetic testing	80%, after deductible	60%, after deductible
Hearing aids (testing and exam)	80%, after deductible; subject to office visit copays	60%, after deductible
Hearing aids (hardware - $1,000 per ear per calendar year)	80%, after deductible (hardware only; deductible, coinsurance and copays do not apply to limit)	60%, after deductible
Home health care (120 visits per calendar year)	Aetna: 80%, after deductible Kaiser: 100%	60%, after deductible
Hospice services	Aetna: 80%, after deductible Kaiser: 100%	60%, after deductible
Skilled nursing care (inpatient—120 days per calendar year)	80%, after deductible	60%, after deductible
Private duty nursing (outpatient—60 visits per calendar year)	80%, after deductible	60%, after deductible
Organ transplants: ■ Centers of Excellence ■ Non Centers of Excellence	 ■ 80%, after deductible ■ 60%, after deductible	 ■ N/A ■ 60%, after deductible
Prosthetic devices	80%, after deductible	60%, after deductible
Outpatient rehabilitative therapy	Aetna: $40 copay; deductible doesn't apply Kaiser: $20 copay; deductible doesn't apply	60% after deductible
Outpatient therapy services (cardiac rehab, infusion therapy, chemotherapy/radiation, dialysis/hemodialysis)	$40 copay in the physician's office; deductible and coinsurance applies in other places of service	60% after deductible

* Generally, all out-of-network expenses are subject to the Maximum Reimbursable Charge (MRC) limit. You should note that since in-network charges for covered services have been negotiated with the providers, MRC limits do not apply.

** Annual deductible applies toward out-of-pocket maximum.

***In the Aetna plans, the first mammogram in a calendar year will be covered at 100% by the plan. All subsequent mammograms in a calendar year are subject to the applicable plan provisions.

$900 DEDUCTIBLE PPO PLAN

	In-Network	Out-of-Network*
Annual Deductible		
■ Individual	■ $900	■ $3,000
■ Family	■ $1,800	■ $6,000
Coinsurance for most covered services	80%, after deductible	60%, after deductible
Annual Out-of-Pocket Maximum**		
■ Individual	■ $3,000	■ $6,000
■ Family	■ $6,000	■ $12,000

	In-Network	Out-of-Network*
Lifetime Maximum	None	
Preventive Care		
Routine care and office visits (includes X-ray and lab work when billed as preventive care)	100%	60%, after deductible
Immunizations: (including travel immunizations and flu shots)		
■ Children through age 2	100%	60%, after deductible
■ Children age 3 and over and adults	100%	60%, after deductible
Mammograms***	100%	60%, after deductible
Pap smears	100%	60%, after deductible
Other routine cancer screenings	100%	60%, after deductible
Skin cancer screenings when provider bills as preventive	100%	60%, after deductible
Obesity or health diet counseling	100%	60%, after deductible
Screening and counseling services for misuse of alcohol or drugs	100%	60%, after deductible
Screening and counseling services to stop using tobacco products	100%	60%, after deductible
Sexually transmitted infection counseling	100%	60%, after deductible
Physician Services		
Office visits ■ Primary care physician (PCP) ■ Specialty care physician (Includes X-ray and lab work when performed and billed by the physician's office) Nurse practitioners (NP) and Physicians Assistants (PA) to be billed based on provider office type	■ PCP: $40 copay; deductible doesn't apply ■ Specialists: (Aetna) $80 copay/(Kaiser) $50 copay; deductible doesn't apply	60%, after deductible
Telemedicine (Teladoc) – Available with the Aetna plans only	$40 copay; deductible doesn't apply	
Surgery (physician's office)	80%, after deductible	60%, after deductible
Allergy injections/antigens/serum Note: Covers the injections/serum when there is no office visit charged. Standard is to waive the copay and apply the plan deductible and plan coinsurance.	Aetna: 80%, after deductible; no copay Kaiser: $15 copay	60%, after deductible
Allergy testing and treatment (dispensed by physician's office) Note: Covers both testing and treatment, including injections/serum when billed with an office visit. Standard is to cover same as the PCP or specialist office visit.	Aetna: 100% after applicable PCP or specialist copay; deductible doesn't apply Kaiser: Applicable specialist copay applies	60%, after deductible

	In-Network	Out-of-Network*
Hospital Services		
Inpatient hospital care (semi-private room)	80%, after deductible	60%, after deductible
Inpatient physician's visits/consultations	80%, after deductible	60%, after deductible
Inpatient professional services (surgeon, radiologist, etc.)	80%, after deductible	60%, after deductible
Outpatient physician's visits/consultations	80%, after deductible	60%, after deductible
Outpatient facility services Office/ambulatory surgery center PCP and specialist copay will apply based on provider status	80%, after deductible	60%, after deductible
Outpatient professional services (surgeon, radiologist, etc.)	80%, after deductible	60%, after deductible
Other inpatient health care facilities (e.g., skilled nursing facility, rehab hospital, sub-acute facility)	80%, after deductible	60%, after deductible
Maternity Care (Employee and dependent daughters)		
Physician's office (initial visit)	Aetna: $80 copay; deductible doesn't apply Kaiser: 100%	60%, after deductible
Physician's office (visits)	100%	60%, after deductible
Physician services (pre- and post-natal visits, delivery)	80%, after deductible	60%, after deductible
Mental Health and Substance Abuse		
Inpatient services (facility, professional and other inpatient services)	80%, after deductible	60%, after deductible
Outpatient (individual or group therapy office visit)	$40 copay; deductible doesn't apply	60%, after deductible
Outpatient services (facility, professional and other outpatient services)	80%, after deductible	60%, after deductible
Emergency Services		
Ambulance	80%, after deductible	80%, after deductible
Emergency room (waived if admitted)	80%, after deductible	80%, after deductible
Urgent care	Aetna: 80%, after deductible Kaiser: $40 copay; deductible doesn't apply	Aetna: 60%, after deductible Kaiser: $40 copay; deductible doesn't apply
Other Services		
Abortion/Voluntary Sterilization (dependents covered)	80%, after deductible; subject to office visit copays	60%, after deductible
Acupuncture (Aetna: 12 visits per calendar year/Kaiser: 30 visits per calendar year)	■ Office visit: $80 copay; deductible doesn't apply ■ Other covered services: 80%, after deductible	60%, after deductible
Autism and ABA Therapy	$40 copay; deductible doesn't apply	60%, after deductible
Bariatric surgery (One per lifetime; no dollar limit)	80%, after deductible	60%, after deductible

	In-Network	Out-of-Network*
Chiropractic care (60 visits per calendar year)	$80 copay; deductible doesn't apply	60%, after deductible
Clinical trials (routine patient care services incurred as a participant in an approved clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Dental treatment (due to accidental injury to sound natural teeth provided dental treatment is started within 12 months of an accident, TMJ medical treatment and appliances)	80%, after deductible; subject to office visit copays	60%, after deductible
Diagnostic X-ray & lab	80%, after deductible	60%, after deductible
Durable medical equipment	Aetna: 80%, after deductible Kaiser: 80%; deductible doesn't apply	60%, after deductible
Genetic testing	80%, after deductible	60%, after deductible
Hearing aids (testing and exam)	80%, after deductible; subject to office visit copays	60%, after deductible
Hearing aids (hardware - $1,000 per ear per calendar year)	80%, after deductible (hardware only; deductible, coinsurance and copays do not apply to limit)	60%, after deductible
Home health care (120 visits per calendar year)	Aetna: 80%, after deductible Kaiser: 100%	60%, after deductible
Hospice services	Aetna: 80%, after deductible Kaiser: 100%	60%, after deductible
Skilled nursing care (inpatient—120 days per calendar year)	80%, after deductible	60%, after deductible
Private duty nursing (outpatient—60 visits per calendar year)	80%, after deductible	60%, after deductible
Organ transplants: ■ Centers of Excellence ■ Non Centers of Excellence	 ■ 80%, after deductible ■ 60%, after deductible	 ■ N/A ■ 60%, after deductible
Prosthetic devices	80%, after deductible	60%, after deductible
Outpatient rehabilitative therapy	Aetna: $80 copay; deductible doesn't apply Kaiser: $40 copay; deductible doesn't apply	60% after deductible
Outpatient therapy services (cardiac rehab, infusion therapy, chemotherapy/radiation, dialysis/hemodialysis)	$80 copay in the physician's office; deductible and coinsurance in other places of service	60% after deductible

* Generally, all out-of-network expenses are subject to the Maximum Reimbursable Charge (MRC) limit. You should note that since in-network charges for covered services have been negotiated with the providers, MRC limits do not apply.

** Annual deductible applies toward out-of-pocket maximum.

***In the Aetna plans, the first mammogram in a calendar year will be covered at 100% by the plan. All subsequent mammograms in a calendar year are subject to the applicable plan provisions.

$1,850 DEDUCTIBLE PLAN WITH HSA

	In-Network	Out-of-Network*
Annual Deductible		
■ Individual	■ $1,850	■ $3,700
■ Family	■ $3,700	■ $7,400
Coinsurance for most covered services	80%, after deductible	60%, after deductible
Annual Out-of-Pocket Maximum**		
■ Individual	■ $3,500	■ $7,000
■ Family	■ $6,500	■ $13,000
Lifetime Maximum	None	
Preventive Care		
Routine care and office visits (includes X-ray and lab work when billed as preventive care)	100%	60%, after deductible
Immunizations: (including travel immunizations and flu shots)		
■ Children through age 2	100%	60%, after deductible
■ Children age 3 and over and adults	100%	60%, after deductible
Mammograms***	100%	60%, after deductible
Pap smears	100%	60%, after deductible
Other routine cancer screenings	100%	60%, after deductible
Skin cancer screenings when provider bills as preventive	100%	60%, after deductible
Obesity or health diet counseling	100%	60%, after deductible
Screening and counseling services for misuse of alcohol or drugs	100%	60%, after deductible
Screening and counseling services to stop using tobacco products	100%	60%, after deductible
Sexually transmitted infection counseling	100%	60%, after deductible
Physician Services		
Office visits ■ Primary care physician (PCP) ■ Specialty care physician (Includes X-ray and lab work when performed and billed by the physician's office) Nurse practitioners (NP) and Physicians Assistants (PA) to be billed based on provider office type	80%, after deductible	60%, after deductible
Telemedicine (Teladoc) – Available with the Aetna plans only	$40 copay until deductible is met; then 80% coinsurance	
Surgery (physician's office)	80%, after deductible	60%, after deductible

	In-Network	Out-of-Network*
Allergy injections/antigens/serum Note: Covers the injections/serum when there is no office visit charged. Standard is to waive the copay and apply the plan deductible and plan coinsurance.	80%, after deductible	60%, after deductible
Allergy testing and treatment (dispensed by physician's office) Note: Covers both testing and treatment, including injections/serum when billed with an office visit. Standard is to cover same as the PCP or specialist office visit.	80%, after deductible	60%, after deductible
Hospital Services		
Inpatient hospital care (semi-private room)	80%, after deductible	60%, after deductible
Inpatient physician's visits/consultations	80%, after deductible	60%, after deductible
Inpatient professional services (surgeon, radiologist, etc.)	80%, after deductible	60%, after deductible
Outpatient physician's visits/consultations	80%, after deductible	60%, after deductible
Outpatient facility services Office/ambulatory surgery center PCP and specialist copay will apply based on provider status	80%, after deductible	60%, after deductible
Outpatient professional services (surgeon, radiologist, etc.)	80%, after deductible	60%, after deductible
Other inpatient health care facilities (e.g., skilled nursing facility, rehab hospital, sub-acute facility)	80%, after deductible	60%, after deductible
Maternity Care (Employee and dependent daughters)		
Physician's office (visits)	Aetna: 80%, after deductible Kaiser: 100% (pre-natal); 80%, after deductible (post-natal)	60%, after deductible
Physician services (delivery)	80%, after deductible	60%, after deductible
Mental Health and Substance Abuse		
Inpatient services (facility, professional and other inpatient services)	80%, after deductible	60%, after deductible
Outpatient (individual or group therapy office visit)	80%, after deductible	60%, after deductible
Outpatient services (facility, professional and other outpatient services)	80%, after deductible	60%, after deductible
Emergency Services		
Ambulance	80%, after deductible	80%, after deductible
Emergency room (waived if admitted)	80%, after deductible	80%, after deductible
Urgent care	80%, after deductible	Aetna: 60%, after deductible Kaiser: 80%, after deductible

	In-Network	Out-of-Network*
Other Services		
Abortion/Voluntary Sterilization (dependents covered)	80%, after deductible	60%, after deductible
Acupuncture (Aetna: 12 visits per calendar year/Kaiser: 30 visits per calendar year)	80%, after deductible	60%, after deductible
Autism and ABA Therapy	80%, after deductible	60%, after deductible
Bariatric surgery (One per lifetime; no dollar limit)	80%, after deductible	60%, after deductible
Chiropractic care (60 visits per calendar year)	80%, after deductible	60%, after deductible
Clinical trials (routine patient care services incurred as a participant in an approved clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Dental treatment (due to accidental injury to sound natural teeth provided dental treatment is started within 12 months of an accident, TMJ medical treatment and appliances)	80%, after deductible	60%, after deductible
Diagnostic X-ray & lab	80%, after deductible	60%, after deductible
Durable medical equipment	80%, after deductible	60%, after deductible
Genetic testing	80%, after deductible	60%, after deductible
Hearing aids (testing and exam)	80%, after deductible; subject to office visit copays	60%, after deductible
Hearing aids (hardware - $1,000 per ear per calendar year)	80%, after deductible (hardware only; deductible, coinsurance and copays do not apply to limit)	60%, after deductible
Home health care (120 visits per calendar year)	Aetna: 80%, after deductible Kaiser: 100%	60%, after deductible
Hospice services	Aetna: 80%, after deductible Kaiser: 100%	60%, after deductible
Skilled nursing care (inpatient—120 days per calendar year)	80%, after deductible	60%, after deductible
Private duty nursing (outpatient—60 visits per calendar year)	80%, after deductible	60%, after deductible
Organ transplants: ■ Centers of Excellence ■ Non Centers of Excellence	 ■ 80%, after deductible ■ 60%, after deductible	 ■ N/A ■ 60%, after deductible
Prosthetic devices	80%, after deductible	60%, after deductible
Outpatient rehabilitative therapy	80%, after deductible	60%, after deductible
Outpatient therapy services (cardiac rehab, infusion therapy, chemotherapy/radiation, dialysis/hemodialysis)	80%, after deductible	60%, after deductible

* Generally, all out-of-network expenses are subject to the Maximum Reimbursable Charge (MRC) limit. You should note that since in-network charges for covered services have been negotiated with the providers, MRC limits do not apply.

** Annual deductible applies toward out-of-pocket maximum.

***In the Aetna plans, the first mammogram in a calendar year will be covered at 100% by the plan. All subsequent mammograms in a calendar year are subject to the applicable plan provisions.

$2,850 DEDUCTIBLE PLAN WITH HSA

	In-Network	Out-of-Network*
Annual Deductible		
■ Individual	■ $2,850	■ $5,700
■ Family	■ $5,700	■ $11,400
Coinsurance for most covered services	70%, after deductible	50%, after deductible
Annual Out-of-Pocket Maximum**		
■ Individual	■ $5,500	■ $11,000
■ Family	■ $11,000	■ $22,000
Lifetime Maximum	None	
Preventive Care		
Routine care and office visits (includes X-ray and lab work when billed as preventive care)	100%	50%, after deductible
Immunizations: (including travel immunizations and flu shots)		
■ Children through age 2	100%	50%, after deductible
■ Children age 3 and over and adults	100%	50%, after deductible
Mammograms***	100%	50%, after deductible
Pap smears	100%	50%, after deductible
Other routine cancer screenings	100%	50%, after deductible
Skin cancer screenings when provider bills as preventive	100%	50%, after deductible
Obesity or health diet counseling	100%	50%, after deductible
Screening and counseling services for misuse of alcohol or drugs	100%	50%, after deductible
Screening and counseling services to stop using tobacco products	100%	50%, after deductible
Sexually transmitted infection counseling	100%	50%, after deductible
Physician Services		
Office visits ■ Primary care physician (PCP) ■ Specialty care physician (Includes X-ray and lab work when performed and billed by the physician's office) Nurse practitioners (NP) and Physicians Assistants (PA) to be billed based on provider office type	70%, after deductible	50%, after deductible
Telemedicine (Teladoc) – Available with the Aetna plans only	$40 copay until deductible is met; then 80% coinsurance	
Surgery (physician's office)	70%, after deductible	50%, after deductible

	In-Network	Out-of-Network*
Allergy injections/antigens/serum Note: Covers the injections/serum when there is no office visit charged. Standard is to waive the copay and apply the plan deductible and plan coinsurance.	70%, after deductible	50%, after deductible
Allergy testing and treatment (dispensed by physician's office) Note: Covers both testing and treatment, including injections/serum when billed with an office visit. Standard is to cover same as the PCP or specialist office visit.	70%, after deductible	50%, after deductible
Hospital Services		
Inpatient hospital care (semi-private room)	70%, after deductible	50%, after deductible
Inpatient physician's visits/consultations	70%, after deductible	50%, after deductible
Inpatient professional services (surgeon, radiologist, etc.)	70%, after deductible	50%, after deductible
Outpatient physician's visits/consultations	70%, after deductible	50%, after deductible
Outpatient facility services Office/ambulatory surgery center PCP and specialist copay will apply based on provider status	70%, after deductible	50%, after deductible
Outpatient professional services (surgeon, radiologist, etc.)	70%, after deductible	50%, after deductible
Other inpatient health care facilities (e.g., skilled nursing facility, rehab hospital, sub-acute facility)	70%, after deductible	50%, after deductible
Maternity Care (Employee and dependent daughters)		
Physician's office (visits)	Aetna: 70%, after deductible Kaiser: 100%	50%, after deductible
Physician services (delivery)	70%, after deductible	50%, after deductible
Mental Health and Substance Abuse		
Inpatient services (facility, professional and other inpatient services)	70%, after deductible	50%, after deductible
Outpatient (individual or group therapy office visit)	70%, after deductible	50%, after deductible
Outpatient services (facility, professional and other outpatient services)	70%, after deductible	50%, after deductible
Emergency Services		
Ambulance	70%, after deductible	70%, after deductible
Emergency room (waived if admitted)	70%, after deductible	70%, after deductible
Urgent care	70%, after deductible	50%, after deductible

	In-Network	Out-of-Network*
Other Services		
Abortion/Voluntary Sterilization (dependents covered)	70%, after deductible	50%, after deductible
Acupuncture (Aetna: 12 visits per calendar year/Kaiser: 30 visits per calendar year)	70%, after deductible	50%, after deductible
Autism and ABA Therapy	70%, after deductible	50%, after deductible
Bariatric surgery (One per lifetime; no dollar limit)	70%, after deductible	50%, after deductible
Chiropractic care (60 visits per calendar year)	70%, after deductible	50%, after deductible
Clinical trials (routine patient care services incurred as a participant in an approved clinical trial conducted in relation to the prevention, detection or treatment of cancer or another life-threatening disease or condition)	Covered according to the type of benefit and the place where the service is received.	Covered according to the type of benefit and the place where the service is received.
Dental treatment (due to accidental injury to sound natural teeth provided dental treatment is started within 12 months of an accident, TMJ medical treatment and appliances)	70%, after deductible	50%, after deductible
Diagnostic X-ray & lab	70%, after deductible	50%, after deductible
Durable medical equipment	70%, after deductible	50%, after deductible
Genetic testing	70%, after deductible	50%, after deductible
Hearing aids (testing and exam)	70%, after deductible; subject to office visit copays	50%, after deductible
Hearing aids (hardware - $1,000 per ear per calendar year)	70%, after deductible (hardware only; deductible, coinsurance and copays do not apply to limit)	50%, after deductible
Home health care (120 visits per calendar year)	70%, after deductible	50%, after deductible
Hospice services	70%, after deductible	50%, after deductible
Skilled nursing care (inpatient—120 days per calendar year)	70%, after deductible	50%, after deductible
Private duty nursing (outpatient—60 visits per calendar year)	70%, after deductible	50%, after deductible
Organ transplants: ■ Centers of Excellence ■ Non Centers of Excellence	 ■ 70%, after deductible ■ 50%, after deductible	 ■ N/A ■ 50%, after deductible
Prosthetic devices	70%, after deductible	50%, after deductible
Outpatient rehabilitative therapy	70%, after deductible	50%, after deductible
Outpatient therapy services (cardiac rehab, infusion therapy, chemotherapy/radiation, dialysis/hemodialysis)	70%, after deductible	50%, after deductible

* Generally, all out-of-network expenses are subject to the Maximum Reimbursable Charge (MRC) limit. You should note that since in-network charges for covered services have been negotiated with the providers, MRC limits do not apply.

** Annual deductible applies toward out-of-pocket maximum.

***In the Aetna plans, the first mammogram in a calendar year will be covered at 100% by the plan. All subsequent mammograms in a calendar year are subject to the applicable plan provisions.

COVERED SERVICE DESCRIPTIONS

This section describes the services highlighted in "Benefits Covered by the Medical Plan" beginning on page 45.

PREVENTIVE CARE

The Medical Plan uses prevailing clinical standards to determine preventive care guidelines. The plan covers preventive care services, which include:

Well Child Care

These services are covered for each covered child through age two including periodic assessments and immunizations.

Women's Preventive Health Care

Women's preventive health care is covered at 100%, including oral contraceptives (generic and brand name), contraceptive devices and implants.

Routine Physical Exams

Routine physical exams, health care assessments, wellness visits and any related services will be covered for each covered individual age three and older (including immunizations). A routine physical exam is a medical exam given by a physician for a reason other than to diagnose or treat a suspected or identified illness or injury, and also includes radiological services and X-rays.

Immunizations

The full series of standard immunizations recommended by the Department of Health. Covered immunizations include, but are not limited to, the following:

- Diphtheria Pertussis Tetanus Toxoid (DPT).
- HiB.
- Polio.
- Hepatitis A and B.
- Measles Mumps Rubella (MMR).
- Meningococcal vaccine.
- Chicken pox.
- Pneumococcal vaccine.
- Rotavirus.
- Human papillomavirus.
- Flu vaccines.

Cancer Screenings

Covered expenses include charges incurred for routine cancer screenings and related office visits.

- **Gynecological exam, including cervical cancer screening:** The cervical cancer screening benefit includes an exam and laboratory tests for early detection and screening of cervical cancer, and the doctor's interpretation of the lab results. Coverage for cervical cancer screening includes a Pap smear screening, liquid based cytology and human papilloma virus detection and should follow the American Cancer Society guidelines.
- **Screening mammograms:** Screening mammograms are covered along with a doctor's interpretation of the results. In the Aetna plans, the first mammogram in a calendar year will be covered at 100% by the plan. All subsequent mammograms in a calendar year are subject to the applicable plan provisions.
- **Prostate screening:** Prostate Specific Antigen (PSA) tests or equivalent serological tests are covered.
- **Colorectal cancer screenings** including:
  - Fecal occult blood test (including a digital rectal examination (DRE)).
  - Flexible sigmoidoscopy (including a DRE).
  - Fecal occult blood test plus flexible sigmoidoscopy (including a DRE).
  - Double contrast barium enema (including a DRE).
  - Colonoscopy (including a DRE).
  - Lung cancer screenings.
- **Skin cancer screenings and other standard cancer screenings.**

Additional Services

- **Obesity or health diet counseling:** Preventive counseling visits, nutritional counseling, healthy diet counseling visits for members with high cholesterol. For members 22 and older, the maximum annual visits is 26 with no more than 10 visits for healthy diet counseling. There is no visit limit for members under age 22.
- **Screening for misuse of alcohol or drugs:** Preventive counseling visits, risk factor reduction intervention and a structured assessment. Maximum of five (5) visits per member per year. A 60-minute session is equal to one visit.

- **Screening for use of tobacco products:** Preventive counseling visits, treatment visits and class visits. When prescribed by a physician FDA- approved prescription drugs and over the counter drugs to help stop the use of tobacco products.
- **Sexually transmitted infection counseling:** Eligible services include counseling services to help you prevent or reduce sexually transmitted infections.
- **Genetic risk of counseling for breast and ovarian cancer:** Eligible services include the counseling and evaluation services to help you assess whether or not you are at increased risk for breast and ovarian cancer.
- **Lactation support and counseling services:** Eligible services include assistance and training in breastfeeding from a certified lactation support provider.
- **Breast pump:** The purchase of an electric breast pump once every three years or the purchase of a manual breast pump once per pregnancy.

PHYSICIAN SERVICES

Covered medical expenses include charges made by a physician during a visit to treat an illness or injury. The visit may be at the physician's office, in your home, in a hospital or other facility during your stay or in an outpatient facility.

Covered services also include:

- Care such as consultations and second surgical opinions.
- Office surgery.
- Radiological services, X-rays and tests.
- Medical supplies.
- Allergy treatment/injections and allergy serums.
- Assistant surgeon and co-surgeon charges:
  - The maximum amount payable will be limited to charges made by an assistant surgeon that does not exceed a percentage of the surgeon's allowable charge as specified in Aetna or Kaiser Reimbursement Policies. (For purposes of this limitation, allowable charge means the amount payable to the surgeon prior to any reductions due to coinsurance or deductible amounts.)
  - The maximum amount payable for charges made by co-surgeons will be limited to the amount specified in Aetna or Kaiser Reimbursement Policies.

HOSPITAL/FACILITY SERVICES

Inpatient Hospital Services

The plan provides coverage when you are admitted to a hospital as an inpatient. If you are admitted before the effective date of coverage, benefits will not be available for services received prior to the effective date. If you are in the hospital as an inpatient at the time you begin a new benefit period, you may have to meet a new deductible for covered services from doctors or other professional providers. You should work with your doctor to make sure pre-certification has been requested. Pre-certification must be obtained in advance from Aetna or Kaiser or your benefits may be reduced or denied.

Covered services include:

- Medical care provided by a doctor or other professional provider.
- Room and board at the hospital's current rate for a semi-private room. Private rooms are paid up to the cost of a semi-private room.
- Use of the operating room, delivery room, recovery room, nursery and related services.
- General nursing care.
- Special care units (e.g., intensive care or critical care) at the plan's negotiated rate for in-network care and the daily room rate for out-of-network care.
- Drugs administered by the hospital.
- Diagnostic services and medical supplies.
- Use of appliances and equipment ordinarily provided by the hospital.
- Short-term rehabilitative therapies and other therapies.

Outpatient Services

Benefits are provided for outpatient services received in a hospital, a hospital-based facility or an outpatient clinic.

Covered services include:

- Medical care provided by a doctor or other professional provider.
- General nursing care.
- Drugs administered by the facility.
- Diagnostic services.
- Medical supplies.
- Use of appliances and equipment ordinarily provided by the facility for the care and treatment of outpatients.

- Operating room, observation room, recovery room and related services (outpatient surgery).
- Short-term rehabilitative therapies and other therapies.

Multiple Surgical Reduction

Multiple surgeries performed during one operating session result in payment reduction of 50% to the surgery of lesser charge. The most expensive procedure is paid as any other surgery.

Other Health Care Facilities

The plan provides benefits for covered services received in other health care facilities including a skilled nursing facility, rehabilitation hospital or sub-acute facility for medical care and treatment. You should work with your doctor to make sure pre-certification has been requested. Pre-certification must be obtained in advance from Aetna or Kaiser or your benefits may be reduced or denied. Skilled nursing facility services are limited to a combined in-network and out-of-network maximum of 120 days per calendar year. Except for any day of confinement, covered expenses exclude charges that exceed the daily limit.

MATERNITY CARE

Maternity care benefits are available to covered employees and dependent daughters. Maternity care includes prenatal care, labor and delivery and post-delivery care. Prenatal care is all care related to the pregnancy before the baby's birth. Labor and delivery services for mother and newborn received during an inpatient hospital stay are covered. Post-delivery care is all care for the mother after the baby's birth that is related to the pregnancy.

Delivery

The plan covers an inpatient hospital stay for the mother and her newborn for 48 hours for a vaginal delivery or 96 hours for a cesarean section, without pre-certification by Aetna or Kaiser. However, the plan may pay for a shorter stay if the attending provider (e.g., your doctor or nurse midwife), after consultation with the mother, discharges the mother or newborn earlier. If the mother chooses a shorter stay, coverage is available for a home health visit for post-delivery follow-up care if received within 72 hours of discharge. In order to avoid a penalty, pre-certification is required for inpatient stays extending beyond 48 hours following a vaginal delivery or 96 hours following a cesarean section.

Newborn Care

Inpatient newborn care of a well baby, excluding pediatric and specialty physician charges, is covered under the mother's maternity benefits described above only during the first 48 hours after a vaginal delivery or 96 hours after delivery by cesarean section. This inpatient newborn care (well baby) requires only one benefit period deductible for both mother and baby. Benefits also include newborn hearing screening ordered by a doctor to determine the presence of permanent hearing loss.

For additional coverage of the newborn, whether inpatient (sick baby) or outpatient, the newborn must be enrolled for coverage as a dependent child. At this time, the baby must meet the individual benefit period deductible if applicable and pre-certification are required to avoid a penalty.

Termination of Pregnancy (Abortion)

Benefits for abortion include elective and non-elective procedures, or when the life of the mother is in danger.

MENTAL HEALTH SERVICES

Covered expenses include charges made for the treatment of mental disorders that impairs behavior, emotional reaction or thought processes. Expenses for the treatment of any physiological conditions related to mental health are not covered.

Inpatient Care

Benefits are payable for charges incurred in a hospital (including partial hospitalization) and residential treatment facility for the treatment and evaluation of mental health. Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your admission. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

The plan covers partial hospitalization services (more than four hours, but less than 12 hours in any 24-hour period). The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility. Two days of residential treatment services are billed at the same rate as one day of hospital treatment.

Remember, you or your provider must call Aetna or Kaiser for pre-certification of overnight stays at network and out-of-network hospitals or benefits may be reduced or denied.

Outpatient Care

Covered expenses include charges for treatment received while not confined in a hospital or residential treatment facility. Coverage includes treatment in an individual, group or mental health intensive outpatient therapy program.

SUBSTANCE ABUSE SERVICES

Covered expenses include charges made for the treatment of the psychological and physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care and treatment. Expenses for the treatment of any physiological conditions related to rehabilitation services for alcohol, drug abuse or addiction are not covered.

Inpatient Care

Benefits are payable for charges incurred in a hospital (including partial hospitalization) and residential treatment facility for the treatment of substance abuse or addiction to alcohol and/or drugs. Covered expenses include charges for room and board at the semi-private room rate, and other services and supplies provided during your admission. Inpatient benefits are payable only if your condition requires services that are only available in an inpatient setting.

The plan covers partial hospitalization services (more than four hours, but less than 12 hours in any 24-hour period). The partial hospitalization will only be covered if you would need inpatient care if you were not admitted to this type of facility. Two days of residential treatment services are billed at the same rate as one day of hospital treatment.

Remember, you or your provider must call Aetna or Kaiser for pre-certification of overnight stays at network and out-of-network hospitals or benefits may be reduced or denied.

Outpatient Care

Covered expenses include charges for treatment received while not confined in a hospital or residential treatment facility. Coverage includes outpatient rehabilitation in an individual or substance abuse intensive outpatient therapy program.

EMERGENCY AND URGENT CARE

In the case of an emergency, the plan provides benefits for emergency services.

An emergency is the sudden and unexpected onset of a condition of such severity that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of an individual, or with respect to a pregnant woman the health of the pregnant woman or her unborn child, in serious jeopardy.
- Serious physical impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.
- Death.

Heart attacks, strokes, uncontrolled bleeding, poisonings, major burns, prolonged loss of consciousness, spinal injuries, shock and other severe, acute conditions are examples of emergencies.

What to Do in an Emergency

In an emergency, you should seek care from an emergency room or other similar facility. If necessary and available, call 911 or use other community emergency resources to obtain assistance in handling life threatening emergencies.

Pre-certification is not required for emergency services. Your visit to the emergency room will be covered if your condition meets the definition of an emergency.

Care Following Emergency Services

In order to receive in-network benefits for follow-up care related to the emergency (such as office visits or therapy once you left the emergency room or were discharged from the hospital), you must use in-network providers. Follow-up care related to the emergency condition is not considered an emergency and will be treated the same as a normal health care benefit.

Urgent Care

The plan also provides benefits for urgent care services. Urgent care includes services provided for a condition that occurs suddenly and unexpectedly and requires prompt diagnosis or treatment such that, in the absence of immediate care, the member could reasonably be expected to suffer chronic illness, prolonged impairment or the need for more serious treatment. Fever over 101 degrees Fahrenheit, ear infection, sprains, some lacerations and dizziness are examples of conditions that would be considered urgent. When you need urgent care, call your physician, a specialist or go to an urgent care provider.

Ambulance Services

The plan covers services for licensed ambulance services to or from the nearest hospital where the needed medical care and treatment can be provided. Non-emergency ambulance transfers that do not either begin or end at a hospital are not covered.

OTHER SERVICES

Acupuncture

This plan covers medically necessary acupuncture for adults for any of the following conditions:

- Nausea and vomiting associated with pregnancy.
- Nausea and vomiting associated with chemotherapy.
- Postoperative nausea and vomiting.
- Postoperative dental pain.
- Limited other chronic painful conditions when used as an adjunct to standard therapy.

Contact Aetna or Kaiser for details and restrictions.

Autism and Applied Behavior Analysis

The plan covers services and supplies for the diagnosis and treatment of Autism Spectrum Disorders prescribed by a physician or other behavioral health provider with no annual maximum such as Applied Behavior Analysis (ABA). ABA is an educational service that is the process of applying intensive behavioral interventions:

- That systematically change behavior, and
- That are responsible for observable improvements in behavior.

Bariatric Surgery

The plan provides coverage for bariatric surgery (including procedures to adjust or reverse bariatric surgery). Bariatric surgery, or weight loss surgery, is surgery to reduce the size of the stomach through any of the following:

- An implanted medical device.
- Removal of a portion of the stomach.
- Resecting and re-routing the small intestines to a small stomach pouch.

Coverage for bariatric surgery is based upon specific criteria outlined in Aetna's or Kaiser's Coverage Policy for Bariatric Surgery. Contact Aetna or Kaiser for details and restrictions prior to receiving services.

Bariatric Surgery Exclusions

The Plan does not cover bariatric surgery procedures that are not considered medically necessary, or that are deemed experimental, investigational or unproven. Please contact Aetna or Kaiser for details. Some excluded procedures include (but are not limited to):

- Roux-en-Y gastric bypass (when combined with simultaneous banding)
- Gastroplasty (stomach stapling)
- Intestinal bypass (jejunoieal bypass)
- Intragastric balloon
- Loop gastric bypass
- Mini-gastric bypass
- Vagus nerve blocking
- Vagus nerve stimulation

Chiropractic Care

Charges made for diagnostic and treatment services used in an office setting by chiropractic physicians. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment of specific joints to restore motion, reduce pain and improve function.

- Benefits are limited to a combined in- and out-of-network calendar year maximum of 60 days per person.

Chiropractic Care Exclusions

- Occupational therapy provided for purposes other than enabling persons to perform the activities of daily living after an injury or sickness.

- Services of a chiropractor which are not within his scope of practice, as defined by state law.
- Charges for care not provided in an office setting.
- Maintenance or preventive treatment consisting of routine, long-term or non-medically necessary care provided to prevent recurrence or to maintain the patient's current status.
- Vitamin therapy.

Clinical Trials

The plan provides benefits for routine patient care as the result of a phase II, III and IV clinical trial for the purposes of prevention, early detection or treatment of cancer, if approved by one of the following entities, and the treating facility and personnel have the expertise and training to provide the treatment and treat a sufficient number of patients:

- The National Institutes of Health (NIH), including an NIH cooperative group or center, or National Cancer Institute (NCI) and conducted at academic or National Cancer Institute Center, Centers for Disease Control and Prevention (CDC), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), or a research arm of the Department of Defense (DOD) or Department of Veterans Affairs (VA).
- Conducted under an investigational new drug application (IND) reviewed by the FDA, or an investigational new drug exemption as defined by the FDA.
- For phase II clinical trials, the person is enrolled in the Phase II clinical trial, not merely following protocol of a Phase II clinical trial.
- A qualified research entity that meets the criteria for NIH Center support grant eligibility.

Routine patient care costs are defined as follows:

- Drugs and devices that have been approved for sale by the FDA, regardless of whether they have been approved by the FDA for use in treating the patient's particular condition.
- Reasonable and medically necessary services needed to administer a drug or device under evaluation in a clinical trial.
- All services and supplies required for the diagnosis and treatment of complications as a result of the cancer trial.

The plan covers participation in Clinical Trials as described above at all Commission on Cancer-approved facilities and cancer centers designated by the NCI.

Clinical Trial Exclusions

- Investigational item or service itself.
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.
- Items and services customarily provided by the research sponsors free of charge for any enrollee in the trial.

Dental Treatment Covered Under Your Medical Benefit

The plan provides coverage for:

- Charges made for a continuous course of dental treatment started within 12 months of an injury to sound, natural teeth.
- Dental implants to repair defects in the jaw due to a removed tumor/cyst, severe atrophy in a toothless arch, exposed nerves, non-union of a jaw fracture, loss of a tooth/teeth due to an accidental injury or a birth defect diagnosed within 31 days of birth.
- Medically necessary surgical treatment of Temporomandibular joint (TMJ) disease (on a limited, case by case basis).
- Orthognathic surgery to repair or correct a severe facial deformity or disfigurement that orthotics alone cannot correct.

Dental Treatment Not Covered Under Your Medical Benefit

- Orthodontic braces.
- Dentures and dental implants.
- Crowns and bridges.
- Treatment for periodontal disease.
- Extractions.
- Dental root form implants or root canals.
- Injury related to chewing or biting.
- No other dental services.

Diagnostic Services

Diagnostic procedures help your physician find the cause and extent of your condition in order to plan for your care. Benefits may differ depending on where the service is performed and if the service is received with any other service or associated with a surgical procedure.

Separate benefits for the interpretation of diagnostic services by the attending doctor are not provided. In addition, benefits for that doctor's medical or surgical services are not included, except as otherwise determined by Aetna or Kaiser, as applicable.

Durable Medical Equipment

Benefits are provided for durable medical equipment and supplies required for operation of equipment when prescribed by a doctor. Equipment may be purchased or rented at the discretion of the plan. The plan provides benefits for repair or replacement of the covered equipment. Benefits will end when the equipment is no longer medically necessary. Certain durable medical equipment requires pre-certification or services will not be covered.

Examples of covered durable medical equipment include:

- Wheel chairs.
- Hospital beds.
- Crutches.
- Respiratory (inhalation) or suction and dialysis machines.

Durable Medical Equipment Exclusions

- Appliances that serve no medical purpose or that are primarily for comfort or convenience.
- Repair or replacement of equipment due to abuse or desire for new equipment.

Family Planning

Benefits are provided for family planning including physical exams, related laboratory tests, medical supervision in accordance with generally accepted medical practices and other medical services.

Contraception

Contraception devices (e.g., Depo-Provera and Intrauterine Devices (IUDs)) and diaphragms are covered at 100% as mandated by the Patient Protection and Affordable Care Act (PPACA).

Sterilization

Sterilization includes female tubal ligation and male vasectomy.

Infertility and Sexual Dysfunction Services

Covered services include:

- Testing and treatment performed in connection with an underlying medical condition.
- Testing performed specifically to determine the cause of infertility.
- Treatment and/or procedures performed specifically to restore fertility (e.g., procedures to correct an infertility condition).

Family Planning Exclusions

- Infertility drugs.
- In vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) and variations of these procedures.
- Reversal of male and female voluntary sterilization.
- Infertility services when the infertility is caused by or related to voluntary sterilization.
- Donor charges and services.
- Cryopreservation of donor sperm and eggs.
- Any experimental, investigational or unproven infertility procedures or therapies.

Gender Reassignment Counseling, Surgery and Injectable Hormone Replacement Therapy

For individuals seeking care for gender dysphoria, a variety of therapeutic options can be considered. The number and type of interventions applied and the order in which these take place may differ from person to person. IQVIA follows the recommendations of the World Professional Association for Transgender Health, treatment options include the following:

- Changes in gender expression and role (which may involve living part time or full time in another gender role, consistent with one's gender identity);
- Hormone therapy to feminize or masculinize the body;
- Surgery to change primary and/or secondary sex characteristics (e.g., breasts/chest, external and/or internal genitalia, facial features, body contouring);
- Psychotherapy (individual, couple, family, or group) for purposes such as exploring gender identity, role, and expression; addressing the negative impact of gender dysphoria and stigma on mental health; alleviating internalized transphobia; enhancing social and peer support; improving body image; or promoting resilience.

Genetic Testing

Benefits are provided for genetic testing that uses a proven testing method for the identification of genetically-linked inheritable disease.

Coverage for genetic testing is based upon specific criteria outlined in Aetna's or Kaiser's Coverage Policy for Genetic Testing. Contact Aetna or Kaiser for details and restrictions prior to receiving services.

Hearing Aids

Hearing aids are covered at the applicable coinsurance after the deductible up to a $1,000 benefit maximum per ear once per calendar year.

Home Health Care

Home health care services are covered by the plan if you require skilled care, cannot obtain the required care as an ambulatory outpatient and do not require inpatient treatment at a hospital or other health care facility.

Home health care, including nursing and home infusion, requires pre-certification or services will not be covered. Coverage for home health care expenses is limited to a combined in- and out-of-network maximum of 120 visits per calendar year.

Benefits will be provided for:

- Professional services of a registered nurse (RN) or licensed practical nurse (LPN) for visits totaling 16 hours a day. Multiple visits can occur in one day, with a visit defined as a period of two hours or fewer. Outpatient private duty nursing is covered when approved as medically necessary.
- Short-term rehabilitative therapies (subject to the benefit limits described under "Therapies").
- Medical supplies and home infusion therapy.
- Oxygen and its administration.
- Medical social service consultations.
- Home health aide services, provided by someone other than a professional nurse, which are medical or therapeutic in nature and furnished to a member who is receiving covered nursing or therapy services.

Home Health Care Exclusions

- Services that are provided by a close relative or a member of your household.

Hospice Services

Your coverage provides benefits for hospice services for care of a terminally ill covered individual with a life expectancy of six months or fewer. Hospice services are covered only as part of a licensed health care program that provides an integrated set of services and supplies designed to give comfort, pain relief and support to terminally ill patients and their families. A hospice care program is centrally coordinated through an interdisciplinary team directed by a doctor.

Covered services include:

- Bed, board, services and supplies at an inpatient hospice facility.
- Outpatient services at a hospice facility.
- Professional services of a physician.
- Counseling from a psychologist, social worker, family counselor or ordained minister for individual or family counseling.
- Bereavement counseling.
- Pain relief treatment, including drugs, medicines and medical supplies.
- Part-time care under the supervision of a nurse or a health care professional.
- Physical, occupational and speech therapy.

Hospice Services Exclusions

- Services that are provided by a close relative or a member of your household.
- Services and supplies that are primarily to aid you in daily living.

Laboratory, Radiology and Other Diagnostic Testing

Laboratory studies are services such as diagnostic blood, urine tests or an examination of biopsied tissue (i.e., tissue removed from your body by a surgical procedure). Radiology services are diagnostic imaging procedures such as X-rays, ultrasounds, computed tomographic (CT) scans and magnetic resonance imaging (MRI) scans.

Other diagnostic testing includes electroencephalograms (EEGs), electrocardiograms (ECGs), Doppler scans and pulmonary function tests (PFTs). Certain diagnostic imaging procedures, such as CT scans and MRIs, require Pre-certification or services will not be covered.

Organ Transplants

The plan provides benefits for transplants, including solid organ and bone marrow/stem cell procedures for the transplants listed below. Covered services include medical, surgical and hospital services, medications and the cost for organ or bone marrow/stem cell procurement.

- Cornea.
- Heart.
- Simultaneous pancreas and kidney.
- Lung, single and bilateral.
- Liver.
- Combined heart and lung.

- Intestine: Small bowel or multi-visceral.
- Pancreas.
- Simultaneous small bowel and liver.
- Kidney.
- Simultaneous liver and kidney.
- Allogenic and autologous bone marrow transplants.

Transplant services are covered at 80% in the $400, $900 and $1,850 Deductible Plans and 70% in the $2,850 Deductible Plan, after the medical plan deductible if you use a Center of Excellence. Services are covered at 60% in the $400, $900 and $1,850 Deductibles Plans and 50% in the $2,850 Deductible Plan, after the medical plan deductible if you use a non-Center of Excellence.

Benefits are also provided for reasonable travel expenses when a covered member travels a distance of 100 miles or greater for a pre-approved organ/tissue transplant (excluding cornea) performed at a Center of Excellence. A maximum travel benefit of $10,000 per transplant per lifetime is provided. Coverage varies by the plan. Lodging is covered up to $50 per day for one person staying alone or up to $100 per day for two people. Food and meals are not covered.

Pre-certification must be obtained in advance from Aetna or Kaiser for all transplant related services or your benefits may be reduced or denied.

Transplants Exclusions

- Transplants that are considered experimental or investigational.
- Services, drugs and supplies for or related to transplants, except those transplants specifically listed as covered services.

Overseas Care (Emergency and Non-Emergency)

If you are traveling overseas for a short-term visit (non-Expat), your Aetna or Kaiser plan will provide emergency coverage, it will not cover routine care.

If you are an eligible Expat, you will be covered under the Aetna International Plan. Coverage is provided for in-network and out-of–network care, as well as for care received outside of the U.S. While no annual deductible applies outside of the U.S., there is an out-of-network deductible inside the U.S. There is also an out-of-pocket maximum for in-network and out-of-network services received in the U.S. Coverage for Expats under the Aetna International Plan differs from coverage provided under the plans described in this SPD. Contact your benefits representative for details.

Prosthetic Appliances

External Devices

The plan provides benefits for the initial purchase and fitting of medically necessary external prosthetic appliances and devices prescribed by a doctor. Coverage is limited to the most appropriate and cost effective alternatives as determined by the utilization review physician. External prosthetic appliances and devices include prostheses/prosthetic appliances and devices, orthoses/orthotic devices (including custom foot and other orthoses), braces and splints.

Internal Devices

The plan provides benefits for internal prosthetic/medical appliances that provide permanent or temporary internal functional support for non-functional body parts. Medically necessary repair, maintenance or replacement of a covered appliance is also covered.

Reconstructive Surgery

Reconstructive surgery or therapy to repair or correct a severe physical deformity or disfigurement which is accompanied by functional deficit (other than abnormalities of the jaw or conditions related to TMJ disorder) is covered if:

- The surgery or therapy restores or improves function.
- Reconstruction is required as a result of medically necessary, non-cosmetic surgery. (Includes breast reduction surgery with supported medical documentation.)
- The surgery or therapy is performed before age 19 and is required as a result of the congenital absence or agenesis (lack of formation or development) of a body part.
- Repeat or subsequent surgeries for the same condition are covered only when there is the probability of significant additional improvement as determined by the utilization review physician.

Rehabilitative Therapies

The plan provides coverage for the following therapy services to promote the recovery from an illness, disease or injury. A doctor or other professional provider must order these services.

Short-Term Rehabilitative Therapies

Short-term rehabilitative therapy that is part of a rehabilitation program, including physical, speech, occupational, cognitive, cardiac therapy, osteopathic manipulative and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting.

In network therapy, days are provided as part of an approved home health care plan and accumulate to the short-term rehabilitative therapy maximum. If multiple outpatient services are provided on the same day, the services count as having been received on one day.

- Please note that occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an illness, injury or sickness.

Therapy Exclusions

Short-term rehabilitative therapy services that are not covered include, but are not limited to:

- Sensory integration therapy, group therapy, treatment of dyslexia, behavior modification or myofunctional therapy for dysfluency, such as stuttering or other involuntarily acted conditions without evidence of an underlying medical condition or neurological disorder.
- Treatment for functional articulation disorder such as correction of tongue thrust, lisp, verbal apraxia or a swallowing dysfunction that is not based on an underlying diagnosed medical condition or injury.
- Maintenance or preventive treatment consisting of routine, long-term or non-medically necessary care provided to prevent recurrence or to maintain the patient's current status.

Short-Term Rehabilitative Therapies (for covered members with a development delay diagnosis)

- Speech, physical, and occupational therapy are covered for Developmental Delays. However, occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Illness or Injury or Sickness.

Therapy Exclusions (for covered members with a development delay diagnosis)

- Non-medical counseling or ancillary services, including, but not limited to Custodial Services, education, training; vocational rehabilitation; behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy; employment counseling, back to school, return-to-work services, work hardening programs; driving safety and services; training; educational therapy; or other non-medical ancillary services for learning disabilities.

Telehealth Services

The IQVIA Plan includes coverage for telephone and online video consultations through Teladoc offered through Aetna. Teladoc connects you to a board-certified doctor by phone or online video chat 24 hours a day, seven days a week, 365 days a year. Teladoc doctors can treat many non-emergency conditions such as:

- Allergies
- Bronchitis
- Cold & Flu
- Ear Infections
- Sinus Infections
- Skin Inflammations
- Sports Injuries
- Urinary Tract Infections
- And More

You must register for the service either online at Teladoc.com/Aetna or call 855-Teladoc (835-2362).

BENEFITS NOT COVERED BY THE MEDICAL PLAN

While the Medical Plan covers a wide variety of medically necessary services, there are some expenses that are not covered. Some of these are listed below.

Exclusions that apply to many services are listed in this section and in "Benefits Covered by the Medical Plan" beginning on page 45. In addition, the plan does not cover charges for services, supplies, drugs for the following:

- Care for health conditions that are required by state or local law to be treated in a public facility.

- Care required by state or federal law to be supplied by a public school system or school district.
- Care for military service disabilities treatable through governmental services if you are legally entitled to such treatment and facilities are reasonably available.
- Treatment of an illness or injury which is due to war, declared or undeclared.
- Charges for which you are not obligated to pay or for which you are not billed or would not have been billed except that you were covered under your Medical Plan.
- Assistance in the activities of daily living, including but not limited to eating, bathing, dressing or other custodial services or self-care activities, homemaker services and services primarily for rest, domiciliary or convalescent care.
- Any services and supplies for or in connection with experimental, investigational or unproven services. Experimental, investigational and unproven services are medical, surgical, diagnostic, psychiatric, substance abuse or other health care technologies, supplies, treatments, procedures, drug therapies or devices that are determined by Aetna's or Kaiser's, as applicable, medical director to be:
  - Not demonstrated, through existing peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which its use is proposed.
  - Not approved by the U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency to be lawfully marketed for the proposed use.
  - The subject of review or approval by an Institutional Review Board for the proposed use, except as provided in the "Clinical Trials" section of "Other Services" beginning on page 62.
  - The subject of an ongoing phase I, II or III clinical trial, except as provided in the "Clinical Trials" section of "Other Services" beginning on page 62.
  - Cosmetic surgery and therapies. Cosmetic surgery or therapy is defined as surgery or therapy performed to improve or alter appearance or self-esteem or to treat psychological symptomatology or psychosocial complaints related to one's appearance.
- Abdominoplasty, panniculectomy, redundant skin surgery, removal of skin tags, acupressure, craniosacral/cranial therapy, dance therapy, movement therapy, applied kinesiology, rolfing, prolotherapy and extracorporeal shock wave lithotripsy (ESWL) for musculoskeletal and orthopedic conditions, regardless of clinical indications.
- Non-surgical treatment of TMJ disorder.
- Dental treatment of the teeth, gums or structures directly supporting the teeth, including dental X-rays, examinations, repairs, orthodontics, periodontics, casts, splints and services for dental malocclusion, for any condition. However, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within six months of the accident. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.
- Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic or custodial evaluations.
- Court ordered treatment or hospitalization, unless such treatment is being sought by a participating physician or otherwise covered under "Benefits Covered by the Medical Plan."
- Infertility drugs, in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
- Reversal of male and female voluntary sterilization procedures.
- Any services, supplies, medications or drugs for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia and premature ejaculation.
- Medical and hospital care and costs for the infant child of a dependent, unless this infant child is otherwise eligible under the Medical Plan.

- Non-medical counseling or ancillary services, including, but not limited to custodial services, education, training, vocational rehabilitation, behavioral training, biofeedback, neurofeedback, hypnosis, sleep therapy, employment counseling, back school, return-to-work services, work hardening programs, driving safety and services, training, educational therapy or other non-medical ancillary services.
- Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance, including, but not limited to routine, long-term or maintenance care which is provided after the resolution of the acute medical problem and when significant therapeutic improvement is not expected.
- Consumable medical supplies other than ostomy supplies and urinary catheters. Excluded supplies include, but are not limited to bandages and other disposable medical supplies, skin preparations and test strips, except as specified in the "Inpatient Hospital Services," "Outpatient Facility Services" or "Home Health Services" sections of "Benefits Covered by the Medical Plan" beginning on page 45.
- Private hospital rooms and/or private duty nursing except as provided in the Home Health Services section of "Benefits Covered by the Medical Plan" beginning on page 45.
- Personal or comfort items such as personal care kits provided on admission to a hospital, television, telephone, newborn infant photographs, complimentary meals, birth announcements and other articles which are not for the specific treatment of illness or injury.
- Artificial aids, including but not limited to corrective orthopedic shoes, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
- Aids or devices that assist with non-verbal communications, including, but not limited to communication boards, pre-recorded speech devices, laptop computers, desktop computers, Personal Digital Assistants (PDAs), Braille typewriters, visual alert systems for the deaf and memory books.
- Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or post cataract surgery).
- Routine refraction, eye exercises and surgical treatment for the correction of a refractive error, including radial keratotomy.
- All non-injectable prescription drugs, injectable prescription drugs that do not require physician supervision and are typically considered self-administered drugs, non-prescription drugs and investigational and experimental drugs, except as provided in "Benefits Covered by the Medical Plan" beginning on page 45.
- Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
- Membership costs or fees associated with health clubs, weight loss programs and smoking cessation programs.
- Genetic screening or pre-implantation genetic screening. General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically-linked inheritable disease.
- Fees associated with the collection or donation of blood or blood products, except for autologous donation in anticipation of scheduled services where in Aetna's or Kaiser's medical director's opinion the likelihood of excess blood loss is such that transfusion is an expected adjunct to surgery.
- Blood administration for the purpose of general improvement in physical condition.
- Cost of biologicals that are medications for the purpose of travel or to protect against occupational hazards and risks. Travel immunizations are covered.
- Cosmetics, dietary supplements and health and beauty aids.
- Nutritional supplements and formulas are excluded, except for infant formula needed for the treatment of inborn errors of metabolism.
- Expenses incurred for medical treatment by a person age 65 or older, who was covered under the Medical Plan as a retiree, or his/her dependents, when payment is denied by the Medicare plan because treatment was not received from an in-network provider. Note that retiree medical coverage ends when the participant reaches age 65. There is no retiree medical coverage for terminated or retired employees age 65 or older.

- Expenses incurred for medical treatment when payment is denied by the primary plan because treatment was not received from an in-network provider of the primary plan.
- Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
- Telephone, e-mail & Internet consultations.
- Massage therapy.

This list is subject to change at any time.

FILING A MEDICAL CLAIM

- Aetna: For in-network claims, the Aetna provider will handle claim filing on your behalf. To receive benefits from the plan for out-of-network covered medical expenses, you must file a claim form with Aetna and include the necessary supporting documentation. Separate claim forms must be submitted for each person filing a claim.

  Claim forms are available at www.aetna.com. To download a claim form, log in and click "Manage Claims".
- Kaiser: If you need a claim form to request payment or reimbursement for a covered service, or if you need help completing the form, call Kaiser Permanente at 1-800-464-4000 or go to https://healthy.kaiserpermanente.org.

Before you submit your claim form, make sure you include all the necessary information.

APPEALING CLAIMS

If a claim for reimbursement under the Medical Plan is denied, either in whole or in part, you can appeal the denial by following the appropriate procedures described in the *Administrative Information* section.

PRESCRIPTION DRUG COVERAGE

Summary Plan Description

When you enroll in an Aetna Medical Plan, you'll automatically receive prescription drug coverage through Express Scripts. Prescription drug coverage through Kaiser is administered by Kaiser. This coverage gives you the option of having prescriptions filled at a retail pharmacy or through a convenient home delivery service.

For More Information

For details about eligibility for benefits, when you can change your coverage and how you pay for coverage, see the *Participating in the Health Care Plans* section. For more information about your legal rights under ERISA, general information on claims review and appeals procedures and other important administrative details, see the *Administrative Information* section. To contact the plan administrator, use the information listed in the *Contacts* section.

IN THIS SECTION ..... SEE PAGE

AT A GLANCE

What's Covered	The program covers in-network retail and mail order pharmacy generic, brand name and specialty drugs. No coverage is provided for prescriptions filled at a non-network pharmacy.
Retail Pharmacy Network	The Express Scripts network includes over 68,000 pharmacies nationwide. To locate a pharmacy, visit www.express-scripts.com or call 866-790-8276. For Kaiser pharmacies, call 800-464-4000. No coverage is provided for prescriptions filled at a non-network pharmacy.
Mail Order Pharmacy	Mail order allows you to order up to a 90-day supply of prescription medication and have it delivered to your home. You can order online at www.express-scripts.com, by phone at 866-790-8276 or Kaiser online at https://healthy.kaiserpermanente.org/, by phone at 800-464-4000 or through the mail. With Express Scripts, you can also fill a 90-day supply of maintenance medication at a CVS network pharmacy using the CVS Smart90 Program.

The table below highlights the key differences between retail and mail order:

Question	Retail Pharmacy	Mail Order Pharmacy
When should I use retail vs. mail order?	Short-term, immediate medication needs	Long-term, ongoing medication needs
How much can my doctor prescribe?	Up to 30-day supply plus refills	Up to 90-day supply* plus refills
Do I have to file claims?	No (unless you don't have your ID card – you can call Express Scripts or Kaiser to get your plan information and share it with the pharmacy)	No

*100-day supply with Kaiser.

The table below shows your cost per prescription under each medical plan option:

	$400 Deductible PPO Plan	$900 Deductible PPO Plan	$1,850 Deductible Plan with HSA	$2,850 Deductible Plan with HSA
Retail Pharmacy—30-day Supply				
Generic	$10 copay	$10 copay	20% after the medical plan deductible*	30% after the medical plan deductible*
Brand Formulary	$30 copay	30% (min. $25/max. $50)	20% after the medical plan deductible*	30% after the medical plan deductible*
Brand Non-Formulary	$60 copay	45% (min. $40/max. $80)	20% after the medical plan deductible*	30% after the medical plan deductible*
Mail Order – 90-day Supply*				
Generic	$25 copay	$25 copay	20% after the medical plan deductible**	30% after the medical plan deductible**
Brand Formulary	$75 copay	30% (min. $62.50/max. $125)	20% after the medical plan deductible**	30% after the medical plan deductible**
Brand Non-Formulary	$150 copay	45% (min. $100/max. $200)	20% after the medical plan deductible**	30% after the medical plan deductible**

* 100-day supply with Kaiser.

** Except for preventive maintenance medications. If you enroll in the $1,850 or $2,850 Deductible Plan, preventive maintenance medications for asthma, diabetes, high cholesterol and high blood pressure are covered 100% before the deductible. Visit the Express Scripts website or contact Kaiser for a list of covered preventive medications.

You pay no copays/coinsurance for smoking deterrents.

MANDATORY GENERICS

The plan encourages the use of generic drugs instead of brand-name drugs whenever possible. Typically, brand-name medications are 50% to 75% more expensive than generics.

The Express Scripts or Kaiser network pharmacy will always dispense an available generic medication unless otherwise indicated by the prescriber or the member.

With Express Scripts, if you choose the brand-name drug where a generic exists, you must pay the difference between the brand and generic in addition to your copayment.

SPECIALTY MEDICATIONS

You are required to use Express Scripts Exclusive Specialty mail order pharmacy, Accredo, after your first two fills of a specialty medication at a retail pharmacy in order to receive coverage. For Kaiser, specialty medications are dispensed at their pharmacies.

NO COST PREVENTIVE MAINTENANCE MEDICATIONS IN THE $1,850 AND $2,850 DEDUCTIBLE WITH HSA PLANS

Because we know how important medication compliance is, employees with Asthma, Diabetes, High Cholesterol, and High Blood Pressure who select the $1,850 or $2,850 Deductible with HSA Plans will receive their medications to treat those conditions at NO COST. This is an important consideration if you (or a covered dependent) are relatively healthy and managing one of these conditions.

Pharmacy Networks

To access a list of Express Scripts network pharmacies, visit www.express-scripts.com. For Kaiser, visit https://healthy.kaiserpermanente.org/

Please Note: When you don't have your ID card with you at a network pharmacy, you pay 100% of the cost for the prescription. Then, you will need to file a claim form to get reimbursed for the cost of the prescription less the applicable copay/coinsurance. You can call Express Scripts or Kaiser to get your plan information while you are at the pharmacy if you don't have your ID card. Prescriptions filled at a non-network pharmacy are not covered.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

Am I required to use a generic drug?

The Express Scripts or Kaiser network pharmacy will always dispense an available generic medication unless otherwise indicated by the prescriber or the member.

With Express Scripts, if you choose the brand-name drug where a generic exists, you must pay the difference between the brand and generic in addition to your copayment.

Will I pay the brand-name copay/coinsurance if there is not a generic alternative for my prescription?

Yes, that is correct.

Am I required to use mail order for maintenance medications?

After the first two 30-day fills of a maintenance medication at a retail pharmacy, you are required to fill any subsequent fills of those maintenance medication prescriptions with 90-day fills through Express Scripts mail order or through a CVS retail pharmacy if you have Express Scripts) in order to receive coverage.

Am I required to use the Express Scripts mail order specialty care pharmacy for specialty medications?

Yes, after the first two 30-day fills of a specialty medication at a retail pharmacy, you are required to fill any subsequent prescriptions through Express Scripts Exclusive Specialty pharmacy, Accredo, in order to receive coverage.

What is the difference between generic and brand-name drugs?

The main difference is cost. The generic name of a brand-name drug is its active chemical name. The brand name is the trade name under which it is advertised or sold.

By law, generic and brand name drugs must meet the same standards for safety, purity, strength and effectiveness. When authorized by your doctor and permitted by law, a pharmacy is able to dispense a generic drug when one is available. This saves you money. When you need a prescription drug, ask your doctor whether a generic can be substituted for a brand name drug.

What do I do if I need to refill a medication early because I am going out of town?

Depending on the length of your trip, you may qualify for a vacation override for some medications.

HOW THE PRESCRIPTION DRUG PROGRAM WORKS

Each time you need a prescription filled, you can:

- Go to a network pharmacy.
- Use mail order (or the CVS Smart90 program if you have Express Scripts).

The following provisions apply:

- Each family will be issued two ID cards. You can also download the Express Scripts app to your mobile device, where you can view an electronic ID card. In the Kaiser plans, each covered member will receive an ID card which will serve as a combined medical and prescription card.
- In the **$400 Deductible PPO Plan,** you have a copay for generic, brand formulary, brand non-formulary and specialty drugs.
- In the **$900 Deductible PPO Plan,** you have a copay for generic drugs, and coinsurance for brand formulary, brand non-formulary and specialty drugs.
- In the **$400 Deductible PPO Plan and $900 Deductible PPO Plans**, prescription drug costs do not count toward the medical plan deductible.
- In the **$1,850 Deductible with HSA Plan and $2,850 Deductible with HSA Plan,** you pay coinsurance for generic, brand formulary, brand non-formulary and specialty drugs after your deductible, except for preventive medications which are covered at 100%.
- In the **$1,850 Deductible with HSA Plan and $2,850 Deductible with HSA Plan**, prescription drug costs do count toward the combined medical and prescription drug deductible. You pay the full cost of prescription drugs until you meet the combined deductible, then you pay coinsurance (except for preventive medications).
- Certain chronic and/or genetic conditions require special pharmacy products and can only be dispensed through Express Scripts Exclusive Specialty pharmacy, Accredo. With Express Scripts, you are required to use the mail order specialty pharmacy after the first two fills of a specialty medication at a retail pharmacy. Specialty medications are dispensed through Kaiser's pharmacy.
- Only medically necessary drugs prescribed by a licensed physician are covered.

Brand Name vs. Generic Drugs

Federal law requires both generic and brand name drugs to meet the same standards of strength, dosage, safety and effectiveness. Generic drugs typically cost less than brand name drugs and are generally considered to be equally effective.

- Brand Name Drugs: Drugs that are manufactured and marketed under a product name by a pharmaceutical company. Typically, the company holds a patent on the drug's chemical components for a specified period of time. Express Scripts and Kaiser split the "brand" drug tier into brand formulary and non-brand formulary drugs. Non-brand formulary drugs will cost you more out-of-pocket because they are more expensive to provide. You can still choose the medications that are right for you, but you will realize the biggest savings by choosing a brand formulary drug over a non-brand formulary drug.
- Generic Drugs: FDA-approved generic drugs have been tested for quality and strength, and can be expected to work as well as brand name drugs. They provide the same health benefits as their brand name versions, but at a lower cost to you.

USING A RETAIL NETWORK PHARMACY

When you need a prescription filled for short-term medications, simply present your ID card. To find a retail network pharmacy near you or to see if your pharmacy is in the network, go to www.express-scripts.com. For Kaiser, https://healthy.kaiserpermanente.org/. When you use a retail network pharmacy:

- Your purchases are limited to a 30-day supply for each prescription filled.

- After the first two 30-day fills at a retail pharmacy, maintenance drug products must be filled in an amount equal to a consecutive 90-day supply per prescription order through the mail order pharmacy (or the CVS Smart90 program if you have Express Scripts). Otherwise, the Plan will not cover the maintenance drug product.
- You will not need to file a claim (unless you don't have your ID card with you when you fill your prescription). If you do not show your ID card at a network pharmacy, you will have to pay 100% of the cost for the prescription and then file a claim form for reimbursement. The plan will reimburse you for the submitted amount less the applicable copay/coinsurance. You can call Express Scripts or Kaiser to get your plan information while you are at the pharmacy if you don't have your ID card.

The Plan does not provide coverage when you use a non-network pharmacy.

USING MAIL ORDER

Mail order is designed to provide you with discounted long-term maintenance drugs through the mail. Some examples of long-term maintenance medications are those used to control or treat:

- Arthritis.
- High cholesterol.
- Diabetic conditions.
- High blood pressure.

If you use maintenance medications, you are required to use the Express Scripts or Kaiser mail order pharmacy. With Express Scripts, you can also use the CVS Smart90 program and fill your maintenance medications at a CVS retail pharmacy with the same benefits as you receive at Express Scripts mail order pharmacy.

Using Mail Order

Learn More about Filling Prescriptions for Maintenance Medication

For more information, log in to the Express Scripts or Kaiser websites to:

- Learn how to transfer prescriptions to a new pharmacy
- Learn more about using mail order

When you're ready to use Express Scripts mail order pharmacy or the Kaiser mail order pharmacy for the first time, follow these steps:

- Ask your doctor for two prescriptions: One for at least 90 days and the other for short-term use you can fill at a retail network pharmacy while you process your mail order.
- Complete a mail service order form and send it to Express Scripts or Kaiser.
- When your medication arrives, be sure to pay your invoice promptly. Credit cards, checks and money orders are accepted.
- Your medications will arrive about 3-5 business days after your order is received. If your prescription is new, it can take 7-14 days business days.
- When it's time for a refill, you can use the mail service order form and pre-addressed envelope you received with your order. Or, you can go online or order by phone.

CVS Smart90 Program

The CVS Smart90 program offers two ways to get a 90-day supply of your long-term maintenance medication. You can conveniently fill these prescriptions through the Express Scripts mail order pharmacy or any CVS network pharmacy. Your copay/coinsurance for your 90-day supply of medication will be the same whether you fill your prescriptions through home delivery or at a CVS network pharmacy.

Mandatory Use of Mail Order Pharmacy

Keep in mind, that you are required to use Express Scripts or Kaiser mail order (or through the CVS Smart90 program if you have Express Scripts) after your first two fills of a maintenance medication (up to a 30-day supply) at a retail pharmacy in order to receive coverage.

DRUGS COVERED BY THE PRESCRIPTION DRUG PROGRAM

Most prescription drugs approved by the US Food and Drug Administration (FDA) for outpatient care are covered under the prescription drug program. The following list includes some of the covered prescription drugs. For the most current information on the types of drugs covered under the program, please visit www.express-scripts.com or https://healthy.kaiserpermanente.org/. **This list may change at any time:**

Women's Preventive Care

Remember, all women's preventive prescriptions, including oral contraceptives (generic and brand name), are covered by the Plan at 100%.

- Federal legend drugs (other than those identified as not covered).
- State restricted drugs.
- Compounded medications that contain at least one prescription medication.
- Smoking deterrents.
- Insulin.
- Needles and syringes.
- Injectable drugs (some exclusions apply).
- Over-the-counter diabetic supplies.
- Oral contraceptives, contraceptive devices and implants.
- Drugs to treat infertility and impotency.

SPECIALTY CARE PHARMACY

Complex conditions, such as hepatitis C, multiple sclerosis, asthma and rheumatoid arthritis, are treated with specialty medications. Specialty medications are typically injectable medications administered either by you or a healthcare professional, and they often require special handling. If you use specialty medications, you'll have access to the services offered through Express Scripts Exclusive Specialty pharmacy, Accredo, or the Kaiser pharmacy:

- Answers to your questions or concerns about your specialty medications from a pharmacist 24 hours a day, 7 days a week.
- Personalized counseling from a dedicated team of registered nurses and pharmacists.
- Patient education for your specific condition and evaluations to assess your progress.
- Fast, confidential scheduled delivery of your medications to the location of your choice (i.e., home, doctor's office, vacation destination, etc.).

Mandatory Use of Mail Order Specialty Pharmacy

Keep in mind, that you are required to use Express Scripts Exclusive Specialty pharmacy, Accredo, after your first two fills of a specialty medication at a retail pharmacy in order to receive coverage. Specialty medications are dispensed through Kaiser's pharmacy.

LIMITS ON COVERAGE

Certain programs are in place to ensure prescription drugs are covered appropriately under the prescription drug program.

Quantity Limits

To help you get the medications you need safely and affordably, Express Scripts and Kaiser limit the amount of certain prescription drugs you can have filled at one time. This ensures that you receive the medications you need in the quantity considered safe.

Quantity limits also help you save money. If your medicine is available in different strengths, you might take one dose of a higher strength instead of two or more doses of a lower strength – saving you money since you pay for fewer dosage units.

For example, if you take a medication that requires two 10 milligram pills a day for a month, that equals 60 pills for a 30-day supply. Because you can only get up to 50 pills for a 30-day supply based on quantity limits, you would be limited to a 25-day supply. This means you would need to fill your prescription more frequently to get the prescribed dosage for the entire month. As an alternative, you could take one 20 milligram pill and split the pill in two, which equals only 30 pills for a 30-day supply.

There are also drugs that have a quantity limit in place regardless of where you obtain your medication. This list of drugs is subject to change. Please verify with Express Scripts or Kaiser to confirm the status and eligibility of a drug.

Prior Authorization

Prior authorization (PA) is required for certain medications prior to use or when exceeding recommended quantities. The selected drugs will not be filled at the point of service until the medication use has been approved. Aetna will conduct an evaluation to determine if the patient meets the defined guidelines for use of the medication. You are required to have your physician contact Express Scripts or Kaiser to provide information necessary for the evaluation. Once a patient is approved, normal claims processing will occur.

Prior authorizations promote appropriate prescribing of prescription drugs. For the most current information on the prescription drugs that require prior authorization under the program, please visit www.express-scripts.com or https://healthy.kaiserpermanente.org/.

Drugs Not Covered by the Prescription Drug Program

For the most current information on the types of drugs that are not covered under the program, please visit www.express-scripts.com or https://healthy.kaiserpermanente.org/. **This list may change at any time.**

HOW TO FILE CLAIMS

Network Pharmacy

You do not need to submit a claim form to receive benefits when you use a network pharmacy. The pharmacy will submit claims on your behalf. However, if you do not have your ID card at a network pharmacy, you will have to pay 100% of the cost for the prescription and then file a claim form for reimbursement. The plan will reimburse you for the submitted amount less the applicable copay/coinsurance. You can call Express Scripts or Kaiser to get your plan information while you are at the pharmacy if you don't have your ID card. Order forms are available at www.express-scripts.com or https://healthy.kaiserpermanente.org/ or by calling Express Scripts at 866-790-8276 or Kaiser at 800-464-4000.

APPEALING CLAIMS

If a claim for reimbursement is denied, either in whole or in part, you can appeal the denial by following the procedures described in the *Administrative Information* section. To initiate an appeal, you must submit a request for an appeal in writing to the claims administrator within 365 days of receipt of a denial notice.

Questions

If you have questions about your prescription drug benefits or you need claim forms, call Express Scripts at 866-790-8276 or Kaiser at 800-464-4000 or log on to www.express-scripts.com or https://healthy.kaiserpermanente.org/.

GROUP CRITICAL ILLNESS ADVANTAGE PLAN

Summary Plan Description

For plan details, go to:

IQVIA Critical Illness Insurance Overview.pdf

GROUP ACCIDENT INSURANCE PLAN

Summary Plan Description

For plan details, go to:

IQVIA Accident Insurance Overview.pdf

HEALTH HOSPITAL INDEMNITY INSURANCE PLAN

Summary Plan Description

For plan details, go to:

IQVIA Hospital Indemnity Insurance Overview.pdf

DENTAL COVERAGE

Summary Plan Description

Good dental habits are an important part of safeguarding your general health, and can also help you reduce dental bills. IQVIA dental coverage, provided by Delta Dental, is designed to encourage good preventive care to help you maintain healthy teeth and gums.

Under this coverage, you have two options available to you and your eligible dependents that cover various dental services. Both options are designed to encourage preventive care, such as regular checkups, and to correct minor dental problems before they become more serious and costly. Delta Dental offers you a broad range of services when treatment is needed.

For More Information

For details about eligibility for benefits, when you can change your coverage and how you pay for coverage, see the *Participating in the Health Care Plans* section. For information about your legal rights under ERISA, general information on claims review and appeal procedures and other important administrative details, see the *Administrative Information* section. To contact the plan administrator, use the information listed in the *Contacts* section.

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AT A GLANCE

Questions?

If you have questions about your dental benefits or need claim forms, call Delta Dental at 800-932-0783, or log on to their website at www.deltadentalins.com.

IQVIA offers two dental coverage options: The Standard Plan and The Enhanced Plan. You can see any dentist you want, whether they are in network or out of network. If you see a network dentist, you save money because network dentists discount their services and don't charge more than the discounted rate, so you never receive a "balance due" bill. Preventive care is covered at 100% in and out of the network but out-of-network charges may be subject to balance billing. Here is a quick look at what both plans cover. For more details about the type of covered services, see "Benefits Covered by the Dental Plan" on page 88.

Covered Services	Standard Plan	Enhanced Plan
Preventive (check-ups, cleanings, fluoride treatment, bitewing X-rays, sealants)	100% no deductible	
Annual Deductible for Basic and Major Services	$50 individual/$150 family	$50 individual/$150 family
Basic (fillings, root canal treatment, simple tooth extractions)	80% after deductible	
Major (crowns, bridges, dentures, implants)	50% after deductible	
Calendar Year Maximum for Basic and Major Services Combined	$1,500 per calendar year per person	$2,000 per calendar year per person
Orthodontia (braces and related treatment)	Not covered	$2,500 per person*)

* The plan will pay 50% of the benefit for orthodontia treatment at the time of the initial treatment and the remaining 50% 12 months later, assuming you continue to be enrolled in the Enhanced Dental Plan. The general plan of treatment for orthodontic care is 18 to 24 months. If the course of treatment is less than 12 months, the plan will make one payment at the time of the initial treatment.

Charges are paid in full up to the coinsurance amount in-network or at the coinsurance amount out-of-network up to the Program Allowance. This Program Allowance limit applies to preventive care as well as the other services listed.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

Can I carry over any dental expenses from one year to the next to meet my deductible?

No, expenses that apply toward your deductible in one calendar year can't be applied toward the next calendar year deductible.

What expenses are not applied to the deductible?

The following services do not apply toward the deductible:

- Services not covered by the plan.
- Expenses in-excess of Program Allowance charges.

Does the plan pay for treatment started before my coverage starts?

No. The plan doesn't pay for any treatment performed before you or your covered family members were covered by the plan.

I prepaid my entire orthodontia costs when I started treatment. How do I get this reimbursed to me from Delta Dental?

To receive benefits from the plan for covered orthodontia expenses, you will need to file a claim form with Delta Dental. The orthodontia benefit is administered in periodic payments. Claim forms are available at www.deltadentalins.com. See "Filing a Dental Claim" on page 90 for details.

HOW THE DENTAL PLAN WORKS

ID Cards

All dental plan participants will receive dental ID cards (two per family). Additional cards can be printed on www.deltadentalins.com or downloaded to your smartphone.

There are two levels of dental coverage:

- **The Standard Plan:** Offers coverage levels that may be appropriate if you have minimal dental expenses and wish to keep your monthly coverage contribution low. There is no coverage for orthodontia.
- **The Enhanced Plan:** Offers enhanced coverage that may be appropriate if you need more extensive dental services. The plan's maximums are higher. In addition, orthodontia is offered for adults and dependent children to age 26. There is no deductible for orthodontia services.

With both coverage options:

- You can use any dentist you choose.
- Delta Dental offers a network of dentists who have agreed to charge lower, fixed fees for services. You save money by using network dentists.
- Preventive care is covered at 100% at an in-network provider or 100% up to the Program Allowance at an out-of-network provider.
- You may have to file a claim form if you use an out-of-network provider. Claim forms are available at www.deltadentalins.com.
- To access your specific eligibility, benefits, and claims detail online, you will need to register at www.deltadentalins.com. On the homepage, go to Online Resources on the top right of the page. Click "Register Today," and follow the instructions. You will need your member ID on your Delta Dental ID card, or you can use your Social Security Number.

IN-NETWORK BENEFITS

If you choose to see a dentist in the PPO Provider or Premier Provider Network, your out-of-pocket expenses will usually be less. The plan will pay benefits for covered expenses based on negotiated, fixed fees.

To see if your dentist is in the network, log in to www.deltadentalins.com and use the Find a Dentist tool on the bottom right of the homepage.

If you need any assistance locating your dentist in the network, call Delta Dental at 800-932-0783.

OUT-OF-NETWORK BENEFITS

If you go to an out-of-network provider, the plan will pay benefits based on the Program Allowance. Because these providers are not a part of Delta Dental's network, your out-of-pocket expenses may be higher.

PAYING FOR YOUR CARE

Preventive care is covered at 100% at an in-network provider or 100% up to the Program Allowance at an out-of-network provider. For basic and major services, you must meet the annual deductible before you and IQVIA begins to share the cost of services. There is no annual deductible for orthodontia services in the Enhanced Plan.

DEDUCTIBLE

Deductible

The deductible is the amount you pay each year for eligible dental expenses before the plan begins to pay benefits.

The deductible is the amount of covered charges you pay each year for basic and major services combined before the plan begins paying benefits. In both plans, you pay a $50 per person deductible each year for individual coverage and $150 deductible for family coverage. With family coverage, the maximum deductible is $150.

Meeting the Deductible

The annual deductible applies to basic and major services combined – you don't have to meet a separate deductible for each type of service you receive.

For example, if you satisfy the individual deductible after paying for basic treatment, like a filling, no deductible would be required if you need major treatment, such as a crown, later in the year.

If you have selected family coverage, a combination of covered family members must meet the family annual deductible. Once the family deductible is met, no one person has to meet the individual deductible for the remainder of a given year.

COINSURANCE

Coinsurance

After you meet the deductible, you and IQVIA each pay for a percentage of the cost for covered services called coinsurance.

After you meet the deductible for basic and major services, you and IQVIA share a percentage of the cost each time you receive dental services. The coinsurance amount for basic and major services that the plan pays is the same for both plan options and is listed below for each type of service:

- Basic (e.g., filling, simple extractions, root canals, gum treatment): 80% after deductible
- Major (e.g., crowns, bridges, dentures, implants): 50% after deductible

In the Enhanced Plan, the plan will pay 50% of the benefit for orthodontia treatment at the time of the initial treatment and the remaining 50% 12 months later, assuming you continue to be enrolled in the Enhanced Dental Plan. The general plan of treatment for orthodontic care is 18 to 24 months. If the course of treatment is less than 12 months, the plan will make one payment at the time of the initial treatment.

CALENDAR YEAR MAXIMUM

The plan continues to pay a percentage of your covered basic and major services combined until the maximum annual benefit has been paid. Once you reach the maximum, the plan stops paying benefits for the rest of the plan year. Remember, if you use a Delta Dental network dentist, you pay discounted fees, so you can maximize your plan benefits by using in-network providers. Below are the benefit maximums for each plan option:

- Standard Plan: $1,500 per person per calendar year
- Enhanced Plan: $2,000 per person per calendar year

ORTHODONTIA LIFETIME MAXIMUM

In the Enhanced Plan, the plan will pay a percentage of your covered orthodontia services up to the lifetime maximum benefit of $2,500 per person. Then, the plan stops paying benefits. Remember, if you use a Delta Dental network dentist, you pay discounted fees, so you can maximize your plan benefits by using in-network providers.

OTHER PLAN FEATURES

Tip: Ask for a Pre-Treatment Estimate

Find out what the plan will pay before you receive treatment to ensure you get the best treatment at an affordable cost.

Pre-treatment Estimate for Benefits

Pre-treatment estimate requests are not required; however, your provider may file a claim form before beginning treatment, showing the services to be provided to you. Delta Dental will estimate the amount of benefits payable under the contract for the listed services. By asking your provider for an estimate from Delta Dental before you agree to receive any prescribed treatment, you will have an estimate up front of what Delta Dental will pay and the difference you will need to pay. The benefits will be processed according to the terms of the contract when the treatment is actually performed.

Suitable Plan of Treatment

If more than one covered service will treat a dental condition, payment is limited to the least costly service provided it is a professionally accepted, necessary and appropriate treatment. If you request or accept a more costly covered service, you are responsible for expenses that exceed the amount covered for the least costly service.

If You Are Out of Town

Delta Dental's network is national and available in all 50 states, Puerto Rico, and the District of Columbia. If you are out of town and need dental work, call Delta Dental at 800-932-0783 for a list of network dentists in the area or go to www.deltadentalins.com.

If You Need Emergency Dental Treatment

The plan pays the same amount for emergency service charges made by an in- or out-of-network provider. Dental emergency services are required immediately to either alleviate pain or to treat the sudden onset of an acute dental condition. These are usually minor procedures performed in response to serious symptoms, which temporarily relieve significant pain, but do not effect a definitive cure, and which, if not rendered, will likely result in a more serious dental or medical complication.

BENEFITS COVERED BY THE DENTAL PLAN

The list of services below are covered by the plan if the service is ordered or prescribed by a dentist, essential for the necessary care of teeth and is within the scope of coverage limitations. In addition, charges for these services will be paid only if the deductible is met (if applicable), the maximum benefit is not exceeded and the amount is not more than what is allowed under a suitable treatment plan.

Class I: Preventive and Diagnostic Services

- Oral exams: Two each calendar year.
- Emergency treatment for pain relief.
- X-rays:
  - Bitewing: Two of any bitewing X-ray procedures within a calendar year.
  - Full mouth (10 or more teeth at one time): One within a five (5)-year period.
  - Panoramic: One within a five (5)-year period.
- Cleanings (routine): Two each calendar year.
- Fluoride treatment: Once each calendar year (to age 19).
- Sealants: One per posterior tooth, without caries, within a five (5)-year period.
- Space maintainers (to age 19).
- Palliative (emergency) treatment.

Class II: Basic Restorative Services

- Amalgam fillings.
- Composite/resin fillings for all teeth.
- Root canal therapy.
- Periodontal scaling and cleaning root planing.
- Periodontal maintenance (cleaning): Two of any cleanings (routine or periodontal) each calendar year.
- Bridge recement (once per quadrant per lifetime).
- Extractions:
  - Simple extractions.
  - Endodontic treatment, including root canals.
  - Periodontic treatment or surgery to remove diseased gum tissue or bone.
- Anesthesia:
  - Local anesthetic, analgesic and routine postoperative care.
  - IV sedation.
- Pin retention.
- Therapeutic pulpotomy.
- Pulp caps: One per tooth (as medically necessary).
- Apiceotomy.

Class III: Major Restorative Services

- Osseous surgery.
- Extractions: Impacted teeth.
- Crowns and inlays:
  - Crown build-ups and lengthening.
  - Restorations covered only as a result of extensive caries or fracture and cannot be replaced with amalgam, silicate, acrylic or plastic restoration.
  - Crown and inlay recement (once per tooth per lifetime).
- Onlays.
- Dentures (full and partial), including adjustments during the six-month period following installation and relining once per arch every three (3) calendar years and more than six months from the date of insertion.
- Bridges (fixed or removable).
- Prosthesis (replacement covered only if the existing prosthesis is at least five years old).
- General anesthesia (only if performed as part of a covered surgical procedure).

Class IV: Orthodontia

- Cephalometric X-rays.
- Diagnostic casts.
- Active and retention appliances.
- Active treatment.

The plan will pay 50% of the benefit for orthodontia treatment at the time of the initial treatment and the remaining 50% 12 months later, assuming you continue to be enrolled in the Enhanced Dental Plan. The general plan of treatment for orthodontic care is 18 to 24 months. If the course of treatment is less than 12 months, the plan will make one payment at the time of the initial treatment.

BENEFITS NOT COVERED BY THE DENTAL PLAN

The following expenses are not covered under the Dental Plan:

- Bite registrations; precision or semi-precision attachments; splinting.
- Charges above the Program Allowance.
- Charges made by a hospital performing services for the U.S. Government for a condition connected to military service.
- Charges that would not have been made if you had no insurance.
- Charges you are not legally required to pay.

- Cosmetic dentistry.
- Dental services that do not meet common dental standards.
- Charges covered under an auto insurance policy in compliance with the "no-fault" or uninsured motorist law. Delta Dental will take into account any adjustment option you or any of your dependents choose.
- Charges that are paid or are eligible for payment through a public program, other than Medicaid.
- Charges that are unlawful where you reside when the expenses are incurred.
- Experimental or investigational procedures and treatments.
- Injury resulting from, or in the course of, any employment for wage or profit.
- Instruction for plaque control, oral hygiene and diet.
- Medical services.
- Prescription drugs.
- Procedures, appliances or restorations, other than full dentures, that:
  - Change vertical dimension.
  - Diagnose or treat conditions of TMJ.
  - Stabilize periodontally involved teeth.
  - Restore occlusion.
- Procedures performed by a dentist who is a member of the covered person's family (e.g., spouse, siblings, parents, children, grandparents and the spouse's siblings and parents).
- Replacement of a bridge or denture within five years of installation or if it still meets the dental standards of functional acceptability.
- Replacement of a lost or stolen appliance.
- Services and supplies received from a hospital.
- Sickness covered under any Workers' Compensation or similar law.
- Unnecessary care, treatment or surgery.

In addition, your benefits will be reduced so that the total payment will not be more than 100% of the charge made for a dental service, if benefits are provided for that service under this plan and the IQVIA Medical Plan.

If You Have a Spending Account

If you sign up for a Health Savings Account, Combination Health Care Flexible Spending Account or Health Care Flexible Spending Account, you may submit eligible out-of-pocket expenses or eligible expenses that are not covered by the Dental Plan.

FILING A DENTAL CLAIM

To receive benefits from the plan for covered dental expenses from an out-of-network provider, you may need to file a claim form with Delta Dental. Separate claim forms must be submitted for each person filing a claim. Claim forms are available at www.deltadentalins.com.

To download a claim form, click "Enrollees," then "Managing Costs", and then "How to file a Dental Claim", and then "Delta Dental PPO, DPO and Delta Dental Premier."

Complete claim forms and itemized bills should be sent to the address noted on the claim form.

Before you or your provider submits your claim form, make sure you include your member ID and account number located on your benefits ID card.

APPEALING CLAIMS

If a claim for reimbursement under the Dental Plan is denied, either in whole or in part, you can appeal the denial by following the appropriate procedures described in the *Administrative Information* section.

VISION COVERAGE

Summary Plan Description

IQVIA offers vision coverage to help you and your family pay for eligible vision expenses. You have a choice of two vision plans administered by EyeMed. This coverage helps you save money on your eye care needs and includes eye exams, glasses and contact lenses. EyeMed gives you access to a nationwide network of vision care professionals and offers discounts on selected eyewear.

For More Information

For details about eligibility for benefits, when you can change your coverage and how you pay for coverage, see the *Participating in the Health Care Plans* section. For information about your legal rights under ERISA, general information on claims review and appeal procedures and other important administrative details, see the *Administrative Information* section. To contact the plan administrator, use the information listed in the *Contacts* section.

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Questions?

If you are not sure whether a service or treatment is covered by the plan, or if you have questions about your vision benefits, call EyeMed at 866-939-3633, or log on to the EyeMed website at www.eyemed.com/en-us.

IQVIA provides vision coverage through EyeMed for eye exams, glasses and contact lenses. You choose from two vision plans – the Standard or Enhanced plan. You can see any vision care provider you want, but there are advantages to using EyeMed network doctors:

- You will receive a higher level of benefits when you use EyeMed network doctors.
- You do not have to file claims for reimbursement when you receive services.
- EyeMed has a large national network of doctors and eyewear providers to choose from.

Most network services are covered at 100% after you pay your copay each time you receive care. Here's a quick look at what both plans cover.

Benefit	How Often?
Exam	One exam per person every 12 months
Lenses	One pair of lenses per person every 12 months
Frames	One frame per person every 24 months (Standard); every 12 months (Enhanced)
Contact lenses	One pair of lenses per person every 12 months (in lieu of spectacle lenses and frames)

ANSWERS TO FREQUENTLY ASKED QUESTIONS

Once I find a EyeMed network doctor, or if I decide to change my EyeMed network doctor, how do I notify EyeMed of my selection?

It is not necessary to notify EyeMed when selecting or changing EyeMed network doctors. When you're ready, simply make an appointment with your new EyeMed network doctor and inform them of your EyeMed coverage through IQVIA.

Does EyeMed's network of doctors include optometrists as well as ophthalmologists?

Yes, EyeMed's network of doctors includes professionally certified optometrists and ophthalmologists. To find a network provider, go to www.eyemed.com and choose "Find an eye doctor," then select the Insight Network.

What is the difference between a routine eye exam and a contact lens exam?

Routine eye exams are designed to detect vision problems and are an important preventive measure for maintaining your overall health and wellness. In fact, according to the American Optometric Association, a thorough eye exam can detect certain medical conditions, such as glaucoma and diabetes.

Contact lens exams are designed to evaluate your vision with contact lenses. Although your vision may be clear and you feel no discomfort from your lenses, there are potential risk factors with improper wearing or fitting of contact lenses that can affect the overall health of your eyes.

Do I need an ID card for the Vision Plan?

No. There are no EyeMed ID cards. Just tell your EyeMed network provider that you have EyeMed. The provider can locate you in the EyeMed system without a card.

HOW THE VISION PLAN WORKS

EyeMed maintains a nationwide network of participating providers who have agreed to accept EyeMed's allowances for exam and lens services. You can maximize your vision benefits when you visit one of EyeMed's participating providers. Certain services, such as medically necessary contact lenses, are paid in full. An allowance is available for elective contacts and discounts are available for many other vision services. You may also choose a provider outside the network and be reimbursed for part of the cost. Note that there are limits on how often you can receive benefits.

IN-NETWORK BENEFITS

If your provider is part of the EyeMed Insight Network, you pay the applicable copays for most services.

To use an EyeMed network provider:

- Go to **www.eyemed.com** and choose "Find an eye doctor," then select the Insight Network.
- When you make your appointment, provide your name (or the name of the IQVIA employee), the last four digits of the employee's Social Security Number and your date of birth. (You do not need an ID card.) If you (or your covered dependent) do not provide this information, any services you receive will be considered as out-of-network, or received through an Open Access provider.
- When you go to your appointment, you will pay the copay, and the provider will bill EyeMed the remaining balance. You do not have to submit any claim forms.

OPEN ACCESS BENEFITS

If your provider is not part of the EyeMed Insight Network, the services you receive are considered to be out-of-network (received from an Open Access provider). In this case, you pay the full cost at the time of service, and get an itemized receipt. You will need to submit your claim to EyeMed within six months of the date of service. For details on submitting an out-of-network claim:

- Go to www.eyemed.com/en-us and login
- Access the claims form from the "Claims" tab and follow the instruction to submit.

Remember to Get a Receipt

Be sure to get an itemized receipt from your Open Access provider, and submit your claim within six months.

PAYING FOR YOUR CARE

Your out-of-pocket costs for vision services are based on whether you choose an in-network or Open Access provider.

COPAYS

Copay

The dollar amount you pay *for a specific health care expense.*

When you use an EyeMed in-network provider, you will pay a copay for some services, such as exams, lenses and frames.

PLAN ALLOWANCE

Plan Allowance

The plan allowance is the maximum amount the plan will pay for a benefit during the coverage period.

The plan allowance is the maximum amount the plan will pay for a benefit during the coverage period. If your provider charges less than the plan's allowance for a specific service, you'll be reimbursed only up to the actual charges. If your provider charges more than the plan's allowance, you'll have to pay the difference between your provider's fee and the plan's allowance.

BENEFITS COVERED BY THE VISION PLAN

The following chart shows how exams, lenses, frames and contact lenses are covered by the Vision Plans and how benefits are paid when using an in-network or Open Access provider. Keep in mind that both Vision Plans provide coverage once every 12 months for glasses or contacts—not both.

Benefit	Standard Plan		Enhanced Plan	
	In-Network Provider	**Open Access Provider**	**In-Network Provider**	**Open Access Provider**
Routine exam (one exam per person every 12 months)	100% after $10 copay	Up to $40	100% after $10 copay	Up to $50
Lenses (one pair of lenses per person every 12 months)		Up to:		Up to:
■ Single vision	100% after $25 copay	■ $30	100% after $10 copay	■ $45
■ Lined bifocal		■ $50		■ $70
■ Lined trifocal		■ $70		■ $95
Lens Options	Standard progressive lenses covered 100% after $80 copay; copays range from $110 to $200 for Premium progressive lenses	Progressive lenses reimbursed up to $50	Standard progressive lenses covered 100% after $10 copay; copays range from $95 to $185 for Premium progressive lenses	Progressive lenses reimbursed up to $70
Frames	Every 24 months. Up to a retail allowance of $130, plus 20% off any amount over your allowance	Up to $91	Every 12 months. Up to a retail allowance of $175, plus 20% off any amount over your allowance	Up to $125
Contact lenses (one pair of lenses per person every 24 months, in lieu of spectacle lenses and frames)				
Medically necessary (i.e., if eye glasses will not correct vision impairment)	100%; $0 copay	Up to $300	100%; $0 copay	Up to $300
Elective Contacts	Up to $130 retail allowance	Up to $91	Up to $175 retail allowance	Up to $125

OTHER BENEFITS

Additional discounts are available for the following services received in-network:

Discounted Exam Services

- Retinal Imaging Up to $39

Contact Lens Fit and Follow Up

(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)

- Fit and Follow-up - Standard Up to $40
- Fit and Follow-up - Premium 10% off retail price

Discounted Lens Options

- Photochromic - Non-Glass $75
- Polycarbonate - Standard $0

With Enhanced plan only:

- Scratch Coating - Standard Plastic $15
- Tint - Solid or Gradient $15
- UV Treatment $15

Other Add-On Services and Materials

- 20% off retail price

ADDITIONAL DISCOUNTS

The EyeMed vision plans include the following additional savings for members:

- 40% off additional pairs of safety glasses and a 15% discount on conventional lenses once funded benefit is used –an industry exclusive
- 20% off any item not covered by the plan, including non-prescription sunglasses
- Lasik or PRK from US Laser Network --15% off retail price or 5% off promotional price
- Hearing Care --Through Amplifon Hearing Health Care Network, members receive up to 64% off hearing aids, an extended warranty, and free batteries.

If You Have a Spending Account

If you sign up for a Health Savings Account (HSA) or Health Care Flexible Spending Account, you may submit eligible out-of-pocket expenses or eligible expenses that are not covered by the Vision Plan.

BENEFITS NOT COVERED BY THE VISION PLAN

No benefits will be paid for services or materials connected with or charges arising from:

- Medical or surgical treatment, services or supplies for the treatment of the eye, eyes or supporting structures;
- Refraction, when not provided as part of a Comprehensive Eye Examination;
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state or subdivisions thereof;
- Orthoptic or vision training,
- Subnormal vision aids and any associated supplemental testing;
- Aniseikonic lenses;
- Any Vision Examination or any corrective Vision Materials required by a Policyholder as a condition of employment;
- Safety eyewear;
- Solutions, cleaning products or frame cases;
- Non-prescription sunglasses;
- Plano (non-prescription) lenses;
- Plano (non-prescription) contact lenses;
- Two pair of glasses in lieu of bifocals;
- Electronic vision devices;
- Services rendered after the date an Insured Person ceases to be covered under the Policy, except when Vision Materials ordered before coverage ended are delivered, and the services rendered to the Insured Person are within 31 days from the date of such order;
- Lost or broken lenses, frames, glasses, or contact lenses that are replaced before the next Benefit Frequency when Vision Materials would next become available.

Fees charged by a Provider for services other than a covered benefit and any local, state or Federal taxes must be paid in full by the Insured Person to the Provider. Such fees, taxes or materials are not covered under the Policy. Allowances provide no remaining balance for future use within the same Benefit Frequency. Some provisions, benefits, exclusions or limitations listed herein may vary by state.

COBRA

Summary Plan Description

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), you and/or your dependents may be eligible to continue health care coverage at group rates if your coverage ends. COBRA coverage is available in certain instances, called "qualifying events," where coverage under the IQVIA Health Care Plan (medical, prescription drug, dental, vision and in some instances the health care flexible spending account) would otherwise end. For example, COBRA coverage is available to you and your covered dependents if you are terminated, or if your hours are reduced to the extent that you no longer qualify for IQVIA health care coverage.

The coverage described in this section may change as permitted or required by changes in any applicable law.

For More Information

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. For more information, contact the COBRA administrator at the phone number listed in "Contacting the COBRA Administrator" on page 103. You don't have to show that you're insurable to choose COBRA coverage. However, you do have to pay the entire premium. COBRA coverage is provided subject to your eligibility for coverage as described below. IQVIA reserves the right to terminate your coverage retroactively if it's determined that you're ineligible under the terms of any of the IQVIA health plans.

IN THIS SECTION.....SEE PAGE

AT A GLANCE

Qualifying or Other Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
You leave employment	You and your covered dependents	Up to 18 months
You have a reduction in hours below the level required to meet the benefit eligibility criteria	You and your covered dependents	Up to 18 months
You, your spouse or dependent child is eligible for Social Security disability when eligible for COBRA, or becomes disabled within the first 60 days after an 18-month COBRA coverage period begins	You and your covered dependents	Up to 29 months*
You die	Your covered dependents	Up to 36 months
You and your spouse become divorced or legally separated	Your spouse; also your dependents if a decree causes them to lose coverage	Up to 36 months
You become enrolled in Medicare (Part A, Part B or both)	Your spouse and dependents	Up to 36 months
Your dependent child is no longer an eligible dependent (for example, due to age limit)	Your dependent child	36 months
You or your spouse gives birth to or adopts a child while covered under COBRA	Your dependent child	Remainder of the COBRA coverage period. (Child is considered a qualified beneficiary.)

* To be eligible for the additional 11 months of COBRA coverage, you're required to provide proof of eligibility for Social Security disability benefits within 60 days of the determination period and prior to the end of the 18-month COBRA coverage period.

If you have questions about COBRA coverage, contact the COBRA administrator, Mercer Marketplace at 888-264-9180.

WHO IS ELIGIBLE FOR COBRA

Enrollment Requirements

In order to be eligible for COBRA you must be enrolled in the Health Care Plan on the date of the qualifying event.

If you or a qualified beneficiary is covered by any of the IQVIA Health Care Plan options on the day before a qualifying event, you have the right to choose COBRA coverage if you lose that coverage because:

- Your work hours are reduced.
- You're terminated from employment.
- The employer files for Chapter 11 Bankruptcy.
- The coverage is lost due to Medicare entitlement.

If you're enrolled in the IQVIA Health Care Plan and don't return to work following a leave of absence qualifying under the Family and Medical Leave Act of 1993 (FMLA), the event that will trigger COBRA coverage is the earlier of the date that you indicate you won't be returning to work following the leave or the last day of the FMLA leave period.

If you're the spouse of an eligible employee and you're covered by the IQVIA Health Care Plan on the day before a qualifying event, you're considered a qualified beneficiary.

That means you have the right to choose COBRA coverage for yourself if you lose coverage under the IQVIA Health Care Plan because of any of the following qualifying events:

- Your spouse dies.
- Your spouse's employment is terminated or your spouse's work hours are reduced.
- You divorce or legally separate from your spouse.
- Your spouse becomes entitled to Medicare.
- IQVIA files for Chapter 11 Bankruptcy.

If you're a dependent child of an employee and you're covered under the IQVIA Health Care Plan on the day before a qualifying event, you're also considered a qualified beneficiary. This means you have the right to COBRA coverage if you lose coverage under the IQVIA Health Care Plan because of any of the following qualifying events:

- The employee dies.
- The employee's employment is terminated or the employee's work hours are reduced.
- The employee divorces or legally separates (this includes reducing or dropping your coverage in anticipation of a divorce or separation that occurs later).
- The employee becomes entitled to Medicare.
- You cease to be a "dependent child" under the IQVIA Health Care Plan.
- IQVIA files for Chapter 11 Bankruptcy.

Note: The qualified beneficiary's right to elect COBRA is independent of your rights.

If a covered employee or spouse elect COBRA coverage and then have a child (either by birth, adoption or placement for adoption) during that period of COBRA coverage, the new child is a qualified beneficiary. In accordance with the terms of the IQVIA Health Care Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by calling the COBRA administrator with the new child's birth, adoption or placement for adoption at the telephone number listed under "Contacting the COBRA Administrator" on page 103, within 30 days of the event. This notice should include information about you or the qualified beneficiary receiving COBRA coverage and the new child who will be receiving COBRA coverage. The COBRA administrator may ask you to provide documentation supporting the new child's birth, adoption or placement for adoption.

If you fail to notify the COBRA administrator within 30 days of the event in accordance with the terms of the IQVIA Health Care Plan, you will not be offered the option to elect COBRA coverage for the new child.

Your Duties

Under the law, you must notify IQVIA of a divorce, legal separation or child's loss of dependent status under the IQVIA Health Care Plan within 60 days from the latest of:

- The date of the divorce, legal separation or loss of dependent status.
- The date coverage is lost because of the qualifying event.
- The date on which you were informed of the responsibility to provide the notice and the procedures for providing such notice.

The notice must include information about you or the qualified beneficiary requesting COBRA coverage and the qualifying event that gave rise to the individual's right to COBRA coverage. In addition, you or the qualified beneficiary must provide IQVIA with documentation supporting the occurrence of the qualifying event. Acceptable documentation includes the documents listed below and any other supporting documentation approved by the plan administrator:

- Divorce – a copy of the divorce decree.
- Legal separation – a copy of the separation agreement.
- Child no longer qualifying as a dependent – completion of the Certification of Legal Tax Dependency of Child form.

Remember, in the case of divorce, legal separation or ineligibility of a dependent child, you are responsible for notifying IQVIA within 60 days. If you do not provide notice and all required documentation, you may lose your right to elect COBRA coverage.

Timing

If you fail to provide notice along with supporting documentation to IQVIA during this 60-day period, any covered dependent who loses coverage will lose the right to elect COBRA coverage.

When IQVIA is notified that one of these events has occurred, the COBRA administrator in turn will notify the affected individual that he/she has the right to choose COBRA coverage.

IQVIA's Duties

IQVIA has contracted with Triad to administer COBRA. IQVIA will notify Triad of the qualifying event. Qualified beneficiaries will be notified by Triad of the right to elect COBRA coverage if they lose coverage because of any of the following events:

- The employee dies.
- The employee's employment is terminated or the employee's work hours are reduced.
- IQVIA experiences a bankruptcy under Title 11 of the U.S. Code.

ENROLLING FOR COBRA COVERAGE

Important!

A qualified beneficiary who doesn't choose COBRA coverage within the time period described here, loses the right to elect it.

To elect or inquire about COBRA coverage, contact the COBRA administrator. (See "Contacting the COBRA Administrator" on page 103 for more information.)

Under the law, you must elect COBRA coverage within 60 days from the date you would lose your active coverage because of one of the events described in this Benefits Handbook or, if later, 60 days after you receive notice of your right to elect COBRA coverage. A qualified beneficiary who doesn't choose COBRA coverage within the time period described above loses the right to elect it. You and your covered dependents will be required to reimburse the IQVIA Health Care Plan for any claims mistakenly paid after the date coverage would normally have ended.

Coverage Options

If you choose COBRA coverage, your coverage will be the same coverage you had immediately before the event and the same coverage that is being provided to similarly-situated beneficiaries. "Similarly situated" refers to a current employee or dependent who hasn't had a qualifying event. You'll have the same opportunity to change coverage as active employees have (e.g., at annual open enrollment). This also means that if the coverage for similarly-situated employees or covered dependents is modified, your coverage will be modified in the same way. Your COBRA rights are provided as required by law. If the law changes, your rights will change accordingly.

Separate Elections

Each qualified beneficiary has the right to elect COBRA coverage. This means that a spouse or dependent child can elect COBRA coverage even if you choose not to and, during annual open enrollment, may elect a different option than the one you choose. However, you or your spouse may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

Cost of COBRA Coverage

Important!

The cost of group health coverage periodically changes. If you elect COBRA coverage, the COBRA administrator will notify you of any changes in the cost.

Under the law, you may be required to pay the full amount of the cost of covering an active employee (and eligible dependents, if applicable) plus a 2% administration fee, for a total of up to 102% of the cost of coverage. If your coverage is extended from 18 months to 29 months because of a disability, you may be required to pay up to 150% of the cost of covering yourself and any covered dependents beginning with the 19th month of coverage.

The cost of group health coverage periodically changes. If you elect COBRA coverage, the COBRA administrator will notify you of any changes in the cost. Premiums are established for a 12-month determination period and may increase during that period:

- If the IQVIA Health Care Plan has been charging less than the maximum permissible amount.
- If the qualified beneficiary increases his or her coverage level.
- In the case of a disability extension.

The initial payment for COBRA coverage is due 45 days from the date of your election. Thereafter, you must pay for coverage on a monthly basis within the 30-day grace period. COBRA coverage doesn't begin until payment is made. If you don't make payments on a timely basis, COBRA coverage will terminate as of the last day of the month for which you made a timely payment.

LENGTH OF COBRA COVERAGE

If elected, COBRA coverage begins on the date your coverage as an active employee ends. For dependents who no longer satisfy the requirements for dependent coverage, COBRA coverage begins on the date their dependent coverage ends. However, coverage won't take effect unless COBRA coverage is elected and the required premium is received by the COBRA administrator. The maximum duration of COBRA coverage depends on the reason you or your covered dependents are eligible for COBRA coverage.

If group health coverage ends because your employment ends or your work hours are reduced, COBRA coverage may continue for you and your covered spouse and dependents for up to 18 months.

COBRA coverage for your covered spouse and dependents may continue for up to 36 months if coverage would otherwise end because:

- You die.
- You divorce or legally separate.
- Your dependent child loses eligibility for coverage.

One exception to the rules above is that COBRA coverage under your health care flexible spending account (FSA) cannot extend beyond the end of the calendar year in which your initial qualifying event occurs. No extensions, including any described "Second Qualifying Events" on page 101, can apply to extend health care FSA COBRA coverage beyond that date.

If your COBRA eligibility is because you are a retired employee and IQVIA files for Chapter 11 Bankruptcy, you and your covered dependents may continue COBRA for the duration of your life, after you die, your spouse or child may continue coverage for an additional 36 months.

SECOND QUALIFYING EVENTS

Your spouse and dependents may have additional qualifying events while they're covered under COBRA. These events can extend their 18-month continuation period up to 36 months. In no event will they have more than 36 months of COBRA coverage measured from the date of the first qualifying event (or loss of coverage). This extension may be available to the spouse and any dependent children receiving COBRA coverage if the employee or former employee dies, or gets divorced or legally separated, or if the dependent child stops being eligible under the IQVIA Health Care Plan as a dependent child. This extension will only be available if the additional event would have caused the spouse or dependent child to lose coverage under the IQVIA Health Care Plan had the first event not occurred. If employment ends or work hours are reduced following enrollment in Medicare, the COBRA coverage period for your spouse and dependent children is 36 months from the Medicare enrollment date or 18 months from the subsequent termination or reduction of hours, whichever is longer.

You must notify the COBRA administrator within 60 days of the second qualifying event in order to be eligible for the 36 months of coverage. The notice must include information about the qualified beneficiary requesting additional COBRA coverage and the qualifying event that created the individual's right to additional COBRA coverage. In addition, the qualified beneficiary must provide the COBRA administrator with documentation supporting the occurrence of the qualifying event. See "Who Is Eligible for COBRA" on page 99 for a list of acceptable documentation.

SPECIAL RULES FOR DISABILITY

The initial 18 months of COBRA coverage may be extended to 29 months if you or covered dependent is determined by the Social Security Administration to be disabled at any time during the first 60 days of the COBRA coverage period. This 11-month extension is available to all family members who have elected COBRA coverage due to the termination of employment or reduction in hours, even to those who aren't disabled, and any dependent child who was born or adopted during the initial period of coverage.

To benefit from the extension, the qualified beneficiary must provide the COBRA administrator with the disability determination within 60 days of the Social Security Administration's determination of disability and before the end of the original 18-month period.

If, during COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the individual must notify the COBRA administrator within 30 days of the date it is made.

If a qualified beneficiary is receiving COBRA coverage under a disability extension and has another qualifying event during the 29-month continuation period, then the COBRA coverage period extends until 36 months after the date coverage was originally lost. The qualified beneficiary must provide the appropriate notice to the COBRA administrator as described under "Contacting the COBRA Administrator" on page 103.

COBRA AND FMLA

Taking an approved leave under the Family and Medical Leave Act (FMLA) isn't considered a qualifying event that would make you eligible for COBRA coverage. However, a COBRA qualifying event may occur if:

- You or your dependent has a COBRA qualifying event and is covered by the IQVIA Health Care Plan on the day before the FMLA leave begins, or you or your dependent have a COBRA qualifying event during the FMLA leave.
- You don't return to employment at the end of the FMLA leave or you terminate employment during your leave.

Your COBRA coverage may begin on the earlier of the date you inform the COBRA administrator that you're not returning to work, or the end of the leave, (if you don't return to work).

EARLY TERMINATION OF COBRA COVERAGE

The law provides that your COBRA coverage may be cut short before the expiration of the 18-, 29- or 36-month period for any of the following reasons:

- The IQVIA Health Care Plan no longer provides group health coverage to any of its employees.
- The premium for COBRA coverage isn't paid on time (or within the applicable grace period). The initial payment is due 45 days from the date of your election. Then, you must pay for coverage on a monthly basis within the 30-day grace period.
- The qualified beneficiary becomes covered (after the date COBRA coverage is elected) under another group health plan.
- The qualified beneficiary first becomes entitled to Medicare after the date COBRA coverage is elected.
- Coverage has been extended for up to 29 months due to disability, and the Social Security Administration has made a final determination that the individual is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated early because of your participation in that other plan.

COBRA AND USERRA

If you take a leave of absence that qualifies as a leave under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA, also referred to as a "military leave"), and COBRA continuation coverage rights are available to you, an election for continuation coverage will be an election to take concurrent COBRA/USERRA medical coverage. You can continue coverage under USERRA for up to 24 months.

CONTACTING THE COBRA ADMINISTRATOR

If you have any questions about COBRA coverage or the application of the law, contact the COBRA administrator at the phone number listed below.

Also, you must notify the COBRA administrator immediately if:

- Your marital status has changed.
- You, your spouse or a dependent has changed address.
- A dependent loses eligibility for dependent coverage under the terms of the IQVIA Health Care plan.

All notices and other communications regarding COBRA coverage and the IQVIA-sponsored group Health Care Plan should be directed to the COBRA administrator, Mercer Marketplace, at 888-264-9180.

HEALTH SAVINGS ACCOUNT (HSA) AND FLEXIBLE SPENDING ACCOUNTS (FSAS)

Summary Plan Description

IQVIA provides the opportunity to save on your health care and dependent care expenses by participating in a Health Savings Account (HSA) and/or Flexible Spending Account (FSA). These accounts allow you to benefit from tax savings when you set aside money on a pre-tax basis to use towards eligible expenses.

For More Information

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

IN THIS SECTION.....SEE PAGE

AT A GLANCE

You can save money on your health care and dependent care expenses by enrolling in and contributing pre-tax dollars to a Health Savings Account (HSA) and/or Flexible Spending Account (FSA). IQVIA offers the following accounts.

	Health Savings Account (HSA)	Health Care FSA	Combination FSA	Dependent Care FSA
Available to Employees	Enrolled in the $1,850 or $2,850 Deductible Plan	Enrolled in the $400 Deductible or $900 Deductible PPO Plan Not enrolled in an IQVIA medical plan	Enrolled in the $1,850 or $2,850 Deductible Plan (and contributing to HSA)	All employees regardless of medical plan
You Can Contribute (annually)	Employee only —$3,650 Family — $7,300 If you are age 55 or older in 2022, you may contribute an additional $1,000	Up to $2,850	Up to $2,850	Up to $5,000 (or $2,500 if you are married and filing separately)
Eligible Expenses	Medical, prescription drug, dental and vision	Medical, prescription drug, dental and vision	Dental and vision (and medical after the medical plan deductible is met)	Dependent care expenses, such as child day care and elder care
Funds Carry Over	Yes, the money in your account is always yours to keep	No, money cannot be carried over to the next year	No, money cannot be carried over to the next year	No, money cannot be carried over to the next year

Questions?

If you have questions about the Health Savings and Flexible Spending Accounts, call Mercer Marketplace 365 at 866-268-0142 or log on to their website at www.mercermarketplace365plus.com/IQVIA.

HEALTH SPENDING ACCOUNT (HSA)

ANSWERS TO FREQUENTLY ASKED QUESTIONS

What are the tax advantages of an HSA?

A Health Savings Account has a triple-tax advantage. Your contributions, withdrawals for eligible expenses, and earnings on interest or investments, are all tax-free.

What are the contribution limits?

There are HSA rules when it comes to contribution limits. The 2022 contribution limits, as determined by the IRS, are $3,650 for an individual and $7,300 for family. If you are age 55 or older in 2022, you may contribute an additional $1,000.

What is a qualified expense?

HSA qualified expenses are determined by the IRS and include a wide variety of products and services, including prescription medication, copays and lab fees. To find out if an expense is eligible, visit www.mercermarketplace365plus.com/IQVIA.

When can I make contribution changes?

You can change the amount you contribute to your account at any time during the plan year.

Can I have an HSA and a Flexible Spending Account (FSA)?

You can enroll in certain types of FSAs while you're enrolled in a Health Savings Account, including the Combination FSA and a Dependent Care FSA. However, you can't enroll in a Health Savings Account and a Health Care FSA at the same time.

What's the difference between an HSA vs. FSA?

Both accounts can help you save on eligible expenses, but they're very different. What is the biggest difference? An FSA has a "use it or lose it" rule, which means FSA funds must be spent by the end of the plan year. All Health Savings Account funds can roll over from year-to-year.

ELIGIBILITY AND ENROLLMENT

You can contribute to an HSA if you enroll in the $1,850 Deductible Plan or $2,850 Deductible Plan, as long as you are not:

- Claimed as a dependent on anyone else's tax return.
- Covered by any other medical insurance, such as a spouse's or domestic partner's medical plan, TRICARE or Medicaid.
- Covered by Medicare Parts A or B.
- Participating in a Health Care FSA in the same calendar year you sign up for the $1,850 Deductible Plan or the $2,850 Deductible Plan.

You can establish an HSA anytime during the year once you are enrolled in the $1,850 Deductible Plan or $2,850 Deductible Plan, or during annual enrollment. You will need to authorize IQVIA to open the account on your behalf through Mercer Marketplace 365. Then, you can elect your HSA contribution amount.

For more information about eligibility and enrollment, see the *Participating in the Health Care Plans* section.

Making Changes

You can change your contribution elections anytime during the plan year.

HOW THE HSA WORKS

The Health Savings Account is a tax-advantaged account available to IQVIA employees who elect the $1,850 Deductible Plan or $2,850 Deductible Plan

- You decide how much to save and can change that amount at any time. Contribute up to the annual IRS limit of $3,650 for individuals or $7,300 for family coverage; $1,000 additional contribution is allowed for employees age 55 or older in 2022.
- Use the money to pay for eligible medical, prescription drug, dental and vision care expenses. You can use the HSA debit card to pay after you receive care, or reimburse yourself for payments you've made (up to the available balance in the account). You can pay for deductibles, coinsurance, prescription drugs, out-of-pocket expenses and more — for a complete list; see IRS Publication 502 at www.irs.gov/publications/p502/index.html.
- You can access your funds up to the available balance once services are rendered. You can only get the money out that you've put into the account as of the day you submit the claim.

- Contributions are made from your paycheck on a pre-tax basis, and the money will never be taxed when used for eligible expenses. Money in an HSA can be withdrawn tax-free as long as it is used to pay for qualified health-related expenses. If money is used for ineligible expenses, you will pay ordinary income tax on the amount withdrawn, plus a 20% penalty tax if you withdraw the money before age 65.
- Invest your HSA funds in mutual fund options — just like you would invest your 401k dollars — to grow your balance even more.
- It's your money. Unused money can be carried over each year and invested for the future — you can even take it with you if you leave your job at IQVIA.

How the HSA Debit Card Works

If you enroll in an HSA, you will receive a debit card (Benefits Debit Card) in the mail. No activation is required. With the swipe of your card at approved locations, you automatically withdraw funds from your HSA to pay for eligible expenses.

Keep all receipts for your transactions. The HSA and the debit card are regulated by the IRS, so you may be required to substantiate your purchases. You can check your HSA balance and transaction history any time at http://accounts.mercermarketplace.com. You can also obtain your account information by calling Mercer Marketplace at 866-268-0142.

Annual Contributions

You can contribute up to the annual IRS limit of $3,650 for individuals or $7,300 for family coverage; $1,000 additional contribution is allowed for employees age 55 or older in 2022.

Annual contributions are deducted evenly from each of your paychecks throughout the year.

Eligible Expenses

Examples of eligible HSA expenses include:*:

- Acupuncture
- Chiropractor's fees
- Psychiatric care
- Hospital services
- Operations
- Diagnostic fees
- Ambulance
- Christian Science practitioners' fees
- Psychoanalysis
- Immunization fees
- Eyeglasses
- Artificial limbs
- Osteopathic physicians
- Psychologist visits
- Insulin
- Contact lenses
- Eye exams
- Artificial teeth
- Hearing aids
- Sterilization medication
- Laboratory fees
- Guide dog
- Birth control (pills, condoms, spermicides)
- Contact lens solution
- Transplants (organs)
- Oxygen
- Medical services
- Crutches
- Wheelchair
- Braces
- Prescription drugs
- Hearing aid batteries
- Nursing services
- Dental fees
- X-ray

* A detailed list, IRS Publication 502, Medical and Dental Expenses, is available at www.irs.gov.

FLEXIBLE SPENDING ACCOUNTS (FSAS)

What Is the Combination FSA?

The Combination FSA is a "limited-purpose" FSA available only to participants in the $1,850 Deductible and $2,850 Deductible medical plans who are enrolled in an HSA. It is designed to work together with the HSA for additional tax savings. This account can be used on eligible dental and vision expenses (and medical expenses after the medical plan deductible is met).

Health Care and Dependent Care Flexible Spending Accounts (FSAs) let you contribute to an account you can use to reimburse yourself for eligible health care or dependent care expenses. The following types of FSAs are offered:

- Health Care FSA – available for those enrolled in the $400 Deductible and $900 Deductible PPO Plans only, or no medical coverage.
- Combination FSA – available for those enrolled in the $1,850 Deductible and $2,850 Deductible Plans only and enrolled in an HSA.
- Dependent Care FSA– available to employees regardless of medical coverage.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

May I change my FSA contributions during the year?

Only if you have a change in life status and the change in your contributions is consistent with your life status change. For more about qualified life status changes, see the *Participating in the Health Care Plans* section.

If I do not use up my full account balance, what happens to the money?

Any money left in your account at the end of the calendar year may be used to cover eligible expenses you had while you were contributing to the account during that calendar year. You must file a claim by March 31 of the following year. Then, any money that is left will be forfeited, according to IRS regulations.

What happens to my FSA if I leave employment with IQVIA during the year?

No further contributions will go into your account. You may continue to submit Health Care FSA claims for expenses you had while you were employed for 90 days following your termination date. You may also continue your Health Care FSA through COBRA until the end of the year. Continuation is not available for the Dependent Care FSA. You may submit claims for dependent care throughout the calendar year.

What happens if I terminate employment with IQVIA and I am rehired in the same plan year? Can I elect a new health FSA election?

If you are rehired within 30 days of your termination (within the same calendar year) and wish to participate in the health care FSA, you must resume your previous election for the health care FSA for the remainder of the calendar year. You cannot make a new election until the next annual open enrollment period.

Can I transfer between my Health Care FSA to my Dependent Care FSA?

No. The accounts work separately. Based on IRS rules, you cannot transfer money between the accounts.

Can I have a Flexible Spending Account (FSA) and an HSA?

You can enroll in certain types of FSAs while you're enrolled in a Health Savings Account, including the Combination FSA and a Dependent Care FSA. However, you can't enroll in a Health Savings Account and a Health Care FSA at the same time.

Can I order a replacement FSA debit card or an additional card for my spouse?

Yes, please contact Mercer Marketplace at 866-268-0142 to request a new card.

ELIGIBILITY AND ENROLLMENT

All eligible full-time or part-time employees can participate in the IQVIA Flexible Spending Accounts (FSAs) on your hire date.

You can enroll within 30 days of your date of hire (or within 30 days of when you become eligible, if later). Even if you enroll when first eligible, you must actively enroll during open enrollment in the fall if you wish to continue participating in an FSA for the following year. If you don't actively enroll for the FSAs during open enrollment, you will not be able to participate for the following year. However, as long as you participate in an FSA through the end of the calendar year, you may continue to file claims until March 31 of the following year.

For more information about eligibility and enrollment, see the *Participating in the Health Care Plans* section.

Mid-Year Changes

You may not change your contribution amount or stop participating in an FSA during the year unless you experience a qualified life status change (such as marriage, birth of a child, etc.). For more about qualified life status changes, see the *Participating in the Health Care Plans* section.

If you terminate employment before year-end, you may submit Dependent Care claims for expenses incurred during the remainder of the calendar year.

If you terminate employment before year-end, you may submit Heath Care FSA or Combination FSA claims for dates of service on or before your termination date. Health Care FSA or Combination FSA claims must be submitted within 90 days after your termination date. Also, you may be eligible to continue your Health Care FSA or Combination FSA through the end of the calendar year under COBRA. See "The Health Care FSA and Combination FSA" on page 111 for more information.

HOW FSAS WORK

Save Money with an FSA

You pay less in taxes by contributing to a Health Care or Combination FSA and/or Dependent Care FSA.

If you participate in a FSA, you decide how much money to set aside from your paycheck to pay for eligible expenses for you and your dependents.

Separate Health Care FSA, Combination FSA or Dependent Care FSA recordkeeping accounts are set up in your name and your pre-tax contributions are credited to the accounts each pay period. As you pay eligible expenses through the account, you save money by using tax-free dollars.

The FSAs generally work in the same way:

1. You estimate your eligible health care and dependent day care expenses for the upcoming calendar year.
2. You decide how much to contribute to each account. Because of the "Use it or Lose it" rule, it's a good idea to be conservative in your estimates.
3. The company will deduct your contributions from your paycheck before federal, Social Security or Medicare and most state and local income taxes are calculated, and credit your account with those funds.

Sign Up for Direct Deposit

Sign up any time for easy reimbursement through direct deposit.

4. You can pay for eligible expenses with the FSA debit card, which automatically deducts funds from your FSA, with no claim forms to file. Be sure to keep all receipts. The FSAs and the FSA debit card are regulated by the IRS, so you may be required to substantiate your purchases. There are also automatic reimbursement options: the automatic orthodontia reimbursement option for the Health Care and Combination FSA and the automatic dependent care reimbursement option for the Dependent Care FSA.
5. If you can't use the FSA debit card or auto reimbursement to pay expenses, you can still use your FSA to pay for eligible expenses, but you will need to file claims. When you incur an eligible expense, you pay the provider and submit a claim form along with your receipts. Health Care and Combination FSA claims are reimbursed based on your annual contribution amount. Dependent Care claims are reimbursed based on your current account balance. You will be reimbursed by check or direct deposit with tax-free dollars.

"Use it or Lose it"

It is important to plan contributions to the FSAs carefully. In order to maintain a tax-free plan, the Internal Revenue Service (IRS) requires that if you do not use all of the money in your account(s) by the end of the year, it will be forfeited. As an active employee, you have until March 31 of the following year to submit claims incurred during the plan year for the Health Care FSA, Combination FSA and Dependent Care FSA. If you terminate employment during the plan year, you have 90 days after coverage ends to submit claims for the Health Care or Combination FSA. You may submit dependent care expenses incurred through the remainder of the calendar year.

How the FSA Debit Card Works

If you enroll in an FSA, you will receive a debit card (Benefits Debit Card) in the mail. No activation is required. With the swipe of your card at approved locations, you automatically withdraw funds from your Health Care FSA to pay for prescriptions and copays at the doctor's office, emergency room and more. Your debit card is valid for three years.

The FSA debit card will automatically debit your FSA account based on the guidelines established by the IRS. The card may not work for certain health care expenses, including some dental and vision expenses, and medical expenses if you're not enrolled in a IQVIA medical plan. If your card is denied, you can still use your FSA to pay for these expenses, but you will need to file a traditional claim.

Keep all receipts for your transactions. The FSAs and the debit card are regulated by the IRS, so you may be required to substantiate your purchases. You can check your FSA balance and transaction history any time at **www.yourflexbenefits.mercermarketplace365.com**. You can also obtain your account information by calling Mercer Marketplace at 866-268-0142.

THE HEALTH CARE FSA AND COMBINATION FSA

Your Health Care FSA can be used to pay for IRS-approved health care expenses not covered by any other health plan.

The Combination FSA is available to HSA participants. You cannot participate in both an HSA and a regular Health Care FSA. The Combination FSA can be used only on eligible dental and vision expenses (and medical expenses after the medical plan deductible is met).

Annual Contributions

Each year, you may elect to have between $60 and $2,850 deducted from your pay on a pre-tax basis to fund a Health Care or Combination FSA. Annual contributions are deducted evenly from each of your paychecks throughout the year.

Your Dependents

You may submit expenses for dependents up to age 26 who are eligible to participate in the IQVIA Medical Plan, with the exception of domestic partners and their children who you are not able to claim on your tax return. For dependent eligibility requirements, see the *Participating in the Health Care Plans* section.

Eligible Expenses

In order to be eligible for reimbursement from your Health Care or Combination FSA, expenses must not be covered by another health plan and must qualify as eligible expenses by the IRS. **Keep in mind, that the Combination FSA can only be used on eligible dental and vision expenses (and medical expenses after the medical plan deductible is met).** For IRS guidelines regarding eligibility, you may log on to the IRS website at www.irs.gov or call 800-829-3676 and request Publication 502.

Eligible Dependents

You can submit Health Care and Combination FSA expenses for eligible dependents even if they are not enrolled in IQVIA medical coverage.

The following are examples of expenses that may be eligible for reimbursement:

- Acupuncture treatments.
- Birth control items.
- Childbirth classes.
- Copays and coinsurance payments.
- Deductibles.
- Hearing exams and hearing aids.
- Home modifications for medical reasons, e.g., wheelchair ramp.
- Inpatient treatment at a center for alcohol or drug addiction.
- Medically necessary fees paid to doctors, dentists, surgeons, chiropractors, psychiatrists, psychologists and Christian Science practitioners not covered by another plan.
- Prescription drugs not covered by another plan.
- Prescription eyeglasses or contact lenses.
- Qualified long-term care services.
- Smoking-cessation programs and drugs prescribed to alleviate nicotine withdrawal (nicotine gum and nicotine patches, which do not require a prescription, are not eligible).
- Special schooling for physically or mentally handicapped children.
- Speech therapy.
- Transportation costs primarily for and essential to medical care.
- Vision services, including laser vision correction.
- Weight-loss programs associated with a specific disease.
- Wheelchairs and crutches.

Ineligible Expenses

The following are examples of expenses that are not eligible for reimbursement:

- A trip or program for the general improvement of your health.
- Dental bleaching.
- Expenses paid by an insurance company or reimbursed to you from another source.
- Expenses you plan to claim as a deduction on your federal income tax return.
- Expenses reimbursed through your spouse's health care account.
- Health club dues.
- Most cosmetic surgery.
- Nicotine gum and patches that do not require a prescription.
- Premiums for a medical, dental or vision plan.
- Weight-loss programs for general health and appearance.

Accessing Health Care FSA Funds

The FSA debit card gives you direct access to your Health Care or Combination FSA. When you enroll in the Health Care or Combination FSA, you will automatically receive an FSA debit card (Benefits Debit Card). The FSA debit card helps eliminate the need to file claims every time you incur an eligible expense.

Note that if you participate in both the HSA and Combination FSA, you will receive one Benefits Debit Card to use for both accounts.

Automatic Orthodontia Reimbursement

If you or a covered dependent is scheduled for regular orthodontia expenses not covered by a dental plan, you may sign up for automatic orthodontia reimbursement. Fill out the Automatic Orthodontia Request Form available from the Mercer Marketplace website at **www.yourflexbenefits.mercermarketplace365.com**. You'll need to attach a copy of the contract or letter from your orthodontist outlining your payment plan.

Filing a Traditional Claim

If you need to submit a traditional claim, you may do so via:

- Fax
- Online
- Mail

For details on claims filing, go to the Mercer Marketplace website at **www.yourflexbenefits.mercermarketplace365.com**.

You have until March 31 of the following year or 90 days after coverage ends, whichever comes first, to submit expenses incurred during the current calendar year. If you think that your claim will be delivered after March 31, you should send it "Certified" in order to confirm that you mailed it by March 31. If you do not submit claims by March 31, you will forfeit any money remaining in your accounts.

For the Health Care or Combination FSA, you will be reimbursed up to the total amount of your annual contributions, even if the full amount has not yet been credited to your account.

Health Care FSA Example

Assume you have $1,000 deducted from your pay to fund your Health Care FSA for the year ($83.33/month). In March, you incur an eligible health care expense of $500. You may be reimbursed for the entire $500, even though you only have about $250 in your account. Once you reach your $1,000 limit, you may not submit any more claims for the year.

Continuing Your Health Care FSA through COBRA

If you terminate employment during the year, you can elect to continue your participation in the Health Care or Combination FSA for the remainder of the year under certain conditions under COBRA. You may only continue to participate in the Health Care or Combination FSA if you have elected to contribute more money than you have taken out in claims. For example, if you elected to contribute an annual amount of $500 and, at the time you terminate employment, you have contributed $300 but only claimed $150, you may elect to continue coverage under the Health Care or Combination FSA. If you elect to continue coverage, then you would be able to continue to receive your health reimbursements up to the $500. However, you must continue to pay for the coverage just as the money has been taken out of your paycheck, but on an after-tax basis. You may also be charged a 2% administrative fee to provide this benefit.

See the *COBRA* section for more information.

Discontinuing Your Health Care or Combination FSA

If you discontinue your Health Care or Combination FSA as a result of a life status change, you may not submit expenses incurred after that date. You may continue to submit claims for expenses incurred before the change in coverage for 90 days after your contributions end. According to IRS regulations, if there is money remaining in your account after you have been reimbursed for expenses incurred before the change, it will be forfeited.

THE DEPENDENT CARE FSA

If you and your spouse (if you are married) are employed, or your spouse attends school full-time, or is disabled and incapable of self-care, you may contribute pre-tax money to a Dependent Care FSA to cover expenses for the care of dependent children or adults while you are at work. Note: The Dependent Care FSA is for reimbursement of dependent day care expenses only and not dependent health care expenses.

Annual Contributions

Each year, you may elect to have between $60 and $5,000 deducted from your pay on a pre-tax basis to fund a Dependent Care FSA. Annual contributions are deducted evenly from each of your paychecks throughout the year.

Your Dependents

Eligible dependents for the purposes of the Dependent Care FSA are different from those eligible for other benefits, including the Health Care FSA. Dependent Care FSA eligible dependents include:

- Children under age 13 who you claim as dependents on your federal tax return.
- Children under age 13 for whom you have legal custody and do not claim as an exemption on your tax return.
- Any person (child, spouse, elderly parent) who is physically or mentally incapable of self-care for whom you are entitled to claim as a dependent on your federal tax return and who lives with you for more than one-half of the year.

For dependents who are not a "qualifying child," the dependent cannot earn gross income in excess of the annual exemption ($4,300 in 2021).

Contribution Limits

Your annual contributions are reduced from $5,000 to $2,500 if:

- You are married, and you and your spouse file separate tax returns.
- Your spouse contributes to a dependent care account.

Please note: The IRS dependent care limit per family is $5,000.

Eligible Expenses

The Dependent Care FSA pays for IRS approved dependent care expenses that you and your spouse (if married) incur while working or looking for a job. To verify IRS eligibility, you may log on to the IRS website at www.irs.gov or call 800-829-3676 and request Publication 503.

The following are examples of expenses that may be eligible for reimbursement:

- Home-based daycare providers who comply with all state and local regulations.
- Individuals, including relatives, who provide care in or outside your home (other than your dependents or your children under age 19).
- Licensed daycare centers for children and adults, and nursery schools.
- Nanny expenses for services provided in your home.
- Summer day camp.

Ineligible Expenses

The following are examples of expenses that are not eligible for reimbursement:

- Care provided by your spouse, your children under age 19, or any other dependent.
- Care provided for non-work related reasons.
- Educational expenses, supplies or meals unless these costs can't be separated from an eligible expense.
- Elementary school fees and expenses (kindergarten and beyond).
- Expenses paid to a housekeeper, maid, cook, etc., unless specific to the care of your dependent.
- Expenses reimbursed through your spouse's dependent care account.
- Expenses you plan to take as a tax credit on your federal income tax return.
- Overnight camp.

Accessing Dependent Care FSA Funds

The FSA debit card gives you direct access to your Dependent Care FSA. When you enroll in the Dependent Care FSA, you will automatically receive an FSA debit card (Benefits Debit Card). The FSA debit card helps eliminate the need to file claims every time you incur an eligible expense.

Automatic Dependent Care Reimbursement

With the automatic dependent care reimbursement option, you submit one form per year for each day care provider you use and reimbursement is sent automatically. Fill out the Dependent Care Documentation Form available from **www.yourflexbenefits.mercermarketplace365.com**.

Filing a Traditional Claim

To file a traditional claim, you may do so via:

- Fax
- Online
- Mail

For details on claims filing, go to **www.yourflexbenefits.mercermarketplace365.com**.

Submit Your Claims by March 31

Remember to submit your claims by March 31 of the following year.

You have until March 31 of the following year to submit expenses incurred during the current calendar year. If you think that your claim will be delivered after March 31, you should send it "Certified" in order to confirm that you mailed it by March 31. If you do not submit claims by March 31, you will forfeit any money remaining in your accounts.

For the Dependent Care FSA, you will be reimbursed up to the amount of your current account balance.

Dependent Care Example

Assume you have $3,000 deducted from your pay to fund your Dependent Care FSA for the year ($250/month). In January, you incur an eligible dependent care expense of $300. You will be reimbursed for $250 (your current account balance) and will automatically receive a check for the remaining $50 when you have enough money in your account to cover the reimbursement.

Discontinuing Your Dependent Care FSA

If you discontinue your Dependent Care FSA as a result of a life status change, you may not submit expenses incurred after that date. You may continue to submit claims for expenses incurred before the change in coverage for 90 days after your contributions end. According to IRS regulations, if there is money remaining in your account after you have been reimbursed for expenses incurred before the change, it will be forfeited.

OTHER IMPORTANT INFORMATION

Keeping Track of Your Account

You can keep track of your account activity by logging on to the Mercer Marketplace website at www.yourflexbenefits.mercermarketplace365.com. You can also call 866-268-0142.

- Participation in the FSA Plan is optional; you may enroll in one, both or neither of the spending accounts.
- You do not have to enroll in the Medical or Dental Plans to participate in the FSA Plan.
- You do not have to have family medical or dental coverage to submit expenses for your eligible dependents. However, the definition of an eligible dependent is different for the Dependent Care FSA. See the *Participating in the Health Care Plans* section.
- Your life insurance and disability benefits are based on your annual base salary and are not affected by your contributions to the FSA Plan.
- Money in the FSA accounts is nontransferable. If you run out of money in your Dependent Care FSA, you may not use money in your Health Care FSA to pay for dependent care expenses and vice versa.
- You may only submit expenses that are incurred during the current calendar year.
- You have until March 31 of the following year to submit expenses incurred during the current calendar year. If you think that your claim will be delivered after March 31, you should send it "Certified" in order to confirm that you mailed it by March 31. If you do not submit claims by March 31, you will forfeit any money remaining in your accounts.

- You may only submit expenses that are incurred while you (or a dependent) are participating in the FSA Plan.
- If you are hired mid-year, the annual contribution limits do not decrease. You are still eligible to deposit the maximum amount. The total amount you elect will be taken in equal deductions from the remaining pays in that calendar year.
- Because you are not paying FICA taxes on your contributions, participating in the FSA Plan may result in a slight reduction in your Social Security benefits at retirement. Generally, the effect on your benefits will be minimal and offset by the money you save in taxes by participating in the plan.

TAX TREATMENT

There are some important tax issues that you should be aware of when using IQVIA FSAs, including how pre-tax contributions can save you money and details about the dependent care tax credit.

Pre-Tax Contributions

Your contributions and reimbursements are not subject to federal, Social Security or Medicare and in most cases, state and local taxes. By paying for your health and dependent care expenses with pre-tax money, your take-home pay is more than if you paid the expenses after taxes.

An Example

You could save $2,592 each year if:

- You and your spouse both work and together make $90,000 per year.
- You have one dependent child, and you file a joint return.
- You contribute $2,400 to a Health Care FSA.
- You contribute $5,000 to the Dependent Care FSA to pay for care while your spouse works.

Health Care and Dependent Care Expenses

	With the FSAs	Without the FSAs
Gross Monthly Salary	$7,500	$7,500
Health Care FSA	– $200	$0
Dependent Care FSA	– $416	$0
Taxable Income	$6,884	$7,500
Taxes	– $2,409	– $2,625
Take-home Pay after Taxes	$4,475	$4,875
After-tax Health Care Expenses	$0	– $200
After-tax Dependent Care expenses	$0	– $416
Monthly Take-home Pay	$4,475	$4,259
Estimated Tax Savings*	**$216/month, or $2,592/year**	

* The tax savings shown here are general estimates only. Your actual taxes may be more or less, as tax rates may vary based on your location and your tax filing status.

Tip: Take Advantage of Tax Savings

If your family's adjusted gross income is $24,000 or more, your tax advantage is usually greater with the Dependent Care FSA.

Dependent Care FSA vs. Dependent Care Tax Credit

Using the Dependent Care FSA will affect the amount you can deduct for the federal dependent care tax credit. You may not take an income tax credit on your tax return and get reimbursed from your Dependent Care FSA for the same expenses.

You may want to consult a financial advisor regarding your individual situation.

DISABILITY COVERAGE

Summary Plan Description

Your IQVIA benefits are an important part of your overall compensation. One of our primary goals is to provide you with a level of financial protection against a substantial economic loss should you become unable to work due to a disability. The disability plans are designed to provide assurance that you will continue to have income during certain periods of sickness or injury when you cannot work.

The IQVIA disability plans include:

- Short-Term Disability (STD) Plan.
- Long-Term Disability (LTD) Plan.

This section explains the details of the IQVIA disability plans, and how and when you can enroll.

For More LTD Plan Information

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

SHORT-TERM DISABILITY PLAN

Summary Plan Description

The IQVIA Short-Term Disability Plan (STD Plan) is designed to provide you with income protection if you're unable to work for an extended period of time because of an injury or illness, including pregnancy. As an eligible employee, you automatically receive STD coverage and IQVIA pays the cost.

IQVIA contracts with Lincoln National Life Insurance Company, a Lincoln company (referred to as "Lincoln" throughout this document) to provide the STD Plan to eligible employees.

This section explains how the STD Plan works, including your coverage if you qualify for benefits.

IN THIS SECTION.....SEE PAGE

AT A GLANCE

Feature	Benefit
Weekly Benefit	■ 100% of your base salary for the first four weeks, then 70% of your base salary for weeks five to 26. ■ Benefits may be reduced by deductible sources of income and other disability earnings.
Tax Treatment of Benefit	Benefit payments are subject to federal and state income taxes.
Waiting Period	■ **For disabilities due to sickness or illness**, there is a seven-day elimination period. If you are out of work due to an illness for more than seven consecutive days, STD benefits may begin. ■ **For disabilities due to accidental bodily injury,** there is no waiting period. Plan benefits will begin immediately.
Maximum Benefit Duration	26 weeks; if your disability lasts longer than 26 weeks, you may be eligible for the Long-Term Disability Plan. (See *Long-Term Disability Plans* for details.)
Cost of Coverage	STD coverage is fully paid for by IQVIA.

If you have any questions about your coverage, contact the IQVIA Benefits Marketplace at 888-264-9180. To check on the status of a claim, please call Lincoln at 800-213-5608 or visit www.mylincolnportal.com (Company Code: IQVIA).

ANSWERS TO FREQUENTLY ASKED QUESTIONS

What is short-term disability?

Short-term (STD) disability benefits provide you with income protection if you are unable to work for an extended period of time due to an injury or illness. While you are absent from work, STD benefit payments replace a percentage of your weekly earnings for a specified period of time.

STD benefits are paid at 100% of your base salary for weeks one through four of your disability. If your disability lasts longer than four weeks, your STD benefit is reduced to 70% of your base salary for weeks five through 26. STD benefits end after 26 weeks, but if your injury or illness continues you may be eligible to begin receiving benefits under the IQVIA Long-Term Disability Plan.

What happens to my STD benefit if I'm also receiving disability payments from another source?

Benefit payments under the STD Plan are reduced by other sources of income you receive (or are entitled to receive) as a result of your disability. This would include, but is not limited to, any Social Security or retirement plan disability benefits, benefits from another disability insurance plan for which you are eligible or payments you receive under a Workers' Compensation law, occupational disease law, or similar law.

A short list of these other sources of income, or "benefit offsets," can be found in "How Benefits Are Paid" on page 122.

If I leave IQVIA or retire, can my STD coverage be converted to an individual policy?

No. Unlike life insurance coverage, your STD coverage cannot be converted after you leave.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY

Your Regularly Scheduled Work Week

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

You are eligible for the STD Plan if you are a regular, active employee of IQVIA working 30 or more hours per week within the United States. Temporary and seasonal employees are not eligible for the plan.

When determining your eligibility for benefits under the disability plans, if you were actively at work on your last scheduled working day, you will be deemed actively at work on a scheduled non-working day. In general, you are considered to be "actively at work" if you were performing all the regular duties of your job on a regular IQVIA workday before you became disabled. You will be considered actively at work if you were performing your duties either at one of IQVIA' places of business or at another location where IQVIA business required you to travel.

COST OF COVERAGE

IQVIA pays the full cost of your STD Plan coverage.

HOW TO ENROLL

You are automatically enrolled in the STD Plan when you are both eligible and actively at work.

WHEN COVERAGE BEGINS

Your coverage begins on the first day you become eligible for the STD Plan, provided you are actively at work. If you are not actively at work because of injury or illness on the date your coverage would become effective, your coverage will begin on the date you return to work.

Coverage during a Family or Medical Leave of Absence

If you are on a family or medical leave of absence, IQVIA will continue to pay for your STD coverage for up to 12 weeks (or longer, if required by law) after the date your leave began.

Your leave authorization must be in writing. If approved, your family or medical leave of absence will end when the earliest of the following occurs:

- Your leave ends before the agreed upon date.
- Your leave ends on the agreed upon date.
- You are no longer eligible for the plan.
- The plan terminates.

If you become disabled during this time, your STD benefit will be based on your monthly earnings in effect just prior to the date your leave began.

WHEN COVERAGE ENDS

Actively at Work

You will be considered to be "actively at work" if you are performing the material duties of your job on a regularly scheduled workday. You will be considered actively at work on a scheduled non-working day, if you were actively at work on your last scheduled working day.

Generally, your STD coverage ends on the earliest of the following dates:

- The date you are no longer working at least 30 hours per week.
- The date you cease to be actively at work due to a layoff, labor dispute, including a strike, work slowdown, or lockout.

With the exception of approved family and medical leave, you do not have coverage under the STD Plan if you are not actively at work. You do not have coverage under the plan if you are on any leave (other than an approved medical leave), or if you have been laid off or terminated from employment.

HOW THE PLAN WORKS

How Are Weekly Earnings Defined?

Weekly Earnings is defined as the basic weekly rate of pay immediately prior to your disability, before taxes and deductions. Basic weekly earnings does not include overtime, bonuses, and incentive pay, or non-cash compensation.

The STD Plan will provide you with weekly benefit payments, for a maximum of 26 weeks, if you are disabled due to an injury or illness and your disability has been certified by Lincoln.

If your disability is due to:

- **Sickness or illness,** STD benefit payments begin on the eighth consecutive calendar day of a certified absence. Once your claim is approved, IQVIA will provide a benefit to you equal to 100% of your weekly earnings for the first seven days of your absence.
- **Accidental bodily injury,** benefit payments will begin on the first day of an approved disability.

The maximum duration for which benefits may be payable is the first 26 weeks of your disability. This 26-week period includes the elimination period. If your disability extends beyond 26 weeks, you may be eligible for benefits under the Long-Term Disability Plan. See *Long-Term Disability Plans* for details.

- 100% of your base salary for the first four weeks, then 70% of your base salary for weeks five to 26.

STD coverage provides you with a weekly benefit of 100% of your weekly earnings for the first four weeks, then 70% of your weekly earnings for weeks five to 26.

If you are covered by your state's or commonwealth's short-term disability benefit laws (e.g.; California, Connecticut, Hawaii, New Jersey, New York, Rhode Island, Puerto Rico and Washington have state disability laws) and higher benefits are required by law than are provided by the IQVIA STD Plan, you will receive the greater amount. But, in no event will you receive more than 100% of your weekly earnings from all sources.

Your monthly benefit may be reduced by other deductible sources of income or disability earnings you are eligible to receive, as described in "How Benefits Are Paid" beginning on page 122.

DEFINITION OF DISABILITY

You are considered disabled or partially disabled if, due to an injury or illness, all of the following apply:

- You are unable (or have a limited ability) to perform the material duties of your regular job at IQVIA due to your disability.
- You have a 20% or more loss in your weekly earnings due to your disability.
- You are under the regular care of a physician.

The loss of a professional or occupational license or certification does not, by itself, constitute a disability.

To be considered disabled, you must be under the regular care of a physician. During the course of your leave, Lincoln may require that you be examined by a physician and/or vocational expert of their choice or you may be asked to interview with a Lincoln representative about the status of your disability. Examinations or interviews may be requested by Lincoln at any time and at any frequency.

If You Are Disabled and Working

If you are disabled but return to work on a part-time or limited duty basis during your disability, you'll continue to receive monthly payments from the plan. Your disability benefit will be reduced if the combination of work earnings and disability benefit exceed 100% of your pre-disability weekly earnings.

If You Are Pregnant

Special rules apply if you are eligible to receive STD benefits due to pregnancy. These rules differ depending on the delivery of your child.

- **If you have a regular delivery,** you are considered disabled for a minimum of six weeks (beginning on your delivery date), unless you return to work during that six-week period.
- **If you have a Caesarean section,** you are considered disabled for a minimum of eight weeks (beginning on your delivery date), unless you return to work during that eight-week period.

HOW BENEFITS ARE PAID

If your disability claim is approved, benefits will be paid semi-monthly as long as you continue to meet the definition of disability.

Benefits are paid by IQVIA and will be deposited directly into your account, as reflected on IQVIA's payroll records.

Benefit Offsets by Other Sources of Income

STD Overpayments

Any STD overpayments must be repaid. The plan may offset your STD benefits in order to recover any overpayments, including wrongful payments made to you in error.

Your STD benefits will be reduced by compensation you or your family receive (or are eligible to receive) from certain other sources as a result of your disability. This includes, but is not limited to, benefits received from:

- State disability income benefits including statutory benefits provided by the state of California, Connecticut Hawaii, New Jersey, New York, Rhode Island, Puerto Rico, and Washington .
- The United States Social Security Act, the Civil Service Retirement System, the Railroad Retirement Act, the Jones Act, the Canada Pension Plan, the Quebec Pension Plan or similar plan or act that you or your family are eligible to receive because of your disability.
- Any governmental law or program (whether federal, state or local) that provides disability or unemployment benefits as a result of your employment with IQVIA.
- Any amount of earnings you receive from any form of employment including severance.

If you are paid other income benefits in a lump sum, this lump sum will be pro-rated over the period of time it would have been paid if not paid in a lump sum or (if such period of time cannot be determined) over a period of 26 weeks.

The Plan Administrator may make a retroactive allocation of any retroactive other income benefit payments.

TAX TREATMENT OF STD BENEFITS

Because IQVIA pays for your STD coverage, any benefit payments you receive are subject to federal and state income taxes. You may want to consult with your tax advisor regarding the proper income tax treatment of your benefit payments.

Up Close and Personal: Marie

Marie works for IQVIA and is making $52,000 a year ($1,000 a week) when she becomes disabled due to an accidental injury. Under the STD Plan, Marie is entitled to receive a total of $1,000 a week from all disability income sources. Here's how her STD benefit is calculated:

Marie's earnings for weeks 1-4 (100% of weekly earnings)	$1,000
Marie's earnings for weeks 5 - 26 (70% of weekly earnings)	$700

If Marie received any benefit offsets during her disability, these amounts would be deducted from her STD payments.

WHEN BENEFIT PAYMENTS END

Your benefit payments will end on the earliest of the following dates:

- The end of the maximum benefit duration (26 weeks).
- The date your partial disability earnings exceed 80% of your basic weekly earnings.
- The date you are no longer considered disabled (including the first date you are capable of working in your regular occupation on a part-time basis but choose not to).
- The date you fail to provide:
  - Proof of disability, and evidence of continuing disability.
  - Proof that you are under the appropriate care and treatment of a doctor.
  - Any other material information related to your disability which may be requested.
- The date you fail to attend a requested medical examination, or the date you refuse to be examined or interviewed by a physician or plan representative when requested by IQVIA and Lincoln.
- The day you die.
- The date the plan is terminated.

NEW OR RECURRING DISABILITIES

If your period of disability is extended by a new cause while you are receiving payments from the plan, STD benefits will continue while you remain disabled provided both of the following apply:

- Your STD benefits do not continue beyond the end of the original 26-week maximum benefit duration.
- The plan's exclusions apply to the new cause of disability.

If you are disabled, return to work for less than 14 days, and become disabled again due to the same or related condition, you will not have to satisfy a new elimination period. If your return to work was for 14 days or more, or if you become disabled due to a new and unrelated condition, you will need to satisfy a new elimination period. See "When Coverage Ends" on page 121 for details.

WHAT IS NOT COVERED

The STD Plan doesn't cover certain disabilities or pay benefits for:

- Sickness or injury for which Workers' Compensation benefits are paid (or may be paid), if duly claimed.
- Injury, sickness, mental illness or pregnancy when you are not being treated by a physician.
- Disability caused or contributed to by war or act of war (declared or not), or as a result of military service.
- Disability caused or related to elective or cosmetic surgery.
- Disabilities caused by your commission of, or attempting to, commit a felony or misdemeanor.
- Participating in a riot.
- Disability caused or contributed to by an intentionally self-inflicted injury.
- Injury sustained as a result of doing any work for pay or profit for another employer.

CLAIMING BENEFITS

Questions on Your STD Claim

Call Lincoln at 800-213-5608 or visit www.mylincolnportal.com (Company Code: IQVIA) if you have general questions about your claim and/or the status of your claim.

In order to receive STD benefits, you, your supervisor or your physician must contact Lincoln by the third day of your absence. (If notice cannot be given within three days, it must be given as soon as possible after that.) A representative of Lincoln will assist the caller through the claim process and gather the appropriate information.

You can report a claim by calling 800-213-5608 or visit www.mylincolnportal.com (Company Code: IQVIA). First time users will be required to register when they access the site. Please enter IQVIA as the Company Code. After your claim is established you can return to the site to check on the status of your claim.

PROOF OF DISABILITY

If required, written proof of your disability must be sent to Lincoln within 14 days after the start of the period for which you are owed a payment from the plan. From time to time, Lincoln may require further written proof that you are still disabled.

If proof is not given by the time it is due, it will not affect your claim if:

- It was not possible to give proof within the required time.
- Proof is given as soon as possible, but no later than one year after it was due (unless you are not legally competent to provide such proof).

Lincoln has the right to require, as part of the proof of loss:

- Your signed statement identifying all other income benefits.
- Proof satisfactory to Lincoln that you and your dependents have duly applied for all other income benefits that may be available.

In addition, Lincoln may require you to be examined to determine if you are disabled. Any such examination will be made as often as reasonably required by Lincoln. At all times, Lincoln reserves the right to determine if your proof of loss is satisfactory.

Your Claim

Both you and IQVIA will receive notification of Lincoln's determination of your STD claim. In the event that your claim is not approved, you will be provided the reason(s) for the denial and the process for appealing your claim.

FRAUDULENT CLAIMS

It is a crime to knowingly attempt to injure, defraud or deceive Lincoln with an STD claim, or to provide information that you know is false, incomplete or misleading. In such cases, Lincoln will deny your claim and you may be subject to prosecution and punishment under state and/or federal law. IQVIA intends to pursue all appropriate legal remedies in the event of insurance fraud.

LONG-TERM DISABILITY PLAN

Summary Plan Description

The IQVIA Long-Term Disability Plan (LTD Plan) is designed to provide you with income protection if you're unable to work for an extended period of time because of an injury or illness. As an eligible employee, you automatically receive LTD coverage and IQVIA pays the cost.

The LTD Plan is provided through an insurance policy (GF3-850-292043-01) issued by Lincoln National Life Insurance Company, a Lincoln company (referred to as "Lincoln" throughout this document).

The summary is intended to be a general description of the LTD benefits provided by the policy issued by Lincoln. If there is a conflict between this plan description and the LTD policy regarding services, exclusions, limitations or other provisions the LTD policy will be govern. The benefits described in this summary are subject to the terms and conditions of the LTD policy.

This section explains how the LTD Plan works, including your coverage under the plan if you qualify for benefits.

For More Information

For information about your legal rights under ERISA, general information on claims review and appeal procedures, and other important administrative details, see the *Administrative Information* section.

IN THIS SECTION ..... SEE PAGE

AT A GLANCE

Note that in some cases, LTD benefits may be provided before your eligibility for Social Security disability benefits has been determined. In such cases, the claims administrator, Lincoln, will seek recovery or reimbursement of benefit overpayments from retroactive Social Security benefits.

Feature	Benefit
Monthly Benefit	■ 60% of your monthly earnings. ■ Benefits may be reduced by deductible sources of income and other disability earnings.
Maximum/Minimum Monthly Benefit	■ **Maximum:** $15,000. (You may be eligible to receive additional amounts if you participate in Lincoln's Rehabilitation Program.) ■ **Minimum:** The greater of $100 or 10% of your gross disability payment.
Tax Treatment of Benefit	Benefit payments are subject to federal and state income taxes.
Maximum Benefit Duration	The maximum duration of monthly benefit payments will vary depending on the age at which you became disabled.
Cost of Coverage	LTD coverage is fully paid for by IQVIA.

If you have questions about the LTD coverage, please contact the claims administrator, Lincoln, at 800-213-5608 or visit www.mylincolnportal.com (Company Code: IQVIA) .

ANSWERS TO FREQUENTLY ASKED QUESTIONS

What is long-term disability?

Long-term disability (LTD) benefits provide you with income protection if you are unable to work for an extended period of time due to injury or illness. While you are absent from work, LTD benefit payments replace 60% of your monthly earnings, to a maximum of $15,000 per month.

To qualify for LTD benefits, you must be disabled under the terms of the plan, as described under "Definition of Disability" on page 129. You must also satisfy an "elimination period," or a period of time that must pass before LTD payments can begin.

LTD payments continue for as long as you remain disabled. Lincoln may request proof of your continued disability from time to time.

What happens to my LTD benefit if I'm also receiving disability payments from another source?

Benefit payments under the LTD Plan are reduced by other sources of income you receive (or are entitled to receive) as a result of your disability. This would include, but is not limited to, any Social Security or retirement plan disability benefits, benefits from another disability insurance plan for which you are eligible or payments you receive under a Workers' Compensation law, occupational disease law or similar law.

A short list of these other sources of income, or "benefit offsets," can be found in "How Benefits Are Paid" on page 130. For a full list of benefit offsets that may apply, contact Lincoln at 800-213-5608 or visit www.mylincolnportal.com (Company Code: IQVIA).

If I leave IQVIA or retire, can my LTD coverage be converted to an individual policy?

No. Unlike life insurance coverage, your LTD coverage cannot be converted after you leave.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY

Your Regularly Scheduled Work Week

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

You are eligible for the LTD Plan if you are a regular, active employee of IQVIA working 30 or more hours per week within the United States. Temporary and seasonal employees are not eligible for the plan.

When determining your eligibility for benefits under the disability plans, if you were actively at work on your last scheduled working day, you will be deemed actively at work on a scheduled non-working day. In general, you are considered to be "actively at work" if you were performing all the regular duties of your job on a regular IQVIA workday before you became disabled. You will be considered actively at work if you were performing your duties either at one of the IQVIA places of business or at another location where IQVIA business required you to travel.

COST OF COVERAGE

IQVIA pays the full cost of your LTD Plan coverage.

HOW TO ENROLL

You are automatically enrolled in the LTD Plan when you are both eligible and actively at work.

WHEN COVERAGE BEGINS

Actively At Work

You will be considered to be "actively at work" if you are performing the material duties of your job on a regularly scheduled workday. You will be considered actively at work on a scheduled non-working day, if you were actively at work on your last scheduled working day.

Your coverage begins the date you become eligible for the LTD Plan.

If you are not actively at work because of injury or illness on the date your coverage would become effective, your coverage will begin on the date you return to work.

Coverage during a Leave of Absence

If you are on a leave of absence, IQVIA will continue to pay for LTD coverage for up to six months after the date of your leave began.

If you become disabled during this time, your LTD benefit will be based on your monthly earnings in effect just prior to the date your leave began.

WHEN COVERAGE ENDS

Generally, LTD coverage ends on the earliest of the following:

- The date you no longer are in an eligible group.
- The date your eligible group is no longer covered.
- The last day you are actively employed by IQVIA (except if you are on a leave of absence).
- The date you cease active work due to a labor dispute, including any strike, work slowdown or lockout.

Your Elimination Period

The elimination period is a period of time that must pass following your disability date before LTD benefits can begin. Under this plan, your elimination period is the later of 180 days or the date your short-term disability payments end, if applicable.

If you return to work for any thirty or fewer days during the elimination period and cannot continue, Lincoln will count only those days that you are disabled or partially disabled to satisfy the elimination period.

HOW THE PLAN WORKS

Your Monthly Earnings

This is your monthly rate of pay (regular salary or wages), before taxes and before any deductions are made. Your monthly earnings do not include commissions, incentive pay, bonuses, overtime pay, shift differential or any other fringe benefit or extra compensation.

The LTD Plan will provide you with monthly benefit payments if you are continuously disabled beyond the later of 180 days or the date your short-term disability payments end, if applicable. This period is known as the elimination period. Benefit payments will begin after the elimination period has been satisfied and your claim has been approved by Lincoln.

Your LTD monthly benefit amount is equal to 60% of your monthly earnings, to a maximum of $15,000. (However, you may be eligible for additional amounts if you participate in the "Rehabilitation Incentive Benefit " on page 132. The minimum monthly benefit you are eligible to receive is the greater of $100 or 10% of your gross disability payment.

DEFINITION OF DISABILITY

What Is Your Occupation?

For the purposes of the LTD Plan, your occupation is the activity you regularly perform that serves as your source of income. It is not limited to the specific position you held with IQVIA. It may be a similar position, which entails substantially similar functions that could be performed with IQVIA or any other employer. To determine your qualification for benefits, Lincoln will look at your occupation as it's normally performed in the national economy.

If, as a result of sickness or injury, you are unable to perform the material and substantial duties of your own job on a full-time or part-time basis, you are considered disabled or partially disabled.

With respect to partial disability, you are considered partially disabled if you can perform one or more, but not all, of the duties for your job or all the duties of another job, and are earning between 20% and 80% of your pre-disability earnings.

After 24 months of payments, you are considered disabled or partially disabled when Lincoln determines that, due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

You must be under the regular care of a physician in order to be considered disabled. The loss of a professional or occupational license or certification does not, in itself, constitute a disability.

PROPORTIONATE LOSS MONTHLY CALCULATION WITH WORK INCENTIVE BENEFIT

For the first 12 months, the work incentive benefit will be an amount equal to your basic monthly benefit without any reductions from work earnings. The work incentive benefit will only be reduced, if the monthly benefit payable plus any earnings exceed 100% of your basic monthly earnings. If the combined total is more, the monthly benefit will be reduced by the excess amount so that the monthly benefit plus your earnings does not exceed 100% of your basic monthly earnings.

Thereafter, the amount of monthly benefit will be determined as follows:

(A divided by B) x C:

A = Your basic monthly earnings minus your earnings received while partially disabled. This figure represents the amount of lost earnings.

B = Your basic monthly earnings.

C = The monthly benefit plus the earnings you received while partially disabled.

If You are Disabled Due to Mental Illness or Substance Abuse

If you are disabled due to mental illness the lifetime benefit period is limited to 12 months of LTD benefit payments. Because this is a lifetime maximum, this limit will apply even if you have more than one disability period, and even if the disabilities are not continuous or not related.

How Is Mental Illness Defined?

Mental Illness means a psychiatric or psychological condition classified as such in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) regardless of the underlying cause of the Mental Illness. If the DSM is discontinued, Lincoln will use the replacement chosen or published by the American Psychiatric Association.

However, if you remain disabled, you can continue to receive benefit payments beyond 12 months if you meet one or both of the following conditions:

- If you remain in a hospital or institution for mental illness and/or substance abuse at the end of the period of 12 months, the monthly benefit will be paid during the confinement.
- If you are not confined in a hospital or institution for mental illness and/or substance abuse, but are fully participating in an extended treatment plan for the condition that caused disability, the monthly benefit will be payable for up to a period of 36 months.

In no case will you receive LTD benefit payments beyond your maximum benefit duration, as described in "When Benefit Payments End" on page 131.

HOW BENEFITS ARE PAID

LTD Overpayments

Any LTD overpayments must be paid back to Lincoln. The plan may offset your LTD benefits in order to recover any overpayments, including wrongful payments made to you in error.

Once your claim is approved by Lincoln, you will begin receiving LTD benefit payments provided you have completed your elimination period and you are still disabled.

Benefits are paid by Lincoln and will be mailed to your address, or paid via direct deposit.

Benefit Offsets by Other Sources of Income

- The amount for which you are eligible to receive under:
  - Workers' or Workmen's Compensation Laws;
  - Occupational Disease Law;
  - Title 46, United States Code Section 688 (The Jones Act);
  - Railroad Retirement Act;
  - Any governmental compulsory benefit act or law; or
  - Any other act or law of like intent.
- The amount of any disability benefits which you are eligible to receive under:
  - Any other group insurance plan provided by IQVIA;
  - Any governmental retirement system as a result of your employment with IQVIA ; or
  - Any individual insurance plan where the premium is wholly or partially paid by IQVIA. However, Lincoln will only reduce the monthly benefit if your monthly benefit under this policy, plus any benefits that you are eligible to receive under such individual insurance plan that exceed 100% of your basic monthly earnings. If this sum exceeds 100% of your basic monthly earnings, your monthly benefit under this policy will be reduced by the excess amount.
- The amount of benefits you receive under IQVIA's retirement plan as follows:
  - The amount of any disability benefits under a retirement plan, or retirement benefits you voluntarily elect to receive as payment under IQVIA's retirement plan; and
  - The amount you receive as retirement payments when you reach the later of age 62, or the normal retirement age as defined in the IQVIA retirement plan.
- The amount of disability and/or retirement benefits under the United States Social Security Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act, which:
  - You receive or are eligible to receive; and
  - Your spouse, child or children receives or is eligible to receive because of your disability; or
  - Your spouse, child or children receives or is eligible to receive because of your eligibility for retirement benefits.
- Any amount you receive from any unemployment benefits.
- The amount of earnings you receive from any sick leave, salary continuation, employment or severance.

TAX TREATMENT OF LTD BENEFITS

Because IQVIA pays for your LTD coverage, any benefit payments you receive are subject to federal and state income taxes. You may want to consult with your tax advisor regarding the proper income tax treatment of your benefit payments.

Up Close and Personal: Mark

Mark works for IQVIA and is making $36,000 a year ($3,000 a month) when he becomes disabled. Under the LTD Plan, Mark is entitled to receive a total of $2,000 a month (60% of monthly earnings) from all disability income sources. He does not participate in the Rehabilitation and Return to Work Assistance program, but receives $600 a month from Social Security. Here's how his LTD benefit is calculated:

Total monthly LTD benefit (60% of monthly earnings)	$1,800
Less monthly primary Social Security benefit	– $600
Mark's monthly LTD benefit	$1,200

Mark still receives $1,800 a month: $600 from Social Security and $1,200 from the LTD Plan. The LTD benefit is taxable.

Note: This example assumes that Mark doesn't receive family Social Security benefits.

WHEN BENEFIT PAYMENTS END

Your LTD benefit payments will end on the earliest of the following dates:

- The date you are no longer disabled according to this policy.
- The date you fail to provide proof of continued disability or partial disability, or fail to cooperate in the administration of your claim.
- The date you refuse to appropriate available treatment, or to be evaluated at reasonable intervals.
- The date you are able to work on a part-time basis but choose not to.
- If you are working, the date your monthly disability earnings are more than 80% of your pre-disability monthly earnings.
- The date you reach the maximum benefit duration, as shown in the following table:

If you become disabled...	Your maximum benefit duration will be...
Before age 60	To age 65, but not less than five years
At age 60	60 months
At age 61	48 months
At age 62	42 months
At age 63	36 months
At age 64	30 months
At age 65	24 months
At age 66	21 months
At age 67	18 months
At age 68	15 months
At age 69 or older	12 months

- The date you are no longer disabled under the terms of the plan, unless you are eligible to receive assistance under the "Rehabilitation Incentive Benefit " on page 132.
- The date you fail to submit proof of your continuing disability to Lincoln.
- The date you die.

If You Die

If you die while receiving LTD benefit payments, your eligible survivor(s) will receive a lump-sum benefit equal to three times your last monthly benefit, if you had been considered disabled for 180 days. If you qualify for this lump-sum benefit but have no eligible survivor(s), payment will be made to your estate.

RECURRING DISABILITIES

If you have a recurring disability, Lincoln will treat your disability as part of your original claim and you will not have to complete another elimination period if both of the following apply:

- You were covered by the plan for the period between the end of your prior claim and your recurrent disability.
- Your recurrent disability occurs within six months from the end of your prior claim.
- Your claim is due to, or related to, the same causes as your original disability.

Your recurrent disability will be subject to the same terms as your prior claim and will be treated as a continuation of that disability.

Any disability which occurs six or more months after the date your prior claim ended will be treated as a new disability claim. The new claim will be subject to all of the plan's provisions, including the elimination period.

If you become entitled to payments under any other group long-term disability plan as a result of a new disability, you will not be eligible for payments under this plan.

WHAT IS NOT COVERED

The LTD Plan doesn't cover certain disabilities, including disabilities that are the result of:

- Intentionally self-inflicted injuries, while sane or insane.
- Active participation in a riot.
- Loss of professional license, occupational license or certification.
- Committing or attempting to commit a felony or misdemeanor.
- War (declared or undeclared) or any act of war.
- A pre-existing condition.

Pre-Existing Conditions

The LTD Plan does not cover disabilities caused by or related to pre-existing conditions. A pre-existing condition under the LTD Plan is:

- A condition for which you received medical treatment, consultation, care or services (including diagnostic measures), or you took prescribed drugs or medicines in the three months before your effective date of coverage under the plan.
- A disability that begins in the first 12 months after your effective date of coverage under the plan.

REHABILITATION INCENTIVE BENEFIT

Once you become disabled, Lincoln will determine whether you are eligible to participate in the Rehabilitation Program, designed to assist you in returning to work. You must be medically able to engage in a return to work program. Eligibility for the program will be at Lincoln's sole discretion.

If you are selected for the program, a rehabilitation and assistance plan will be developed for your specific needs. This plan may include at Lincoln's discretion (but is not limited to) the following services and benefits:

- physical therapy;
- occupational therapy;
- work hardening programs;
- functional capacity evaluations;
- psychological and vocational counseling;
- rehabilitative employment; and
- vocational rehabilitation services.

If you qualify for the program, you will be notified by Lincoln.

ADDITIONAL BENEFIT PAYMENT

If you are eligible for a Rehabilitation Incentive Benefit Lincoln will increase your monthly LTD benefit by 10%. The increased benefit will begin on the first day of the month after Lincoln receives written proof of your full participation in the Rehabilitation Program.

You will continue to receive this additional LTD benefit until you no longer participate in the Rehabilitation Program, the Rehabilitation program ends, or when your benefit ends.

DISABILITY BENEFITS TERMINATION

If you decline to fully participate in an approved Rehabilitation Program, benefits will terminate on the first day of the month following your decline to fully participate in the approved Rehabilitation Program. If Lincoln recommends rehabilitation, no benefit will be paid from the date the recommendation is made until Lincoln receives your written agreement to fully participate in the Rehabilitation Program.

WORK LIFE ASSISTANCE PROGRAM

Regardless of whether you are disabled, Lincoln offers a Work Life Assistance Program. Under the program, you can call and request assistance with almost any personal and professional issue, from finding day care or transportation for an elderly parent to helping deal with stress in the workplace. The program is designed to handle both everyday issues as well as offer crisis support.

SOCIAL SECURITY CLAIMANT ADVOCACY PROGRAM

Once you are receiving monthly benefit payments from the plan, Lincoln can assist you in applying for Social Security disability benefits. Receiving Social Security disability benefits may allow you to protect your retirement benefits, receive Medicare after 24 months, and enable your family to become eligible for Social Security benefits.

Lincoln can assist you in obtaining Social Security disability benefits by:

- Helping you find appropriate legal representation.
- Obtaining medical and vocational evidence in support of your application.

For program assistance, contact Lincoln.

CLAIMING BENEFITS

Questions on Your LTD Claim

Call Lincoln at 800-213-5608 or visit www.mylincolnportal.com (Company Code: IQVIA) if you have general questions about your claim and/or the status of your claim.

During your short-term disability period, Lincoln will contact you to assist with a transition from short-term to long-term disability benefits. During this process, Lincoln will provide you with the required form(s), if any, and advise you on the steps required before you can begin receiving an LTD benefit.

PROOF OF YOUR CLAIM

When you transition from STD benefits to LTD benefits, you must send Lincoln written proof of your claim within 180 days after your elimination period ends. This proof of disability may be extended for up to one year in certain circumstances; contact Lincoln for details.

Your proof of claim must be provided at your own expense, and must show:

- The date your disability began.
- The cause and extent of your disability, including any restrictions or limitations that prevent you from performing your regular occupation.
- That you are under the regular care of a physician.
- The name and address of any hospital or institution where you received treatment, including all attending physicians.
- Documentation of your monthly earnings.

Lincoln may require that you provide additional information in order to satisfy your proof of claim. You and IQVIA will be notified if anything additional is required and will be given a specified time frame in which to supply this information.

It is your responsibility, not Lincoln's or IQVIA's, to ensure that all requested information is provided to Lincoln. If the appropriate information is not submitted, Lincoln will deny your claim in its entirety or stop sending additional benefit payments.

Your Claim

Both you and IQVIA will receive notification of Lincoln's determination of your LTD claim. In the event that your claim is not approved, you will be provided the reason(s) for the denial and the process for appealing your claim.

FRAUDULENT CLAIMS

It is a crime to knowingly attempt to injure, defraud or deceive Lincoln with an LTD claim, or to provide information that you know is false, incomplete or misleading. In such cases, Lincoln will deny your claim and you may be subject to prosecution and punishment under state and/or federal law. Lincoln intends to pursue all appropriate legal remedies in the event of insurance fraud.

LIFE AND ACCIDENT COVERAGE

Summary Plan Description

Financial protection from the unexpected is an important part of IQVIA's benefits program. To provide financial support for you or your family in the event of death or serious accidental injury, IQVIA offers the following plans:

- Life Insurance Plan.
- Accidental Death and Dismemberment (AD&D) Plan.
- Business Travel Accident (BTA) Insurance Plan.

Basic coverage for you is provided by IQVIA. In addition, you have the option to purchase optional life and voluntary AD&D coverage for yourself and/or your eligible dependents at group rates.

This section explains the details of IQVIA's Life, AD&D and BTA Plans.

For More Information

Additional information about your life, AD&D and BTA coverage can be found on the IQVIA company intranet, IQ. For information about your legal rights under ERISA, general information on claims review and appeal procedures and other important administrative details, see the *Administrative Information* section. To contact the plan administrator, use the information listed in the *Contacts* section.

LIFE INSURANCE PLAN

Summary Plan Description

The IQVIA Life Insurance Plan provides financial protection to you and your beneficiaries in the case of death. Your basic employee coverage is automatically provided by IQVIA to help offer financial protection for your beneficiaries if you die. Optional life insurance coverage for you, your spouse and/or dependent children may be purchased by you at group rates.

The Life Insurance Plan is provided through an insurance policy (SA3-850-292043-01) issued by Lincoln National Life Insurance Company, a Lincoln company (referred to as "Lincoln" throughout this document).

The summary is intended to be a general description of the Life Insurance benefits provided by the policy issued by Lincoln. If there is a conflict between this plan description and the Life policy regarding services, exclusions, limitations or other provisions the Life policy will be govern. The benefits described in this summary are subject to the terms and conditions of the Life policy

This section explains how the Life Insurance Plan works.

IN THIS SECTION ..... SEE PAGE

AT A GLANCE

Feature	Basic Benefit	Optional Benefit
Coverage Levels	Two times your annual base salary, to a maximum of $1,000,000.	■ **For you:** Purchase from one to five times base annual salary up to $2,000,000. ■ **For your spouse:** Up to 50% of your total coverage or $250,000, whichever is less (in increments of $10,000). ■ **For your dependent children:** Up to $20,000 per child (in increments of $5,000).
Enrollment	Automatic following your date of hire.	You must actively enroll yourself and/or your eligible dependents.
Tax Treatment of Benefit	■ Basic coverage above $50,000 is subject to federal income tax (see "Tax Treatment of Life Insurance Benefits" on page 145 for details). ■ Benefit payments to your dependents are not subject to federal income tax.	Benefit payments to you or your dependents are not subject to federal income tax.
Cost of Coverage	Provided by and fully paid for by IQVIA.	You pay the cost of any optional coverage through after-tax payroll deductions.

If you have any questions about your coverage, contact the IQVIA Benefits Marketplace at 888-264-9180.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

How much life insurance coverage is available under the plan?

There are two types of life insurance coverage under the plan—basic coverage and optional coverage.

IQVIA provides basic coverage to you at no cost. This amount is equal to two times your annual base salary, to a maximum of $1,000,000.

You pay for any optional coverage you elect with after-tax dollars deducted from your paycheck. The maximum optional coverage you can elect varies. If the optional coverage is for:

- **You,** purchase from one to five times base annual salary up to $2,000,000.
- **Your spouse,** his or her maximum is 100% of your total coverage or $250,000, whichever is less.
- **Your dependent children,** the maximum is $20,000 per child.

Optional coverage for your spouse can be increased or decreased in increments of $10,000. Optional coverage for your dependent children can be increased or decreased in increments of $5,000. Please note that you can only elect optional coverage for your spouse or dependent children if you also elect optional coverage for yourself.

How is my annual base salary determined, and what happens if it changes at some point during the year?

Your annual base salary is your annual rate of pay (regular salary or wages), before taxes and before any deductions are made. Your annual base salary does not include commissions, incentive pay, bonuses, overtime pay or any other fringe benefit, shift differential or extra compensation.

If your annual base salary changes at any point during the year, your basic coverage amount will automatically increase or decrease as a result. This will be effective the same day as your salary change (if you are actively at work on that day) or the date you return to active work.

If I leave IQVIA or retire, are the conversion and portability features automatic or do I have to enroll?

No, both conversion and portability are not automatic. To continue coverage through conversion and portability, you must complete the appropriate forms (mailed to you by Lincoln) and submit them along with your premium payment within 31 days of the date your IQVIA coverage ends.

If I elect to increase my optional life insurance and the increase is denied, will I lose the coverage I had in place before my increase request?

No. If your election to increase coverage is denied, your coverage will revert to the amount in place before your request.

Will coverage continue for my child age 26 or over who became disabled while covered under the plan?

Coverage will be continued for a child age 26 or over who became physically or mentally disabled while covered under the plan provided:

- The disability was acquired before the child's coverage would have ended;
- The child is incapable of self-sustaining employment;
- The child is institutionalized because of mental or physical disabilities;
- You are the main source of support and maintenance.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY

You are eligible for the Life Insurance Plan if you are a regular, active employee of IQVIA working 30 or more hours per week within the United States. Temporary and seasonal employees are excluded.

Eligible Dependents

If you enroll in optional coverage, you also may enroll your eligible dependents in optional coverage. Your eligible dependents include:

- Your legal spouse.
- Your dependent children until the end of the month in which they turn age 26.
- Your unmarried dependent children of any age who live with you, are unable to support themselves, and who became physically or mentally incapacitated prior to age 26 and remain physically or mentally incapacitated.

For the definitions of legal spouse and dependent children, see the *Participating in the Health Care Plans* section.

IQVIA Couples

If both you and your spouse work for IQVIA, special provisions apply to your eligibility and enrollment in the Life Insurance Plan. If you, your spouse and/or your dependent children are eligible for coverage, you may not select duplicate coverage for yourselves or your eligible dependents. In other words, you each may enroll as individuals or one of you may enroll and elect dependent coverage for your spouse, but none of you may be covered as both an employee and a dependent, nor may you or your spouse cover the same eligible dependents under the Life Insurance Plan. Under no circumstances can an eligible dependent be covered by more than one employee under the plan.

COST OF COVERAGE

Your cost under the Life Insurance Plan depends on the type of coverage you select:

- **Basic life insurance**: IQVIA pays the cost.
- **Optional life insurance:** You pay the cost for yourself and/or your eligible dependents. You can purchase coverage at group rates on an after-tax basis through payroll deductions. The amount of your cost depends on the type of optional coverage you elect (for you, your spouse, and/or eligible dependent children) and the covered amount.

Any contributions you make for optional coverage start when your approved coverage begins or the first pay cycle following your enrollment, whichever is later. Your contributions are automatically deducted from your pay in equal installments.

HOW TO ENROLL

Actively At Work

You will be considered to be "actively at work" if you are performing the material duties of your job on a regularly scheduled workday. You will be considered actively at work on a scheduled non-working day if you were actively at work on your last scheduled working day.

Basic Coverage

You are automatically enrolled in basic coverage when you are both eligible and actively at work.

Optional Coverage

How you enroll in optional coverage depends on when you are enrolling, as described in the following sections.

Enrolling for Coverage

You can enroll in the Life Insurance Plan online at the IQVIA Benefits Marketplace website from any computer that has internet access.

Generally, your elections remain in effect for the entire plan year (January 1 through December 31).

When First Eligible

The enrollment email you receive after you are hired will contain the information and materials you need to enroll in optional coverage for yourself and your eligible dependents. You will have 30 days from your date of hire to enroll.

If you don't enroll in optional life insurance coverage within this 30-day period, you will be enrolled in basic coverage only. However, you will have additional enrollment opportunities during open enrollment or if your needs change, as described in the following sections.

During Open Enrollment

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

Mid-Year Enrollment Changes

After you enroll, your coverage under the Life Insurance Plan will remain in effect for the remainder of the calendar year. Generally, you can make changes only during the open enrollment period. However, because your needs may change when you experience certain life events (such as marriage, divorce, birth or adoption of a child, death of a dependent, etc.), you may be allowed to make mid-year enrollment changes in certain situations in accordance with Internal Revenue Code and as permitted by the plan administrator.

Changes to your coverage must be consistent with the qualified change in status. Depending on the status change, you may be able to enroll, change or drop optional life insurance coverage for yourself, your spouse or your eligible dependent child(ren).

Before a change in optional coverage can be approved, Lincoln may require you and/or your eligible dependents to satisfy certain evidence of insurability (EOI) requirements. (See "Evidence of Insurability (EOI)" on page 142 for details.) Your coverage will begin on the first day of the month after Lincoln approves your EOI. In addition, you must be actively at work on the effective date of your coverage.

Designating a Beneficiary

When you enroll in the Life Insurance Plan, you must name a beneficiary for your benefit in the event of your death. You may name any person (or persons) you wish to be the beneficiary who receives the benefit payment. Visit the IQVIA Benefits Marketplace website to review or change your beneficiary. You may change your beneficiary at any time.

If, at the time of your death, there is no named or surviving beneficiary, Lincoln will pay the benefits to the executor or administrator of your estate. Lincoln may, at its option, pay the benefits to a surviving relative in the following order: spouse, child, parent, sibling. Such payment will release Lincoln of all further liability to the extent of payment.

When you enroll your spouse and/or dependent children in optional coverage, you are automatically the beneficiary. If you and your eligible dependents die at the same time (or within 24 hours of your death), benefits under the Life Insurance Plan will be paid to your estate.

If the plan is required to distribute funds to a beneficiary without the legal capacity to receive payment, Lincoln may pay up to $2,000 to the person or institution that has assumed custody or provides support for the beneficiary.

Evidence of Insurability (EOI)

In some cases, you may be required to provide Evidence of Insurability (EOI) to obtain optional life insurance coverage. EOI is proof of good health for you and/or your eligible dependents. Because your basic life insurance coverage is paid by IQVIA, EOI isn't required.

EOI is required for the following types of optional coverage:

- **For yourself**, EOI is required if:
  - **During your initial open enrollment (when you are first eligible):** The total requested amount of your optional coverage is greater than $500,000.
  - **During subsequent open enrollments:**
    - You enroll more than 30 days after your initial eligibility date.
    - You are re-enrolling in optional coverage after voluntarily cancelling coverage at an earlier date.
    - You elect to increase your coverage by more than one level.
- **For your spouse,** EOI is required if:
  - **During your initial open enrollment (when you are first eligible):** You enroll or increase your spouse coverage above $70,000.
  - **During subsequent open enrollments:**
    - You enroll more than 30 days after your initial eligibility date.
    - You are re-enrolling your spouse in optional coverage after voluntarily cancelling coverage at an earlier date.
    - You elect to increase your spouse's coverage by more than one level.

When you apply for a type of coverage that requires EOI, Lincoln will contact you. Your coverage will become effective on the day your EOI is approved.

WHEN COVERAGE BEGINS

For You

When your coverage begins depends on when you became eligible to enroll or make a change under the Life Insurance Plan, as shown in the following table.

If You:	Your Coverage Begins:*
Are a current participant in the Life Insurance Plan and make changes during open enrollment	The beginning of the following plan year (January 1).
Are a newly-hired or newly-eligible employee	Your date of hire.
Have made a change to your election outside of your initial eligibility period or open enrollment	The date Lincoln approves your EOI.

* If you are electing optional coverage, in all cases your coverage will not begin until your EOI form is approved (if EOI is required).

If you are not actively at work because of injury or illness on the date your coverage would become effective, your coverage will begin on the date you return to work.

For Your Eligible Dependents

If you enroll an eligible dependent in optional coverage, coverage begins on the latest of the following:

- The date your dependent is eligible for coverage.
- The date your eligible spouse's EOI form is approved (if EOI is required).

See "Eligible Dependents" on page 140 for information about who qualifies as an eligible dependent and "Evidence of Insurability (EOI)" on page 142 for information about EOI requirements.

WHEN COVERAGE ENDS

Generally, life insurance coverage ends on the earliest of the following:

- The date you no longer are in an eligible group.
- The date your eligible group is no longer covered.
- The last day of the period for which you made any required contributions.
- The last day in which you are actively employed by IQVIA, unless your coverage is continued due to a covered layoff, leave of absence or due to an injury or sickness.
- The date you cease active employment due to a labor dispute, including any strike, work slowdown, or lockout.
- The date the plan is terminated.

BASIC LIFE INSURANCE

Your Annual Base Salary

This is your annual rate of pay (regular salary or wages), before taxes and before any deductions are made. Your annual base salary does not include commissions, incentive pay, bonuses, overtime pay, shift differential or any other fringe benefit or extra compensation.

Your basic life insurance coverage, provided to you by IQVIA, is equal to two times your annual base salary, rounded to the next highest $1,000 (if not already a multiple of $1,000). For example, if your annual base salary is $40,400, your basic life insurance coverage amount is $81,000. The minimum amount of basic coverage is $10,000; the maximum amount is $1,000,000.

IF YOUR PAY CHANGES

Your basic coverage automatically changes when your annual base salary changes. In other words, if your annual base salary increases or decreases, your benefit amount automatically increases or decreases on the same day, provided you are actively at work on that day.

If the change in your annual base salary becomes effective on a non-working day, your coverage amount will change on:

- That same day, provided you were actively at work on the last scheduled working day before that non-working day.
- The date you return to active work, if you were not actively at work on the date your annual base salary changed.

OPTIONAL LIFE INSURANCE

IQVIA offers optional life insurance coverage for you and your eligible dependents at group rates. You can buy additional coverage for yourself as well as coverage for your spouse, and/or your dependent children.

Once you enroll for this coverage through IQVIA, you will be able to continue coverage even after you end your employment. For information about your options, see "Continuing Coverage" on page 146.

YOUR COVERAGE AMOUNTS

Employee-Only Coverage

Enroll Yourself to Enroll Your Dependents

Optional coverage for your eligible dependents is available only when you also elect optional coverage for yourself.

You may buy optional coverage in amounts from one to five times your base annual salary (rounded to the next higher $1,000) up to $2,000,000. The minimum coverage amount you may purchase is $10,000.

Spouse Coverage

You may buy optional coverage for your spouse in increments of $10,000, up to a maximum of 100% of your total life insurance coverage or $250,000, whichever is less.

Dependent Child Coverage

You may buy optional life insurance coverage for your eligible dependent child(ren) in increments of $5,000, up to a maximum of $20,000 per child. If you and your spouse are both IQVIA employees, only one of you may elect optional coverage for a single dependent child. In other words, a dependent child may be enrolled in optional coverage by you or by your spouse, but not both.

Guaranteed Coverage Amounts

The guaranteed coverage amount is the maximum optional coverage you can buy for yourself or your eligible dependents without providing EOI, as described in "Evidence of Insurability (EOI)" on page 142. How the guaranteed coverage amount applies to you depends, in part, on when you enroll or make changes.

Initial Enrollment

If you enroll in optional coverage for yourself, your spouse or your dependent children when you are first eligible (as a new hire), you can purchase up to the guaranteed amount without providing evidence of insurability. The guaranteed coverage amounts are:

- **You:** $500,000.
- **Spouse:** $70,000.

You must provide EOI for coverage amounts above the guaranteed coverage amount. In this case, only amounts up to the guaranteed coverage amount will be effective at enrollment. Lincoln must approve the amount above the guaranteed coverage amount before the remainder of your coverage is effective.

Subsequent Enrollment

During any subsequent enrollment period, you must provide EOI if:

- You enroll more than 30 days after your initial eligibility date.
- You are re-enrolling in optional coverage for you or your spouse after voluntarily cancelling coverage at an earlier date.
- You elect to increase your optional coverage for you or your spouse by more than one level.

Lincoln must approve the election before the coverage is effective.

COVERAGE REDUCTION AT AGE 65

When you or your spouse reaches one of the ages shown in the table below, basic and optional life insurance coverage for the person reaching the applicable age will be reduced based as shown. The reduction is effective as of the last day of the month in which the birthday occurs.

If you are age:	Basic life insurance coverage will be reduced to:
65 to 69	65% of the coverage amount at age 64
70 or older	50% of the coverage amount at age 70

WHAT THE PLAN DOES NOT COVER

The plan does not cover any losses where death is caused by, contributed to by or resulted from suicide that occurred within 24 months after:

- The initial effective date of coverage.
- The effective date of any optional coverage.

This suicide exclusion applies to any coverage for which you pay all or part of the premium, which includes Optional Life coverage. It also applies to any amount subject to EOI requirements. Lincoln must approve the EOI form as well as the coverage amount.

HOW BENEFITS ARE PAID

To claim a life insurance benefit, you or your beneficiary must email benefit.services@iqvia.com with notification of the covered individual's death. IQVIA will confirm the beneficiary designation and assist in the completion and submittal of paperwork to Lincoln.

Once submitted, Lincoln will review the claim and any supporting documentation. If additional information is needed, the beneficiary of record will be contacted directly.

Lincoln will pay benefits immediately once a life insurance claim is approved. You or your beneficiary will be notified of Lincoln's decision as soon as it is made.

ACCELERATED BENEFIT

If you or a covered dependent are terminally ill (meaning 12 or fewer months to live, as determined by a licensed physician while covered by the plan), the terminally ill person may elect to have up to 80% of his or her life insurance benefit (to a maximum of $250,000) paid in a single lump sum. Upon death, the remaining benefit is paid to the beneficiary on record.

Receiving an accelerated benefit is subject to all of the following:

- It must be requested in writing, on a form acceptable to Lincoln.
- The individual must be terminally ill at the time the accelerated benefit payment is to be made.
- A physician must certify, in writing, that the individual is terminally ill and that his or her life expectancy has been reduced to less than 12 months.
- The physician's certification must be deemed satisfactory to Lincoln.

Any premium payments you are required to make must continue to be paid until you qualify to have your premium waived, as described in "Continuation of Coverage during Disability" on page 147.

If you have assigned your rights under the plan to an assignee or made an irrevocable beneficiary designation, Lincoln must receive consent, in writing, that the assignee or irrevocable beneficiary has agreed to the Accelerated Benefit payment on your behalf in a form acceptable to Lincoln before benefits are payable.

If you or a covered dependent elect to receive an accelerated benefit under the Life Insurance Plan, your remaining life insurance coverage will be affected as follows:

- Any death benefit payable under the Life Insurance Plan will be reduced by the amount received as an accelerated benefit.
- Any life insurance coverage that would be continued under a disability continuation provision (or that may be available under the conversion privilege) will be reduced by the amount received as an accelerated benefit. The remaining life insurance amount will be paid according to the terms and conditions applied to other payments under the Life Insurance Plan.

Any accelerated benefit that is payable may be taxable to the recipient. Consult a tax or financial advisor before taking advantage of this feature.

TAX TREATMENT OF LIFE INSURANCE BENEFITS

While you are participating in the plan, any basic life insurance amounts above $50,000 are considered imputed income and subject to imputed income taxes, as shown in the following table.

Imputed Income

If your basic life insurance coverage exceeds $50,000, the value of the amount of coverage that exceeds $50,000 is considered "imputed income," and subject to imputed income taxes. The monthly value used to determine imputed income is based on a table provided by the IRS, not by IQVIA or Lincoln. The total imputed income is reported each year on your W-2 and you pay taxes on this amount.

To calculate the value of your basic life insurance:

- Subtract $50,000 from your total insurance coverage.
- Divide by $1,000.
- Multiply by the appropriate age-related monthly IRS Uniform Premium Rates. (To determine your Premium Rate, the IRS uses your age at the end of the calendar year.)

For example, assume that you are a 45 year-old IQVIA employee with $85,000 in basic coverage. According to the IRS imputed income tax table, the monthly value of your coverage amount is $.15 per $1,000 of coverage. Using the calculation above, here's how your imputed income would be determined:

- $85,000 – $50,000 = $35,000
- $35,000 ÷ $1,000 = 35
- 35 × $.15 = $5.25

This means that you would pay taxes on an additional $5.25 per month. Assuming a 30% tax bracket, this means $1.58 would be withheld monthly from your paycheck for taxes.

Contact your tax advisor or personal financial planner if you have questions about imputed income.

In general, life insurance proceeds are not subject to federal income taxes. Some exceptions may apply. In addition, other taxes, such as estate taxes, may be applicable. You may want to consult with your tax advisor regarding the proper tax treatment of any payment you or your beneficiary receives.

WHEN BENEFIT PAYMENTS END

When benefit payment(s) end will depend on the amount your beneficiary is eligible to receive:

- **If the total claim is less than $10,000,** Lincoln will pay your beneficiary in a single lump sum. No further payments will be made from the plan.
- **If the total claim is $10,000 or more**, a beneficiary may elect to have the proceeds deposited into a Lincoln Security Account, which is an interest-bearing checking account. A beneficiary may withdraw the entire amount immediately or may make smaller withdrawals over time. If the Lincoln Security Account is not elected, benefits will be paid in a lump sum.

CONTINUING COVERAGE

When coverage under the Life Insurance Plan ends, whether due to termination of employment or your death, you may be able to continue your (or your eligible dependents') life insurance coverage through conversion or portability, as described in the following sections.

CONVERSION PRIVILEGE

If You Die

If you die during the 31 days before your insurance coverage is continued through the conversion or portability features, your beneficiary will receive a lump-sum payment of the amount you were entitled to convert or "port," even if you didn't complete the process.

When coverage ends under the plan, you can convert your coverage to an individual life policy without providing evidence of insurability. You must apply for individual life insurance under this life conversion privilege and pay the first premium within 31 days after the date your employment ends. Converted insurance may be any type of level-premium whole life plan offered by Lincoln.

Lincoln will mail conversion information and forms directly to your home within 30 days of your separation from IQVIA.

PORTABLE GROUP TERM LIFE INSURANCE

If all of your coverage ends, you may be eligible to continue all or a part of the amount that ends, less any amount converted to an individual policy as provided in the conversion privilege. The coverage must end because you are no longer in an eligible class or are no longer in active employment, other than by retirement. Portable group term life insurance is not available if coverage ends because this plan terminates.

If you are eligible for portable group term life insurance, you may also elect portable group term life insurance for your covered dependent spouse or child whose coverage under this plan also ends when your coverage ends.

You may be eligible if:

- You are under age 65.
- You are a citizen of the United States or Canada.
- You are not a full-time member of the armed forces of any country
- Coverage is not continued on a waiver of premium basis.

Portable group term life insurance will contain only term life insurance. It will be issued without evidence of insurability. The premium due will be based on Lincoln's current rate for such plans that apply to you and your covered dependent spouse's class of risk and age.

The amount of portable group term life insurance you may apply for is subject to the following limits:

- The amount of insurance that terminated under the plan, subject to a $500,000 maximum benefit limit.
- The minimum amount for a covered associate is $10,000.
- The minimum amount for a covered spouse is $5,000, and $2,500 for a covered dependent child.

This amount is subject to any reductions due to age that may be contained in the portable group term life insurance policy. The amount of portable group term life Insurance may be decreased at any time. However, once elected, the amount of portable group term life insurance may not be increased.

CONTINUATION OF COVERAGE DURING DISABILITY

If you become totally disabled while insured under this plan you may be eligible for continued life insurance coverage subject to premium payment. In continuing such coverage under this provision, IQVIA agrees to treat all employees equally. The life insurance benefit continued will be the amount in force on your life under this plan on the date you are no longer actively at work due to total disability, subject to any reductions provided by any part of the plan.

Dependent coverage will be continued during your period of total disability subject to premium payments. The amount of continued coverage for covered dependents will be the amount in force at the beginning of your total disability. The amount continued will not include any part of your life insurance that you converted to an individual policy unless you were totally disabled when you applied to convert; and you return the conversion policy to Lincoln without claim other than for a refund of the premiums you paid for it.

Your continued life insurance coverage under this provision will end on the earliest of the date when:

1. IQVIA determines you cease to be totally disabled;
2. you return to active employment;
3. the policy terminates;
4. premium payments stop;
5. you reach age 70;
6. the date you begin receiving a benefit from a retirement or pension plan; or
7. the date IQVIA classifies you as retired.

If continued life insurance coverage ends under this provision, you may convert your life insurance benefit as provided in the conversion privilege. Dependent coverage may be converted.

With respect to this provision, **"total disability"** or **"totally disabled"** means the complete inability, as a result of injury or sickness, to work at any job.

COVERAGE DURING A LEAVE OF ABSENCE

Your coverage will continue for up to six months while on an approved leave of absence, provided premium payments are continued.

ASSIGNMENT OF RIGHTS

The rights to your basic and optional life insurance coverage are owned by you, unless one of the following applies:

- You have previously assigned these rights to someone else (known as an "assignee").
- You assign your rights under the plan to an assignee.

Lincoln will recognize an assignee as the owner of your basic life insurance coverage rights only if:

- The assignment is in writing, signed by you, in a form acceptable to Lincoln.
- A signed or certified copy of the written assignment has been received and registered by Lincoln.

Lincoln will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan's provisions before receiving and registering an assignment. Contact Lincoln for details.

CLAIMING BENEFITS

Questions on Your Life Insurance Claim

Call Lincoln at 888-787-2129 if you have general questions about your claim and/or the status of your claim.

To claim benefits, please email benefit.services@iqvia.com for assistance in completing the process. A valid claim form must be submitted for your life insurance claim to be reviewed for approval. Written notice of a life insurance claim must be sent to Lincoln within 60 days of your (or your eligible dependent's) date of death.

Your Claim

Both you and IQVIA will receive notification of Lincoln's determination of your life insurance claim. In the event that your claim is not approved, you will be provided the reason(s) for the denial and the process for appealing your claim.

Fraudulent Claims

It is a crime to knowingly attempt to injure, defraud or deceive Lincoln with a life insurance claim, or to provide information that you know is false, incomplete or misleading. In such cases, Lincoln will deny your claim and you may be subject to prosecution and punishment under state and/or federal law. Lincoln intends to pursue all appropriate legal remedies in the event of insurance fraud.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Summary Plan Description

The IQVIA' Accidental Death and Dismemberment (AD&D) Insurance Plan provides financial protection to you and your beneficiaries in the case of accidental bodily injury. Your basic employee coverage is provided by IQVIA to help offer financial protection for your beneficiaries if you have a covered accident or die. Voluntary AD&D coverage for you, your spouse, and/or dependent children may be purchased by you at group rates.

The AD&D Plan is provided through an insurance policy (SA3-850-292043-01) issued by Lincoln National Life Insurance Company, a Lincoln company (referred to as "Lincoln" throughout this document).

This summary is intended to be a general description of the AD&D benefits provided by the policy issued by Lincoln. If there is a conflict between this plan description and the AD&D policy regarding services, exclusions, limitations or other provisions the AD&D policy will be govern. The benefits described in this summary are subject to the terms and conditions of the Lincoln Life and AD&D policy.

This section explains how the AD&D Plan works.

IN THIS SECTION.....SEE PAGE

AT A GLANCE

Feature	Basic Benefit	Voluntary Benefit
Coverage Levels	Two times your annual base salary, to a maximum of $1,000,000	■ **For you:** Purchase from one to five times base annual salary up to $2,000,000 ■ **For your spouse:** 50% of your coverage ■ **For your dependent children:** 15% of your coverage. ■ **For your spouse and child:** 40% of your coverage for spouse, 10% of your coverage per dependent child
Enrollment	Automatic following your date of hire.	You must actively enroll yourself and/or your eligible dependents.
Tax Treatment of Benefit	Benefit payments to your dependents are not subject to federal income tax.	Benefit payments to you or your dependents are not subject to federal income tax.
Cost of Coverage	Provided by and fully paid for by IQVIA.	You pay the cost of any voluntary coverage through pre-tax payroll deductions.

If you have any questions about your coverage, contact the IQVIA Benefits Marketplace at 888-264-9180.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

How much AD&D coverage is available under the plan?

There are two types of AD&D coverage under the plan—basic coverage and voluntary coverage.

IQVIA provides basic coverage to you at no cost. This amount is equal to two times your annual base salary, to a maximum of $1,000,000.

You pay for any voluntary coverage you elect with after-tax dollars deducted from your paycheck. The maximum voluntary coverage you can elect varies. If the voluntary coverage is for:

- **You,** purchase from one to five times base annual salary up to $2,000,000.
- **Your spouse,** 50% of your coverage.
- **Your dependent children,** 15% of your coverage per child.
- **For your spouse and child:** 40% of your coverage for spouse, 10% of your coverage per dependent child

How is my annual base salary determined and what happens if it changes at some point during the year?

Your annual base salary is your annual rate of pay (regular salary or wages), before taxes and before any deductions are made. Your annual base salary does not include commissions, incentive pay, bonuses, overtime pay, shift differential or any other fringe benefit or extra compensation.

If your annual base salary changes at any point during the year, your basic coverage amount will automatically increase or decrease as a result. This will be effective the same day as your salary change (if you are actively at work on that day) or the date you return to active work.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY

You are eligible for the AD&D Plan if you are a regular, active employee of IQVIA working 30 or more hours per week within the United States. Temporary and seasonal employees are excluded.

Eligible Dependents

If you enroll in voluntary coverage, you also may enroll your eligible dependents in voluntary coverage. Your eligible dependents include:

- Your legal spouse.
- Your dependent children until the end of the month in which they turn age 26.
- Your unmarried dependent children of any age who live with you, are unable to support themselves, and who became physically or mentally incapacitated prior to age 26 and remain physically or mentally incapacitated.

For the definitions of spouse and dependent children, see the *Participating in the Health Care Plans* section.

IQVIA Couples

If both you and your spouse work for IQVIA, special provisions apply to your eligibility and enrollment in the AD&D Plan. If you, your spouse and/or your dependent children are eligible for coverage, you may not select duplicate coverage for yourselves or your eligible dependents. In other words, you each may enroll as individuals, or one of you may enroll and elect dependent coverage for your spouse, but none of you may be covered as both an employee and a dependent, nor may you or your spouse cover the same eligible dependents under the AD&D Plan. Under no circumstances can an eligible dependent be covered by more than one employee under the plan.

COST OF COVERAGE

Your cost under the AD&D Plan depends on the type of coverage you select:

- **Basic AD&D**: IQVIA pays the cost.
- **Voluntary AD&D:** You pay the cost for yourself and/or your eligible dependents. You can purchase coverage at group rates on a pre-tax basis through payroll deductions. The amount of your cost depends on the type of voluntary coverage you elect (for you, your spouse and/or eligible dependent children) and the covered amount.

Any contributions you make for voluntary coverage start when your coverage begins or the first pay cycle following your enrollment, whichever is later. Your contributions are automatically deducted from your pay in equal installments.

HOW TO ENROLL

Actively At Work

You will be considered to be "actively at work" if you are performing the material duties of your job on a regularly scheduled workday. You will be considered actively at work on a scheduled non-working day if you were actively at work on your last scheduled working day.

Basic Coverage

You are automatically enrolled in basic coverage when you are both eligible and actively at work.

Voluntary Coverage

How you enroll in voluntary coverage depends on when you are enrolling, as described in the following sections.

Enrolling for Coverage

You can enroll in the AD&D Insurance Plan online at the IQVIA Benefits Marketplace website from any computer that has internet access.

Generally, your elections remain in effect for the entire plan year (January 1 through December 31).

When First Eligible

The enrollment email you receive after you are hired will contain the materials you need to enroll in voluntary coverage for yourself and your eligible dependents. You will have 30 days from your hire date to enroll.

If you don't enroll in voluntary AD&D insurance coverage within this 30-day period, you will be enrolled in basic coverage only. However, you will have additional enrollment opportunities during open enrollment or if your needs change, as described in the following sections.

During Open Enrollment

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

Mid-Year Enrollment Changes

After you enroll, your coverage under the AD&D Plan will remain in effect for the remainder of the calendar year. Generally, you can make changes only during the open enrollment period. However, because your needs may change when you experience certain life events (such as marriage, divorce, birth or adoption of a child, death of a dependent, etc.), you may be allowed to make mid-year enrollment changes in certain situations in accordance with Internal Revenue Code and as permitted by the plan administrator.

Changes to your coverage must be consistent with the qualified change in status. Depending on the status change, you may be able to enroll, change or drop optional life insurance coverage for yourself, your spouse or your eligible dependent child(ren).

Designating a Beneficiary

When you enroll in the AD&D Plan, you must name a beneficiary for your benefit in the event of your death. You may name any person (or persons) you wish to be the beneficiary who receives the benefit payment. Visit the IQVIA Benefits Marketplace website to review or change your beneficiary. You may change your beneficiary at any time.

If, at the time of your death, there is no named or surviving beneficiary, Lincoln will pay the benefits to the executor or administrator of your estate. Lincoln may, at its option, pay the benefits to a surviving relative in the following order: spouse, child, parent, sibling. Such payment will release Lincoln of all further liability to the extent of payment.

When you enroll your spouse and/or dependent children in voluntary coverage, you are automatically the beneficiary. If you and your eligible dependents die at the same time (or within 24 hours of your death), benefits under the AD&D Plan will be paid to your estate.

WHEN COVERAGE BEGINS

When your coverage begins for you or your covered dependents depends on when you became eligible to enroll or make a change under the AD&D Plan, as shown in the following table.

If You (or Your Dependents):	Your Coverage Begins:
Are a current participant in the AD&D Plan and make changes during open enrollment	The beginning of the following plan year (January 1).
Are a newly-hired or newly-eligible employee	The date of hire.
Have made a change to your election outside of your initial eligibility period or open enrollment, due to an qualified status change	The date you make the change.

If you are not actively at work because of injury or illness on the date your coverage would become effective, your coverage will begin on the date you return to work.

WHEN COVERAGE ENDS

Generally, AD&D coverage ends on the earliest of the following:

- The date you no longer are in an eligible group.
- The date your eligible group is no longer covered.
- The last day of the period for which you made any required contributions.
- The last day in which you are actively employed by IQVIA, unless your coverage is continued due to a covered layoff, leave of absence or due to an injury or sickness.
- The date you cease active employment due to a labor dispute, including any strike, work slowdown, or lockout.
- The date the plan is terminated.

BASIC AD&D

Your Annual Base Salary

This is your annual rate of pay (regular salary or wages), before taxes and before any deductions are made. Your annual base salary does not include commissions, incentive pay, bonuses, overtime pay, shift differential or any other fringe benefit or extra compensation.

Your basic AD&D coverage, provided to you by IQVIA, is equal to two times your annual base salary, rounded to the next highest $1,000 (if not already a multiple of $1,000). For example, if your annual base salary is $40,400, your basic AD&D coverage amount is $81,000. The minimum amount of basic coverage is $10,000; the maximum amount is $1,000,000.

IF YOUR PAY CHANGES

Your basic coverage automatically changes when your annual base salary changes. In other words, if your annual base salary increases or decreases, your benefit amount automatically increases or decreases on the same day, provided you are actively at work on that day.

If the change in your annual base salary becomes effective on a non-working day, your coverage amount will change on:

- That same day, provided you were actively at work on the last scheduled working day before that non-working day.
- The date you return to active work, if you were not actively at work on the date your annual base salary changed.

VOLUNTARY AD&D

IQVIA offers voluntary AD&D coverage for you and your eligible dependents at group rates. You can buy additional coverage for yourself as well as coverage for your spouse and/or your dependent children.

YOUR COVERAGE AMOUNTS

Employee-Only Coverage

Enroll Yourself to Enroll Your Dependents

Voluntary coverage for your eligible dependents is available only when you also elect voluntary coverage for yourself.

You may buy voluntary coverage in amounts from one to five times your base annual salary (rounded to the next higher $1,000) up to $2,000,000 The minimum coverage amount you may purchase is $10,000.

Spouse Coverage

You may buy voluntary coverage for your spouse equal to 50% of your coverage.

Dependent Child Coverage

You may buy voluntary coverage for your eligible dependent children equal to 15% of your coverage.

If you and your spouse are both IQVIA employees, only one of you may elect voluntary coverage for a single dependent child. In other words, a dependent child may be enrolled in optional coverage by you, or by your spouse, but not both.

Spouse and Dependent Coverage

You can elect voluntary coverage for both your spouse and children equal to 40% of your coverage for your spouse and 10% of your coverage per dependent child.

COVERAGE REDUCTION AT AGE 65

On December 31 of the year in which you reach one of the following ages, your basic and voluntary AD&D coverage amount will be reduced based on your age, as shown in the following table.

If you are age:	Basic AD&D coverage will be reduced to:
65 to 69	65% of the coverage amount at age 64
70 or older	50% of the coverage amount at age 70

WHAT THE PLAN DOES NOT COVER

The AD&D Plan doesn't cover losses caused by, contributed to by, or resulting from:

- Suicide, or attempted suicide, while sane or insane.
- Self-inflicted injury while sane or insane.
- Active participation in a riot.
- Committing or attempting to commit a felony or misdemeanor.
- Controlled substances (as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments) that are voluntarily taken, ingested or injected, unless as prescribed or administered by a physician.
- Boarding, leaving or being in or on any kind of aircraft. However, this exclusion will not apply if you are a fare paying passenger on a commercial aircraft or traveling as a passenger in any aircraft that is owned or leased by or on behalf IQVIA.
- Service on full-time active duty in the Armed Forces of any country or international authority.
- The presence of alcohol in the covered person's blood which raises a presumption that the covered person was under the influence of alcohol and contributed to the cause of the accident. The blood alcohol level is governed by the jurisdiction of the state in which the accident occurred.
- Bacterial infection. This exclusion does not apply to you when the bacterial infection is due directly to an accidental cut or wound.
- War (declared or undeclared) or any act of war.

No benefit will be payable for any loss suffered as a result of accidental injury during any period of incarceration.

HOW BENEFITS ARE PAID

To claim an AD&D benefit, you or your beneficiary must notify the IQVIA Benefits Marketplace at 888-264-9180 of the covered individual's injury or death. IQVIA will confirm the beneficiary designation and assist in the completion and submittal of paperwork to Lincoln.

Once submitted, Lincoln will review the claim and any supporting documentation. If additional information is needed, the beneficiary of record will be contacted directly.

Lincoln will pay benefits immediately once an AD&D claim is approved. You or your beneficiary will be notified of Lincoln's decision as soon as it is made.

AD&D benefits are paid based on your (or your dependent's) coverage amount, depending on the type of loss, as shown below:

If, due to a covered accident, you lose...	You receive this percentage of your AD&D coverage amount...
Your life	100%
Both hands, both feet or entire sight in both eyes	100%
Speech and hearing in both ears	100%
One hand and one foot	100%
One hand or foot and sight of one eye	100%
One hand or one foot	50%
Speech or hearing in both ears	50%
Quadriplegia, paraplegia, hemiplegia, diplegia	50%
Monoplegia	25%
Sight in one eye	50%
The thumb and index finger of one hand	25%

The most Lincoln will pay for any combination of covered losses from any one accident is 100% of your covered amount.

If you or your eligible dependent become paralyzed within 365 days of a covered accident, the AD&D Plan will pay benefits as follows:

- **Monoplegia:** 25 percent of the coverage amount. Monoplegia is the total and irreversible paralysis of one arm or one leg.
- **Hemiplegia:** 50 percent of the coverage amount. Hemiplegia is the total and irreversible paralysis of upper and lower limbs on one side of the body.
- **Paraplegia:** 50 percent of the coverage amount. Paraplegia is the total and irreversible paralysis of both lower limbs.

- **Quadriplegia:** 100 percent of the coverage amount. Quadriplegia is the total and irreversible paralysis of both upper and lower limbs.

To be eligible for AD&D benefits, you must be covered by the plan, the loss must result from accidental bodily injury and the loss must occur within 365 days of a covered accident. In the event of death, benefits are paid to a beneficiary; otherwise, benefits are paid to you or your eligible dependent.

Defining AD&D Terms

For purposes of the AD&D Plan, loss means:

- **For an eye**: An entire and permanent loss of sight that is irrecoverable by natural, surgical or artificial means.
- **For a hand or a foot**: The limb is severed at or above the wrist or ankle.
- **For speech or hearing**: An entire and permanent loss of either speech or hearing that is irrecoverable by natural, surgical or artificial means.
- **For thumb and index finger**: The finger and thumb on the same hand are severed at or above the joint closest to the wrist.

Paralysis and severance is defined as follows under the AD&D Plan:

- **Paralysis**: Total loss of use of a limb. A physician must determine the loss of use to be complete and irrecoverable.
- **Severance:** Complete and permanent separation and dismemberment of the part of the body.

ADDITIONAL AD&D BENEFIT COVERAGE

In addition to the plan's basic and voluntary coverage amounts, additional benefits may be payable if you or your covered dependents experience certain types of covered losses. These additional benefits will depend on the type of coverage you have selected for you and/or your covered dependents.

Additional Benefits

Education Benefit

If you die as a result of a covered accident, the AD&D Plan will pay an additional benefit for any qualified dependent children up to age 26 who are enrolled as full-time students at an accredited post-secondary institution of higher learning at the time of death.

The amount payable to each eligible child will be $2,500 per year. The maximum lifetime benefit per family is $20,000.

Education benefits for an eligible child will end on the earliest of the following:

- The date your eligible child fails to furnish proof of eligibility to Lincoln upon request.
- The date your eligible child turns age 26.
- Four years.
- The date your dependent child attains a bachelor's degree.

Exposure and Disappearance Benefit

If you have unavoidable exposure to the elements as the result of a covered accident, and as a result experience the loss of a limb, speech, hearing or sight, the AD&D Plan will pay benefits to you as specified in "How Benefits are Paid" on page 154.

Lincoln will presume you suffered a loss of life and pay your basic AD&D benefit to your eligible beneficiary if all of the following apply:

- You are riding in a common public passenger carrier that is involved in an accident covered under the plan.
- As a result of the accident, the common public passenger carrier is wrecked, sinks, is stranded or disappears.
- Your body is not found within one year of the accident.

Repatriation of Remains Benefit

If you suffer a covered accidental death while at least 200 miles from home, an additional benefit will be paid for covered expenses (to a maximum of $5,000) associated with the preparation and return your body to a mortuary of his or her choice.

Seat Belt and Air Bag Benefit

The seat belt and air bag provision of the AD&D Plan provides additional benefits if you:

- Die as a direct result of injuries sustained in a motor vehicle accident, whether as a passenger or driver of a private passenger car.
- Were properly wearing a seat belt or lap and shoulder harness at the time of the accident.

For the purposes of this benefit, a private passenger car is a validly registered four-wheel private passenger car (including a company-owned car), station wagon, jeep, pick-up truck or van that used only as a private passenger car.

The official police report of the covered accident must certify the proper use of the seat belt at the time of the accident, or the investigating officer(s) must certify, in writing, the proper use of the seat belt. This certification must be submitted with your or your beneficiary's claim to Lincoln.

No benefits under the plan will be paid if, as the driver of a motor vehicle, you did not hold a valid driver's license or if the official report reflects that you were not wearing the seat belt or the seat belt was worn incorrectly.

If you are eligible for the seat belt and air bag benefit, these amounts are payable only after basic and/or voluntary benefits have been paid from the plan. Contact Lincoln for details.

Seat Belt Benefit

The plan pays you a seat belt benefit equal to an additional 10 percent of your basic AD&D coverage amount up to $25,000, if all of the following apply:

- The private passenger car that you were riding in was equipped with seat belts.
- The seatbelts were in actual use and properly fastened at the time of the covered accident. (An automatic harness seatbelt is not considered fastened unless a lap belt is also used.)
- The position of the seatbelts is certified in the official report of the covered accident (or by the investigating officer).
- If the covered person holds a valid driver's license.

Air Bag Benefit

The plan pays you an air bag benefit equal to an additional five percent of your basic AD&D coverage amount up to $10,000 if the seat belt requirement was met, if the covered person was the driver with a valid driver's license, and the private passenger car was:

- Equipped with a single air bag (if you were driving alone).
- Equipped with an air bag for the driver and an air bag for the front passenger seat (if you were the driver or front seat passenger).
- Equipped with an air bag for the driver seat, an air bag for the front passenger seat and air bags for rear passenger seats (if you were the driver, front seat passenger or rear seat passenger).

Seat Belt Definition

Seat Belt means a combination lap and shoulder restraint system that must meet the Federal Vehicle Safety Standards of the National Highway Traffic Safety Administration and be installed by the manufacturer. A Seat Belt will include a lap belt alone, but only if the automobile did not have a combination lap and shoulder restraint system when manufactured. Seat Belt does not include a shoulder restraint alone.

TAX TREATMENT OF AD&D BENEFITS

In general, AD&D proceeds are not subject to federal income taxes. Some exceptions may apply. In addition, other taxes, such as estate taxes, may be applicable. You may want to consult with your tax advisor regarding the proper tax treatment of any payment you or your beneficiary receives.

WHEN BENEFIT PAYMENTS END

When benefit payment(s) end will depend on the amount your beneficiary is eligible to receive:

- **If the total claim is less than $10,000,** Lincoln will pay your beneficiary in a single lump sum. No further payments will be made from the plan.
- **If the total claim is $10,000 or more,** Lincoln will provide your beneficiary with a retained asset account containing the funds. A beneficiary may withdraw the entire amount immediately or may make smaller withdrawals over a period of time.

WHAT THE PLAN DOES NOT COVER

- War, declared or undeclared, or any act of war.
- Intentionally self-inflicted injuries, while sane or insane.
- Suicide, or suicide attempt, while sane or insane.
- Active Participation in a riot.
- Committing or attempting to commit a felony or misdemeanor.
- Disease, bodily or mental illness (or medical or surgical treatment thereof).
- Controlled substances (as defined in Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and all amendments) that are voluntarily taken, ingested or injected, unless as prescribed or administered by a physician.
- Serving full-time active duty in the Armed Forces of any country or international authority.
- Boarding, leaving or being in or on any kind of aircraft. However, this exclusion will not apply if the covered person is a fare paying passenger on a commercial aircraft or traveling as a passenger in any aircraft that is owned or leased by or on behalf of IQVIA.
- Hazardous sports, including but not limited to, motor sports (land or water), mountain climbing, skydiving, parachuting, bungee jumping, hang gliding and scuba diving.

ASSIGNMENT OF RIGHTS

The rights to your basic AD&D coverage are owned by you, unless one of the following applies:

- You have previously assigned these rights to someone else (known as an "assignee").
- You assign your rights under the plan to an assignee.

Lincoln will recognize an assignee as the owner of your basic AD&D coverage rights only if:

- The assignment is in writing, signed by you, in a form acceptable to Lincoln.
- A signed or certified copy of the written assignment has been received and registered by Lincoln.

Lincoln will not be responsible for the legal, tax or other effects of any assignment, or for any action taken under the plan's provisions before receiving and registering an assignment. Contact Lincoln for details.

CLAIMING BENEFITS

Questions on Your AD&D Claim

Call Lincoln at 888-713-2129 if you have general questions about your claim and/or the status of your claim.

To claim benefits, please contact IQVIA Benefits Marketplace at 888-264-9180 for assistance in completing the process. A valid claim form must be submitted for your AD&D claim to be reviewed for approval. Written notice of an AD&D claim must be sent to Lincoln within 60 days of your (or your eligible dependent's) covered accident or date of death.

Your Claim

Both you and IQVIA will receive notification of Lincoln's determination of your AD&D claim. In the event that your claim is not approved, you will be provided the reason(s) for the denial and the process for appealing your claim.

Fraudulent Claims

It is a crime to knowingly attempt to injure, defraud or deceive Lincoln with an AD&D claim, or to provide information that you know is false, incomplete or misleading. In such cases, Lincoln will deny your claim and you may be subject to prosecution and punishment under state and/or federal law. Lincoln intends to pursue all appropriate legal remedies in the event of insurance fraud.

BUSINESS TRAVEL ACCIDENT (BTA) INSURANCE PLAN

Summary Plan Description

The IQVIA Inc. Business Travel Accident (BTA) Insurance Plan provides financial protection to you and your dependents in the case of death or accidental bodily injury while you are traveling on company business. Your coverage is provided by IQVIA.

The BTA Plan is provided through an insurance policy issued by CHUBB.

This section explains how the BTA Plan works.

IN THIS SECTION.....SEE PAGE

AT A GLANCE

Feature	Benefit
Coverage Levels	Coverage amounts differ depending on the individual: ■ **Coverage for you:** Three times your annual salary (to a maximum of $1,000,000). ■ **Coverage for your spouse:** $100,000. ■ **Coverage for your dependent child(ren):** $25,000 per child.
Enrollment	Automatic following your date of hire.
Tax Treatment of Benefit	Benefit payments to you or your dependents are not subject to federal income tax.
Cost of Coverage	Provided by and fully paid for by IQVIA.

If you have any questions about your coverage, contact the Claims administrator, CHUBB at 800-336-0627.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

What is business travel accident coverage?

Business travel accident (BTA) coverage provides you with income protection if you or your covered dependents are involved in a covered accident while traveling on company business.

Are my dependents covered under the BTA Plan?

In general, your eligible dependents are not covered under the BTA Plan. However, if a covered dependent dies or has a covered accident while traveling with you while you are on company business (including a relocation trip), he or she is eligible for benefits.

ELIGIBILITY AND ENROLLMENT

ELIGIBILITY

You are eligible for the BTA Plan if you are a regular, active employee of IQVIA or Q^2 Solutions, working within the United States.

Eligible Dependents

Your eligible dependents are eligible for the plan if they die or are injured while they are traveling with you on company business or on a relocation trip. Your eligible dependents include:

- Your legal spouse.
- Your unmarried dependent children under age 19 (or age 19 to 25 who are full-time students).
- Your unmarried dependent children of any age who live with you, are unable to support themselves, and who became physically or mentally incapacitated prior to age 19 (or age 25 if a full-time student) and remain physically or mentally incapacitated.

For the definitions of spouse and dependent children, see the *Participating in the Health Care Plans* section.

COST OF COVERAGE

IQVIA pays the cost of BTA coverage.

HOW TO ENROLL

Actively At Work

You will be considered to be "actively at work" if you are performing the material duties of your job on a regularly scheduled workday. You will be considered actively at work on a scheduled non-working day if you were actively at work on your last scheduled working day.

You are automatically enrolled in BTA coverage when you are both eligible and actively at work.

Your eligible dependents are automatically enrolled in BTA coverage on the day your coverage becomes effective. However, no BTA benefits will be paid to any eligible dependent who is not traveling with you while you are on company business at the time of his or her death or accidental bodily injury.

Beneficiary

In the event of your death, any benefits will be made in a single lump sum as follows:

- To your spouse, if living at the time of your death.
- If not living, to your surviving children (in equal shares).
- If none survives, to your surviving parents (in equal shares).
- If neither survives, to your surviving brothers and sisters (in equal shares).
- If none survives, to your estate.
- You are automatically the beneficiary for any BTA benefits payable as a result of death or accidental bodily injury to an eligible dependent. If you and your eligible dependents die at the same time (or within 24 hours of your death), benefits under the BTA Plan will be paid to your estate.

WHEN COVERAGE BEGINS

Your coverage, and coverage for your eligible dependents begins on the day you become eligible. If you are not actively at work because of injury or illness on the date your coverage would become effective, your coverage will begin on the date you return to work.

WHEN COVERAGE ENDS

Generally, BTA coverage ends on the earliest of the following:

- The date you and your covered dependents no longer are in an eligible group.
- The date your eligible group is no longer covered.
- The last day of the policy month in which you are actively employed by IQVIA or Q^2 Solutions, unless your coverage is continued due to a covered layoff, leave of absence or due to an injury or sickness.
- The date the plan is terminated.

WHAT THE PLAN PROVIDES

BTA coverage is provided to you 24 hours a day for accidents sustained anywhere in the world during business travel for the company (including short term assignments up to 180 days). Coverage begins when you (and your covered dependents) leave your home or place of permanent employment, whichever occurs last and continues until you return to your home or place of permanent employment, whichever is first (unless you make a detour for personal reasons). Travel to and from work, vacations, and leaves of absence are not covered.

BTA coverage amounts differ by covered individual:

- **Coverage for you:** Three times your annual base salary (to a maximum of $1,000,000).
- **Coverage for your spouse:** $100,000.
- **Coverage for our dependent child(ren):** $25,000 per child.

In total, the plan has an aggregate limit of $16,000,000 per aircraft accident. In other words, if multiple covered individuals die as the result of an aircraft accident, an on-premises bomb scare, terrorist attack, or act of war, the total coverage payable from the plan will be capped at $16,000,000. If this limit is met as the result of an aircraft accident, on-premises bomb scare, a terrorist attack or act of war, amounts payable to eligible beneficiaries may be reduced and divided proportionally.

WHAT THE PLAN DOES NOT COVER

The BTA Plan doesn't cover losses caused by, contributed to by, or resulting from:

- Suicide, attempt at suicide, intentionally self-inflicted injury, or attempt at intentionally self-inflicted injury.
- A covered accident that occurs while on active duty service in the military, naval or air force of any country or international organization. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
- Acts of declared or undeclared war, except as provided under the bomb scare, explosion, terrorism and war risk benefit described in "Additional BTA Benefit Coverage" beginning on page 163.

- Sickness, disease, bodily or mental infirmity, bacterial or viral infection, or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food. Further exceptions as provided under the out of country emergency accident and sickness benefit described in "Additional BTA Benefit Coverage" beginning on page 163.

HOW BENEFITS ARE PAID

To claim a BTA benefit, you or your beneficiary must notify Employee Benefit Services of your injury or death. IQVIA or Q^2 Solutions will confirm the beneficiary designation and assist in the completion and submittal of paperwork to CHUBB.

Once submitted, CHUBB will review the claim and any supporting documentation. If additional information is needed, the beneficiary of record will be contacted directly.

CHUBB will pay benefits immediately once a BTA claim is approved. You or your beneficiary will be notified of CHUBB's decision as soon as it is made.

How BTA coverage is paid depends on the type of loss, as shown in the following chart. For benefits to be paid, the loss must occur within one year of the covered accident.

If, due to a covered accident, you lose…	You receive this percentage of your BTA coverage amount…
Your life	100%
One member*	50%
Two or more members	100%
The thumb and index finger of one hand	25%

* Member means loss of hand or foot, loss of sight, loss of speech, loss of hearing.

If you or an eligible dependent suffer more than one loss in any one accident, only the largest eligible percentage for any one injury will be paid.

If you or your eligible dependent becomes paralyzed within 365 days of a covered accident, the BTA Plan will pay benefits as follows:

- **Hemiplegia:** 50 percent of the coverage amount. Hemiplegia is the total and irreversible paralysis of upper and lower limbs on one side of the body.
- **Paraplegia:** 75 percent of the coverage amount. Paraplegia is the total and irreversible paralysis of both lower limbs.
- **Quadriplegia:** 100 percent of the coverage amount. Quadriplegia is the total and irreversible paralysis of both upper and lower limbs.

To be eligible for BTA benefits, the loss must occur within 365 days of the date of the covered accident. In the event of death, benefits are paid to a beneficiary; otherwise, benefits are paid to you or your eligible dependent.

Defining BTA Terms

For purposes of the BTA Plan, loss means:

- **For an eye**: An entire and permanent loss of sight in one eye that is irrecoverable by natural, surgical or artificial means.
- **For a hand or a foot**: The limb is actually severed at or above the wrist or ankle, respectively.
- **For speech or hearing**: An entire and permanent loss of either speech or hearing that is irrecoverable by natural, surgical or artificial means.
- **For thumb and index finger**: The finger and thumb on the same hand are actually severed at or above the metacarpophalangeal joints.

Paralysis and severance is defined as follows under the BTA Plan:

- **Paralysis**: Total loss of use of a limb. A physician must determine the loss of use to be complete and irrecoverable.
- **Severance:** Complete and permanent separation and dismemberment of the part of the body.

ADDITIONAL BTA BENEFIT COVERAGE

In addition to the plan's coverage amounts, additional benefits may be payable if you experience certain types of covered losses, as described in the following sections.

Bereavement and Trauma Counseling Benefit

The plan will pay for medically necessary bereavement and/or trauma counseling to help you and/or your covered dependents recover from a death or accidental injury. The plan pays for counseling expenses incurred within one year of the date of the accident, to a maximum of $150 per session for 10 sessions. This limit applies to all counseling sessions for you and/or your immediate family members resulting from the same accident.

On Premises Bomb Scare, Explosion, Terrorism and War Risk Benefit

The plan pays benefits if you suffer a covered injury or loss of life due to a bomb scare, explosion or act of terrorism while working for IQVIA or Q^2 Solutions while on premises at your regular place of employment. In addition, plan coverage includes loss of life or injury due to act(s) of declared or undeclared war while traveling on business outside of your home country or your country of permanent assignment.

Coma Benefit

The plan will pay a monthly coma benefit based on your BTA coverage amount, provided you sustain an injury that results in a coma within 31 days of a covered accident and the coma lasts at least 31 consecutive days. (No benefits will be paid during this 30-day period.)

The monthly coma benefit is equal to one percent of your BTA coverage amount, less any amount paid (or payable) under the plan as a result of the same accident. This amount will be paid for each month that the covered individual is in a coma until the comatose condition has ended, up to a maximum of 11 months. Thereafter, a lump sum of 100% of the remaining principal sum will be paid.

For the purposes of this benefit, "coma" and "comatose" mean a profound stupor or state of complete and total unconsciousness, as the result of a covered Accident.

Emergency Medical Evacuation

If you or a covered dependent requires an emergency medical evacuation while traveling on company business, at least 100 miles from place of permanent residence, the full cost of the evacuation will be covered by the plan. This is provided that United Healthcare Global (UHCG), in consultation with your attending physician, determines that it's medically necessary to evacuate you to the nearest treatment facility where appropriate treatment may be administered.

Contact UHCG at 713-430-7409 for more information about how to access services.

Exposure and Disappearance Benefit

If you have unavoidable exposure to the elements as the result of a covered accident, and as a result experience the loss of a limb, speech, hearing, or sight, the BTA Plan will pay benefits to you as specified in "How Benefits are Paid" on page 162.

CHUBB will presume you suffered a loss of life and pay your BTA benefit to your eligible beneficiary if all of the following apply:

- You are in a vehicle that disappears, sinks, or is stranded or wrecked on a trip covered by this policy; and
- Your body is not found within one year of the covered accident.

Alternative Commuting Benefit

The plan provides benefits if you suffer a covered loss while utilizing an automobile or other means of transportation due to a strike or breakdown of one or more public transportation systems that you typically use. (Ordinary, everyday commuting to and from your regular work place is not covered under the plan.)

Home Alterations and Vehicle Modification Benefit

If you or your eligible dependent has a disability (complete and irrecoverable loss of sight of both eyes, speech, hearing in both ears, or any two limbs hands or feet) resulting from a covered accident and within one year of the covered accident that requires a special housing adaptation or special vehicle to accommodate the disability, this will be covered up to $75,000.

Out of Country Emergency Accident and Sickness Benefit

If you or a covered dependent has an accidental injury or become ill while traveling outside of your country of residence, the plan will provide the following benefits:

- **Hospital admission expenses:** Up to $10,000.
- **Total medical expenses:** Up to $100,000.

This benefit is in addition to any other type of medical benefits payable through your IQVIA or Q^2 Solutions coverage.

Rehabilitation Benefit

If you or your covered dependent requires medically necessary rehabilitative services following a covered accidental injury, the plan will pay covered expenses to a maximum of $100,000.

This benefit is in addition to any other type of medical benefits payable through your IQVIA or Q^2 Solutions' coverage.

Repatriation of Remains Benefit

If you and/or a covered dependent die while at least 100 miles from home, an additional benefit will be paid for covered expenses associated with the preparation and return of the body to a mortuary of your (or your survivor's) choice.

Seat Belt and Air Bag Benefit

The seat belt and air bag provision of the BTA Plan provides additional benefits if you:

- Die as a direct result of injuries sustained in a motor vehicle accident, whether as a passenger or driver of a private passenger car.
- Were properly wearing a properly functioning, factory-installed seat belt or lap and shoulder harness at the time of the accident.

For the purposes of this benefit, an automobile means a self-propelled, private passenger motor vehicle with four or more wheels that is a type both designated and required to be licensed for use on the highway of any state or country. Automobile includes, but is not limited to, a sedan, station wagon, sport utility vehicle, or a motor vehicle of the pickup, van, camper, or motor home type. Automobile does not include a mobile home or any motor vehicle that is used in mass or public transport.

The official police report of the covered accident must certify the proper use of the seat belt at the time of the accident, or the investigating officer(s) must certify, in writing, the proper use of the seat belt. This certification must be submitted with your or your beneficiary's claim to CHUBB.

If an official report is not available or it is unclear, a default payment of $2,500 will be paid.

If you or a covered dependent are eligible for the seat belt and air bag benefit, these amounts are payable only after BTA coverage amounts have been paid from the plan.

Seat Belt Benefit

The plan pays you a seat belt benefit equal to an additional 10 percent of your BTA coverage amount (to a maximum increase of $75,000) if all of the following apply:

- The private passenger car that you were riding in was equipped with seat belts.
- The seatbelts were in actual use and properly fastened at the time of the covered accident. (An automatic harness seatbelt is not considered fastened unless a lap belt is also used.)
- The position of the seatbelts is certified in the official report of the covered accident (or by the investigating officer).

Air Bag Benefit

The plan pays you an air bag benefit equal to an additional 10 percent of your BTA coverage amount (to a maximum increase of $25,000) if the seat belt requirement was met and the private passenger car was:

- Equipped with a single air bag (if you were driving alone).
- Equipped with an air bag for the driver and an air bag for the front passenger seat (if you were the driver or front seat passenger).
- Equipped with an air bag for the driver seat, an air bag for the front passenger seat and air bags for rear passenger seats (if you were the driver, front seat passenger or rear seat passenger).

Travel Assistance Services

In addition to accident coverage while you are traveling on company business, the BTA Plan also offers an array of travel-related services. Through the United Health Care Global program, you can get travel assistance services 24 hours a day when you are traveling on company business more than 100 miles or more from your home or work location.

The United Health Care Global program can provide assistance with a wide range of problems or emergencies that may occur while traveling on company business. Covered services include:

- Pre-departure services (required documentation and immunizations, weather and travel hazards, etc.).

- Personal security assistance.
- Emergency medical assistance.
- Emergency travel services.
- Emergency legal assistance.
- Lost baggage/passport advice.

Contact UHCG at 713-430-7409 for more information about the program and how to access services. You can access UHCG online services at https://members.uhcglobal.com. To set up/use a username and password:

1. Select "Create User."
2. Under "Policy Number," enter IQVIA ID number 335841.
3. Create a unique username and password and accept the User Agreement.
4. Click "Register Now," complete final information and click "Finish."
5. Be sure to retain your username and password for future Global Intelligence Center access when not on the IQVIA network.

TAX TREATMENT OF BTA BENEFITS

In general, BTA proceeds are not subject to federal income taxes. Some exceptions may apply. In addition, other taxes, such as estate taxes, may be applicable. You may want to consult with your tax advisor regarding the proper tax treatment of any payment you or your beneficiary receives.

WHEN BENEFIT PAYMENTS END

CHUBB will provide you or your beneficiary with a retained asset account containing the funds. You or your beneficiary may withdraw the entire amount immediately or may make smaller withdrawals over a period of time.

CLAIMING BENEFITS

Questions on Your BTA Claim

Call 800-336-0627 if you have general questions about your claim and/or the status of your claim.

To claim benefits, please contact Claims administrator, CHUBB at 800-336-0627 for assistance in completing the process. A valid claim form must be submitted for your BTA claim to be reviewed for approval. Written notice of a BTA claim must be sent to CHUBB within 60 days of your covered accident or date of death.

Your Claim

Both you and IQVIA will receive notification of CHUBB's determination of your BTA claim. In the event that your claim is not approved, you will be provided the reason(s) for the denial and the process for appealing your claim.

Fraudulent Claims

It is a crime to knowingly attempt to injure, defraud or deceive CHUBB with a BTA claim, or to provide information that you know is false, incomplete or misleading. In such cases, CHUBB will deny your claim and you may be subject to prosecution and punishment under state and/or federal law. CHUBB intends to pursue all appropriate legal remedies in the event of insurance fraud.

401(k) PLAN

Summary Plan Description

The IQVIA 401(k) Plan is designed to help you save for your retirement. The 401(k) Plan makes it easy for you to save for your future through pre-tax and/or post-tax contributions from your pay. The Plan is sponsored by IQVIA Inc. for eligible employees who work for a Participating Employer.

BACKGROUND ON THE 401(K) PLAN

The IQVIA 401(k) Plan was created effective January 1, 2018 by the merger of the IMS Health Incorporated Savings Plan (the "IMS 401(k)") with and into the Quintiles 401(k) Plan (the "Quintiles 401(k)") following the merger of the two companies. The merged 401(k) Plan was renamed the IQVIA 401(k) Plan with all legacy IMS and Quintiles employees now participating in the single 401(k) plan. As part of the plan merger, all IMS 401(k) Plan accounts were automatically transferred to the IQVIA 401(k) Plan effective January 1, 2018.

In connection with the merger of the IMS and Quintiles 401(k) Plans, certain aspects of both plans were amended under the new IQVIA 401(k) Plan. This summary describes those changes and the overall operation of the IQVIA 401(k) Plan.

In addition, assets from the Q Squared 401(k) Plan were merged in to the IQVIA 401(k) Plan as of May 6, 2022.

For More Information

For information about your legal rights under ERISA and other important administrative details, see the *Administrative Information* section. The Administrative Information section on the 401(k) Plan along with the 401(k) Plan information included here form an ERISA Summary Plan Description (SPD) for the 401(k) Plan. To contact the Plan Administrator, use the information listed in the *Contacts* section. To see the summary annual report for the 401(k) Plan, it can be found in the employee handbook on the IQ intranet site.

IN THIS SECTION SEE PAGE

AT A GLANCE

Plan Feature	Highlights
Who's eligible	You are generally eligible to participate on the first day of the month following your hire date after you meet the following eligibility requirements: ■ You work for a Participating Employer (see "Participating Employers" on page 172). ■ You are at least age 18.
When participation begins	For employees first hired on or after January 1, 2018, you will be automatically enrolled in the Plan at a three percent (3%) deferral percentage within sixty (60) days of satisfying the Plan's eligibility requirements unless you affirmatively decline or opt out of the automatic enrollment. *Note: legacy Quintiles and IMS employees subject to the automatic deferrals under one of the respective 401(k) Plans prior to 2018 will continue participating subject to the automatic deferral rules and deferral percentages in place at the time of the merger unless an affirmative election is made to change.*
Contributions	As a participant, you can make five types of contributions: ■ Pre-tax contributions from your pay of up to 50% (including automatic deferrals). ■ Roth 401(k) post-tax contributions from your pay of up to 50% of pay. ■ Rollover contributions from a previous employer's plan. ■ Catch-up contributions. If you will be age 50 or older at any time during a plan year and are making the maximum contributions allowed under the Plan for that plan year, you may make additional pre-tax and/or post-tax "catch-up" contributions throughout the year. (Note: The maximum percentage of pay that can be deferred increases to 90% for Participants eligible to make catch-up contributions.) ■ After-tax contributions. Participants can make additional after-tax contributions up to maximum annual IRS contribution limit calculated by counting both pre-tax and Roth 401(k) contributions and company matching contributions for the year. *(Note: the ability to make after-tax contributions is a new addition for legacy Quintiles 401(k) participants.)* The total contribution percentage cannot exceed 50% in aggregate for Pre-tax, Roth or After-tax. The company can make two types of discretionary contributions: ■ Matching contributions. ■ Profit sharing contributions. Participants who are automatically enrolled in the Plan (as of January 1, 2018) will have their deferral percentage election automatically set at three percent (3%) but may change future deferral percentages at any time after being enrolled, including reducing their deferral percentage to zero. Automatic deferrals will be invested in the Vanguard Target Retirement Trust Plus Fund nearest to the date you will attain age 65 unless you make an alternative investment fund election. You may change your investment fund elections at any time. *(Note: Legacy Quintiles 401(k) participants automatically enrolled at the six percent (6%) rate in effect under the Quintiles 401(k) will continue to defer at that rate after 2017 unless they make an affirmative change.)*
Vesting	You are always 100% vested in your 401(k) elective contributions (including both regular pre-tax deferrals and Roth post-tax contributions), automatic deferrals, rollover contributions, and any after-tax contributions. You are generally 100% vested in company matching contributions after two years of service and company profit sharing contributions after six years of service. You are partially vested with fewer years of service. See "Vesting in Company Contributions" on page 176 for more information.
Your accounts	Your accounts are held in your name by the trustee (Fidelity), including your contributions, company matching contributions, profit sharing contributions and any rollover contributions.
Your retirement dates	You are eligible for normal retirement at age 65 and for early retirement at age 55 with five years of service.

Plan Feature	Highlights
Forms of payment	Your 401(k) accounts will generally be paid as a lump sum distribution following termination or retirement. The Plan permits certain post-termination distributions to be made in installments rather than a lump sum and provides for in-service distributions upon attaining age 59-1/2. *(The installment and in-service distribution options are new for legacy Quintiles 401(k) participants.)* *Note: certain exceptions and grandfathering provisions may apply to Participants entitled to installment or other distributions under 401(k) plans of Participating Employers acquired by the legacy IMS and Quintiles groups. In addition, legacy Quintiles 401(k) participants with QINC and Innovex Transfer Accounts may be subject to special Qualified Joint and Survivor Annuity ("QJSA") distribution options. If you have questions regarding particular distribution options in connection with your participation in prior plans, you may contact the Plan Administrator for additional information.*
When payment is made	You can generally elect to receive your account balances: ■ Upon attaining age 59-1/2 even if still employed through an in-service distribution. ■ If you terminate employment with the company. ■ If you die, become disabled, or have a qualifying hardship. *(Note: other distribution options may be available for Qualified Reservist Distributions as well as for certain nonelective employer contributions, if applicable. In addition, other distribution options may apply to certain legacy accounts under plans of predecessor employers, including the Innovex Transfer Account, the Scott-Levin Transfer Account, the QINC Transfer Account, and certain accounts under the Cegedim 401(K) Plan and the Synavant 401(k) Plan. Please contact the Plan Administrator if the above are applicable and you have further questions about available distributions.)*
If you leave before you retire	You can elect to receive your account balance; however, if you are younger than age 59-1/2 and you are not disabled, you will generally have to pay a 10% early withdrawal penalty in addition to applicable income taxes unless you roll over the amount to an Individual Retirement Account (IRA) or another eligible retirement plan.
If you die before you retire	Your spouse or designated beneficiary (requires spousal consent) will be entitled to a benefit equal to the value of your account balances.
Loans	You may take a loan out against your vested account balances, up to the lesser of: (1) $50,000, reduced by your largest outstanding loan balance during the twelve month period prior to the date of the loan; or (2) 50% of your vested account balance. The minimum loan amount is $1,000 and you may have only two loans outstanding at a time. *(Note: Legacy IMS 401(k) Plan participants who had three plan loans outstanding at the time of the merger may continue to maintain three plan loans but are required to pay off at least two of the loans before they are eligible for another loan and will thereafter be limited to a maximum of two loans.)*
Hardship Withdrawals	In certain cases, you can withdraw money from the Plan. If you meet the requirements of a qualified financial hardship you may withdraw amounts up to the amount needed for that hardship (with taxes and penalties) based on the Internal Revenue Code Safe Harbor guidelines.

Questions?

If you have questions about the 401(k) Plan after reviewing the information here, log on to Fidelity NetBenefits® at www.401k.com or call the Fidelity Retirement Benefits Line at 800-835-5097 to speak with a representative or use the automated voice response system, virtually 24 hours, 7 days a week.

ANSWERS TO FREQUENTLY ASKED QUESTIONS

What if I need my money before retirement?

You can apply for a loan or a hardship withdrawal from the plan. See "Loans for Active Employees" on page 180, "In-Service Distributions" on page 180 and "Hardship Withdrawals" on page 181. If you have questions, please call Fidelity Customer Services at 800-835-5097 or log on to www.401k.com.

How often may I change my contribution percentage and where do I change it?

You may change your contribution percentage as often as you like by calling Fidelity at 800-835-5097 or online at www.401k.com. Your new contribution percentage is submitted to payroll semi-monthly and will go into effect on the next available pay date, following the payroll deadline schedule.

HOW THE PLAN WORKS

The 401(k) Plan makes it easy to save for your retirement. The Plan offers you several savings advantages, including:

- **Convenient payroll deductions:** You may contribute from 1% to 50% (90% if making catch-up contributions) of your salary each year, up to applicable IRS limits. Regular elective deferrals under the 401(k) Plan are made on a pre-tax basis as are any automatic deferrals, if applicable. You may also elect to make Roth post-tax contributions and after-tax elections. Your combined regular pre-tax and Roth post-tax contributions cannot exceed the maximum annual deferral amount ($20,500 for 2022, or $27,000 if you are eligible to make catch-up contributions). In addition, any after-tax contributions cannot exceed the annual IRS defined contribution limit ($61,000 for 2022) when combined with your regular pre-tax and Roth post-tax contributions and company matching contributions for the year.
- **Tax deferrals:** You do not pay taxes on regular, pre-tax contributions or any earnings on your account until distribution. Although Roth contributions are made on a post-tax basis, if you meet the requirements for a qualified Roth distribution (which includes leaving your Roth contributions in the 401(k) Plan for at least five years) you will not be taxed on earnings on your Roth contributions. Like Roth post-tax contributions, after-tax contributions go into the Plan on an after-tax basis with earnings accumulating tax-free; however, unlike Roth accounts, the earnings on after-tax contributions are subject to applicable income taxes when withdrawn.
- **Investment choices:** The Plan offers you a broad selection of investment funds for your savings and an opportunity to change your investments on a daily basis.
- **Access to your money:** You may borrow or withdraw money from your 401(k) account before retirement (subject to certain requirements).
- **Vesting:** You are always 100% vested in your contributions. You vest in company contributions based on your years of service.
- **Distribution of your account:** If you leave the company or retire, the full value of your vested account is available to you.

ELIGIBILITY

Eligibility for the 401(k) Plan is different from eligibility for other benefits described in this Summary Plan Description (SPD). You become eligible to participate in the 401(k) Plan generally on the first of the month following your hire date, provided you are at least 18 years of age and your Employer is a Participating Employer in the 401(k) Plan. If you are employed by a Participating Employer but are younger than age 18, you will be eligible on the first day of the month immediately following your 18th birthday.

The Plan is generally open to all eligible employees of IQVIA and its subsidiaries that are "Participating Employers" in the 401(k) Plan (including legacy IMS and Quintiles groups and participating employers) except field-based monitors working on specific Upjohn projects, Quintiles GmbH employees, non-resident aliens receiving no US source income and individuals subject to tax in Puerto Rico. Any employee who was a participant in either the Quintiles 401(k) or the IMS 401(k) on December 31, 2017 automatically continued as a participant in the merged Plan effective January 1, 2018.

Eligibility for Profit Sharing Contributions

Note that participation in the Profit Sharing Portion of the Plan alone will not entitle you to receive a profit sharing contribution. You must satisfy the additional requirements listed under "Enrolling in the Plan" on page 172 to receive a profit-sharing contribution for a particular plan year.

Participating Employers

- Allcare Plus Pharmacy LLC
- BuzzeoPDMA LLC
- Cambridge Pharma Consultancy Inc.
- Clinical Financial Services, LLC
- Clinical Solutions Group, LLC
- DrugDev Inc.
- Epernicus, LLC
- IQVIA CSMS US Inc.
- IQVIA Government Solutions Inc.
- IQVIA Phase One Services LLC
- IQVIA RDS Inc.
- IQVIA Transportation Services Corp.
- Market Dynamics, LLC
- Med-Vantage, Inc.
- Nexelis Group Inc.
- Novasyte, LLC
- PharmaSource Inc.
- Q Squared Solutions LLC
- Secureconsent, LLC

EFFECTIVE DATE AND PLAN YEAR

The current IQVIA 401(k) Plan created by the merger of the Quintiles 401(k) and IMS 401(k) Plans became effective January 1, 2018. (The Quintiles 401(k) Plan was originally established May 1, 1991 and last amended and restated effective January 1, 2018. The IMS 401(k) Plan was originally adopted effective July 1, 1998 and last amended and restated effective January 1, 2017.) The "plan year" is the same as the Employer's taxable year, which is the 12-month period ending on December 31. The "Accounting Date" shall be each March 31, June 30, September 30 or December 31, as applicable. The "Allocation Date" in each year shall be the last day of the plan year (i.e., December 31).

ENROLLING IN THE PLAN

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.

Automatic Enrollment for New Hires:
Employees first hired on or after January 1, 2018, will be automatically enrolled in the Plan within sixty (60) days of satisfying the Plan's general eligibility requirements unless you affirmatively decline or "opt out" of the automatic enrollment during the 60-day period.

Participants who are automatically enrolled in the Plan will have their deferral percentage election automatically set at three percent (3%) but may change their future deferral percentages at any time after being enrolled, including electing to reduce their future deferral percentage to zero. (Automatic deferral percentages will appear as future dated deferrals and such that participants may review them in the NetBenefits® system if they wish to have the deferrals start sooner, change the deferral percentage, or stop the deferrals.)

The Plan will not automatically increase the annual deferral percentages; however, you can elect to have your deferral percentage automatically increased by a percentage amount each year if you wish by enrolling in Fidelity's Annual Increase Program.

Automatic deferrals will be invested in the Vanguard Target Retirement Trust Plus Fund nearest to the date you will attain age 65 unless you make an alternative investment fund election.

As a participant, you may change your investment options or your contribution percentage at any time by contacting Fidelity. Deferral contributions may range from 1% to 50% (90% if making catch-up contributions) of your eligible pay up to the applicable IRS limits.

Enrolling in the Plan or changing your default automatic enrollment is simple: Call Fidelity Customer Services at 800-835-5097 or log on online at www.401k.com.

You will need to decide the percentage of contributions you want deducted from your paycheck, whether you want to make those contributions on a pre-tax or post-tax basis, and how you would like your money invested. If you do not choose how you would like your money invested for any reason, Fidelity the Trustee will invest your undirected Account balance in the most appropriate Fidelity Freedom Fund offered as an investment option under the Plan based on your projected retirement date at age 65.

Automatic Deferrals for Legacy IMS and Quintiles Participants: *Participants in either the legacy Quintiles 401(k) or IMS 401(k) Plans as of the Plans' merger effective January 1, 2018 will continue to participate subject to the automatic enrollment rules applicable prior to the Plan merger such that legacy IMS Participants hired after March 1, 2011 will remain subject to automatic enrollment at a three percent (3%) deferral election while legacy Quintiles Participants hired after January 1, 2015 will remain subject to automatic enrollment at a six percent (6%) deferral election unless changed. For other legacy Participants hired prior to the respective automatic enrollment effective dates, participation in the Plan is voluntary, and you may enroll at any time after becoming eligible. (Note: Participation in discretionary profit sharing contributions from the company is automatic for eligible Participants unless you opt out.)*

YOUR BENEFICIARY

You need to name a beneficiary, or beneficiaries, to receive your Plan account balances if you die. If you are married, your spouse is automatically the beneficiary of your 401(k) Plan account unless the beneficiary designation form is completed and notarized with the spouse's written consent agreeing to another beneficiary.

Any time you change your beneficiary form in which your spouse is not the primary beneficiary, it must be notarized with your spouse's signature. Contact Fidelity for beneficiary and consent forms. You may designate beneficiaries online at www.401k.com or by calling Fidelity at 800-835-5097.

YOUR CONTRIBUTIONS

There are five ways you can contribute to the Plan:

- Pre-tax contributions from your pay through regular elective deferrals or automatic deferrals.
- Post-tax contributions from your pay through Roth elective deferrals.
- After-tax contributions from your pay through elective deferrals other than Roth deferrals.
- Rollover contributions from a previous plan.
- Catch-up contributions for participants age 50 or older, if you are already contributing the maximum elective deferral of 50% or will exceed the annual allowable limit.

Definition of Compensation for Elective Deferrals

For elective deferrals, your Compensation as defined by the 401(k) Plan includes your regular wages, bonuses, and overtime. It does not include:

- Amounts realized from the exercise of a non-qualified stock option or when restricted stock (or property) held by an employee either becomes freely transferable or is no longer subject to substantial risk of forfeiture.
- Amounts realized from the sale, exchange or other disposition of stock acquired under a qualified stock option (including the Company's Employee Stock Purchase Plan (the "ESPP")).
- Non-regular wage amounts attributable to post-severance compensation and amounts attributable to certain fringe benefits under the applicable tax rules.

Federal tax laws limit the total amount of compensation that may be taken into account under the plan for certain purposes each plan year. For 2022, the maximum amount of compensation that may be counted for plan purposes (e.g., for calculating matching contributions) is $305,000. This limit may change in future years.

Contribution Limits

Each calendar year the IRS sets a maximum employee contribution amount. For 2022, the maximum amount is $20,500, which includes both regular pre-tax contributions and/or combined Roth post-tax contributions. If you reach the annual contribution limit, your 401(k) Plan contributions will be discontinued until the following January. IRS regulations also require that the plan cannot discriminate in favor of highly-paid employees and may require that highly-paid employees' contributions be limited to amounts below the maximum annual IRS limit and refunded in certain cases. If you are a highly-paid employee, you will be notified in the unlikely event that this situation occurs.

Catch-up Contributions

If you are age 50, or if you will turn age 50 during a plan year, then throughout the year you may make additional deferral contributions to your 401(k) account in the form of catch-up contributions. This is provided you are already contributing 50% to the Plan or will exceed the maximum annual contribution limit (e.g., $20,500 for 2022).

You may contribute up to an additional $6,500 of your eligible pay during 2022 as pre-tax or Roth catch-up. The amount is indexed annually for inflation. Matching contributions will not be made on catch-up contributions.

To make a catch-up contribution, call Fidelity Customer Services at 800-835-5097 or log on to www.401k.com.

Changing Your Contributions

You may change, stop or resume your elective deferral contributions at any time by calling Fidelity Customer Services at 800-835-5097 or online at www.401k.com.

You also may elect to have your contribution percentage automatically increased by a set amount each year by enrolling in Fidelity's Annual Increase Program. For more information on the Annual Increase Program, contact Fidelity Customer Services. (Unlike some 401(k) plans, the company has elected not to automatically increase the deferral percentages for automatic deferral elections each year. As such, the automatic deferral percentage will stay at the initial percentage unless an automatic enrollee affirmatively changes his or her deferral percentage.)

Although you can elect to stop or change future deferral contributions, you cannot change the designation of prior deferral contributions. In other words, you generally cannot change regular pre-tax contributions already made to the Plan to Roth post-tax contributions, or vice-versa.

Special Rights upon Return from Military Service

If you return to work for the company after a qualifying military leave, you can "make up" the elective deferrals that you could have made if you had not gone on military leave. Your right to "make up" contributions lasts for a specific period of time. By law, that period is three times your military leave period (but not more than five years). For example, if you had been on active duty for 12 months, you would have the right to make up any missed contributions for a period of three years following your return.

The Plan rules and federal tax limits in effect during your military leave may limit your "make up" contributions. For further information, contact Fidelity Customer Services at 800-835-5097.

PRE-TAX CONTRIBUTIONS WITH REGULAR DEFERRALS

You may contribute between 1% and 50% of your pay on a pre-tax basis by making regular elective deferrals. (The 50% limit increases to 90% if you are making catch-up contributions.) You may choose a contribution percentage in hundredths of a percent (for example, 11.55%).

POST-TAX CONTRIBUTIONS WITH ROTH DEFERRALS

You may elect to contribute between 1% and 50% (90% if making catch-up contributions) of your pay on a post-tax basis by making Roth elective deferrals. You may choose a contribution percentage in hundredths of a percent (for example, 11.55%).

The tax rules governing Roth elective deferrals are complicated. You may want to consult your tax advisor regarding the financial impact of designating Roth elective deferrals, and how they might fit into your retirement income planning.

AFTER-TAX CONTRIBUTIONS

In addition to the pre-tax, Roth post-tax, and catch-up contributions discussed above, Participants in the Plan may also make after-tax contributions to the Plan between 1% and 50% of your pay by deferring a portion of their salary after taxes have been deducted. Such contributions permit earnings on after-tax contributions to grow tax free but, unlike post-tax deferrals with Roth contributions, the earnings are subject to income taxes when ultimately distributed from the Plan. The maximum after-tax contributions can be made, when combined with pre-tax, Roth post-tax, and employer matching contributions, are capped by the IRS at a maximum limit each plan year ($61,000 in 2022).

ROLLOVER CONTRIBUTIONS

You may roll over all or part of an "eligible rollover distribution" from a prior employer's qualified retirement plan into your 401(k) account if Fidelity approves. A prior plan may be a 401(k) plan, a 403(b) tax-sheltered annuity that allows cash distributions, a governmental Section 457 plan, or a distribution from a rollover conduit Individual Retirement Account (IRA) that consists solely of an eligible rollover distribution and earnings from the rollover distribution.

If the rollover is not a direct rollover (i.e., if you received a cash distribution from a prior employer's qualified plan or from your rollover IRA), then it must be received by Fidelity within 60 days of your receipt of the distribution. Rollover contributions are subject to the terms of the Plan but are always fully vested and nonforfeitable.

All rollovers must be approved by Fidelity before they can occur. Call Fidelity Customer Services at 800-835-5097 for information and forms.

INVESTING CONTRIBUTIONS

Investment decisions are your responsibility. You may currently choose to invest contributions among a number of investment funds and the Vanguard Target Retirement Trust Plus Funds. See "The Investment Funds" on page 179 for more information on the current investment options. (Investment funds are subject to change, with notice.) You decide how your contributions will be invested when you enroll in the Plan. If you fail to make investment fund elections (including if you fail to direct the investment of automatic deferrals under the Plan), the Plan's "default fund" is the Vanguard Target Retirement Trust Plus Fund nearest to the date your will attain age 65.

You may invest in as many funds as you like. The value of your account balances will go up or down depending on investment performance and your investment decisions.

The primary purpose of the 401(k) Plan is to provide you with a tax-advantaged investment vehicle to supplement your retirement income. Based on this objective, you should consider expected returns over longer periods of time. You may want to check with a financial advisor for the right combination of investments for you.

Changing Your Investment Mix

You may change how your future contributions will be invested and transfer money among funds by calling Fidelity Customer Services at 800-835-5097 or online at www.401k.com.

Tracking Your Savings

You will receive a personalized account statement four times a year. The statement will give you details on the status of your account as of the prior quarter. To ensure prompt delivery of your statement, please update any address changes in the Workday system under Personal Information.

You can get daily updates of your account by calling Fidelity Customer Services at 800-835-5097 or by going online at www.401k.com.

COMPANY CONTRIBUTIONS

There are two ways the company can contribute to the Plan:

- Matching contributions (matching a percentage of your regular pre-tax deferrals, Roth post-tax contributions and/or after-tax).
- Profit sharing contributions.

In both cases, the contributions are discretionary and may not be made every year or, if made, the contributions may not be made in the same percentage or amount each year.

VESTING IN COMPANY CONTRIBUTIONS

For purposes of vesting, participants generally earn a "year of service" for vesting purposes for each year you remain continuously employed with the IQVIA or a Participating Employer through your next employment anniversary date provided you are an eligible employee.

Note: Legacy Participants in the IMS 401(k) and Quintiles 401(k) Plans retained the vesting percentages and are generally subject to the same vesting rules in place under their respective plans at the time of the plan merger on January 1, 2018. In addition, legacy participants under the IMS 401(k) and Quintiles 401(k) Plans may receive credit for prior service with various predecessor employers and/or Participating Employers that were acquired by the IMS or Quintiles' groups prior to the IQVIA plan merger and have had that prior credit carried forward within the IQVIA 401(k) Plan. If you have questions regarding the calculation of vesting credit under predecessor employers, please contact the Plan Administrator.

The vesting methodology under the legacy Quintiles 401(k) Plan was previously amended effective January 1, 2014 to provide for vesting using the "elapsed time" method currently in use. (For legacy Quintiles 401(k) Participants hired on or after January 1, 2006 but prior to 2014, a "year of service" was earned each plan year in which the Participant worked at least 1,000 hours during a plan year applying the equivalency method on a weekly basis.)

Note: All legacy Quintiles Participants hired prior to 2006 are fully vested with respect to Company Matching Contributions. Legacy IMS Participants generally had service credited based on a similar "elapsed time" method using a monthly equivalency method that has been carried forward to the IQVIA 401(k) Plan. If you should have any questions regarding the historic crediting of your service under the merged IQVIA 401(k) Plan, please contact the Plan Administrator.

Vesting of Company Matching Contributions

Under the merged IQVIA 401(k) Plan, the matching contributions of all Participants (including legacy IMS 401(k) Participants) are subject to a 2-year graduated vesting schedule using the elapsed time method. Accordingly, all Participants are generally entitled to 50% vesting after 1 Year of Service and 100% vesting after 2 Years of Service as illustrated in the following table:

Years of Service	Vested Percentage
Fewer than 1 year	0%
At least 1 year but fewer than 2 years	50%
2 years of more	100%

(Important note: This change may provide accelerated vesting for legacy IMS Participants who were previously subject to a 3-year cliff vesting requirement. For example, if you were a legacy IMS Participant who worked for IMS for just over 1 year at the time of the plan merger, you will now be eligible for 50% vesting in your matching contributions with the remaining 50% vesting after 2 Years of Service when you previously would have had to accrue 3 Years of Service in order to vest in any portion of your matching contribution.)

Vesting of Profit Sharing Contributions

For discretionary profit sharing contributions or other non-elective contributions, as applicable, Participants are subject to a graduated, six-year vesting schedule as follows:

Years of Service	Vested Percentage
Fewer than 2 years	0%
At least 2 years but fewer than 3 years	20%
At least 3 years but fewer than 4 years	40%
At least 4 years but fewer than 5 years	60%
At least 5 years but fewer than 6 years	80%
6 years of more	100%

Vested Status of Legacy Quintiles 401(k) Plan Accounts

As of September 25, 2003, participants were fully vested in all other legacy Quintiles 401(k) Plan accounts other than matching contribution and profit sharing accounts. In addition, all legacy Quintiles 401(k) Participants hired prior to 2006 are fully vested in their matching contribution accounts under the Plan.

MATCHING CONTRIBUTIONS

The company may declare and make a matching contribution in an amount to be determined annually prior to the beginning of a plan year. Such determination will be approved by the Benefits Committee of the company. Any matching contribution will be equal to a percentage of deferral contributions, so you must make regular pre-tax deferrals (including automatic deferrals), Roth post-tax contributions or after-tax deferrals in order to receive a matching contribution. No matching contributions will be made on catch-up contributions. The plan does not make true-up contributions.

For the 2018 plan year, the matching contribution for participants other than those participating in the IMS Health Incorporated Retirement Plan (the "IMS Retirement Plan") is 100% of the first 3% of a participant's compensation deferred under the 401(k) Plan and 50% of the next 3% of compensation deferred under the 401(k) Plan. In no event will matching contributions be provided on any contributions in excess of a participant's first 6% of compensation deferred under the 401(k) Plan. Matching contributions are subject to a vesting schedule as described above.

Important Note for Participants in the IMS Retirement Plan: *Due to the separate retirement benefits available to participants covered under the IMS Retirement Plan prior to it being frozen at the end of 2016, the matching contributions under the 401(k) Plan are 50% of elective deferrals and after-tax contributions up to the first 6% of a participant's compensation.*

Note that the Plan makes matching contributions based on a participant's compensation each payroll period rather than based on total annual compensation subject to year-end adjustments. There are no "true-up" adjustments. Under the payroll period matching contribution method, in order for a participant to receive his or her maximum matching contribution from the Employer, elective deferrals generally need to be spread evenly over the full plan year rather than "front-loaded."

PROFIT SHARING CONTRIBUTIONS

For each plan year, the Employer may contribute to the Plan such amount as the Benefits Committee of the company determines reasonable and appropriate. Profit sharing contributions are discretionary and it is possible that the Employer may decide not to make a profit sharing contribution for a particular year.

If you have one year of service and are actively employed on the last day of the plan year (or if you terminate employment on account of retirement, disability or death during the plan year regardless of hours of service), you will receive a portion of any profit sharing contribution made for that plan year. The amount is determined by multiplying the profit sharing contribution percentage by your compensation for the plan year.

For profit sharing contributions, the term "compensation" is defined the same as it is for your elective deferral contributions to the 401(k), but excludes pre-tax amounts deducted from your paycheck to pay for benefits. Further, the term generally means total compensation earned during the plan year without regard to the date you enter the Plan.

In order to earn a year of service under the Plan for purposes of qualifying for any discretionary profit sharing contributions (or other Employer non-elective contributions or forfeiture allocations), you must earn 1,000 hours of service within the plan year. In tracking hours of service, however, the Plan employs an equivalency method crediting participants with 45 hours of service for each week in which the participant receives credit for at least one hour of service. (You generally receive credit for an hour of service for any hour for which you are paid or are entitled to be paid.)

For purposes of calculating all vesting credit under the Plan, including vesting in any profit sharing contributions, the Plan employs an "elapsed time method" whereby you earn a year of service for each year worked as of your employment anniversary date. (Note: The methods used for crediting vesting service under the legacy 401(k) Plans has changed throughout the years. If you have questions regarding the calculation of historic vesting credit under the legacy 401(k) Plans, please contact the Plan Administrator for additional information.)

COMBINED PROFIT SHARING ACCOUNTS

In addition to potential discretionary profit sharing contributions, legacy Quintiles 401(k) Plan participants may also have the following profit sharing accounts:

1. A "Profit Sharing Account" (formerly an "ESOP Account" and "Other Investments Account") credited with amounts attributable to Employer stock held in the Plan as of September 25, 2003, if any, together with any Profit Sharing Contributions made on your behalf after that date. (The amounts in all such accounts are subject to a vesting schedule. For vesting details, see page 176.)
2. A "QINC Transfer Account" (formerly a "Profit Sharing Transfer Account") was credited with amounts received in a direct trustee-to-trustee transfer from the Quintiles, Inc. Profit Sharing Plan and Trust effective December 31, 1989. Your QINC Transfer Account, if any, is generally paid as a joint and survivor annuity if you are married and a life annuity if you are unmarried. See "Payment of QINC Transfer Account and Innovex Transfer Account" on page 183 for more information. (As of May 1, 1999, the amounts in all such accounts were fully vested.)

401(K) ACCOUNTS

Participant accounts under the 401(k) Plan may include:

1. An "Employee Deferral Account" credited with any regular elective deferrals (including any automatic deferrals) you make on a pre-tax basis. (The amounts in this account are always fully vested.)
2. An "Employee Roth Deferral Account" credited with any Roth elective contributions you make on a post-tax basis. (The amounts in this account are always fully vested.)
3. An "Employee Catch-Up Account" credited with any catch-up pre-tax contributions you make. (The amounts in this account are always fully vested.)
4. An "Employee Roth Catch-Up Account" credited with any catch-up post-tax contributions you make. (The amounts in this account are always fully vested.)
5. An "Employer Matching Account" credited with any matching contributions made on your behalf for both regular and Roth elective deferrals or after-tax deferrals. (Amounts in the Employer Matching Account may be subject to a vesting schedule. See "Vesting in Company Contributions" on page 176.)
6. An "After-Tax Account" credited with any after-tax contributions made by you (The amounts in this account are always fully vested.)
7. A "Qualified Discretionary Contribution Account" credited with any Qualified Discretionary Contributions made on your behalf. (The amounts in all such accounts are always fully vested.)
8. A "Rollover Account" credited with any rollover contributions received on your behalf. (The amounts in all such accounts are always fully vested.)
9. An "Innovex Transfer Account" (formerly a "Retirement Savings Transfer Account") was credited with amounts received in a direct trustee-to-trustee transfer from the Innovex Inc. Retirement Savings Plan effective April 1, 1997. Your Innovex Transfer Account, if any, is generally paid as a joint and survivor annuity if you are married and a life annuity if you are unmarried. See "Payment of QINC Transfer Account and Innovex Transfer Account" on page 183 for more information. (As of September 25, 2003, the amounts in all such accounts were fully vested.)
10. A "Scott-Levin Transfer Account" was credited with amounts received in a direct trustee-to-trustee transfer from the Scott-Levin 401(k) Plan effective October 1, 1999. You may take an in-service distribution of all or any portion of the amounts held in your Scott-Levin Transfer Account, if any, without terminating employment upon attainment of age 59-1/2. (As of September 25, 2003, the amounts in all such accounts were fully vested.)

THE INVESTMENT FUNDS

The list of current investment fund options is available by calling Fidelity at 800-835-5097 or online at www.401k.com once you have registered.

The available investment funds have different investment objectives, so the risk and returns on each fund are different. Before you make your investment choices, you should think about the investment goals of each fund, as well as your own investment goals and your tolerance for risk. Each fund has a prospectus and summary description which provides information on the several aspects of the funds, including its:

- Specific investment objectives.
- Risk/return characteristics.
- Type of investments.
- Investment diversification.

For historical fund performance, prospectuses, summary descriptions, financial statements, terms of investment contracts and other investment fund information, call Fidelity Customer Services at 800-835-5097 or go online at www.401k.com once you have registered. Keep in mind that past fund performance is no guarantee of future performance.

The 401(k) Plan currently offers mutual funds and a common collective trust fund as investment options. Each investment fund offered under the Plan charges investment management fees (which are normally based on a specified percentage of fund assets) and may have other operating expenses that affect the fund's investment return. In addition, the funds may impose deferred sales charges, sales loads and redemption or exchange fees. Current information on a fund's operating expenses, fees and charges can be found in the most recent prospectus and summary description for the fund.

The plan administrator has the right to change the investment funds offered under the 401(k) Plan at any time.

INVESTMENT EARNINGS, LOSSES AND GAINS

Your account balances change over time, as the value of your investments change and you earn dividends and/or interest. Any dividends and/or interest your investments earn automatically are reinvested in that fund. When a fund shows earnings, gains and/or losses, your account balance reflects this change on a daily basis.

INVESTMENT RESTRICTIONS

A number of funds have begun to impose trading restrictions that are intended to curb short-term and other trading abuses. For example, many funds are restricting excessive short-term trading practices by sending a written warning to any person who has engaged in such trading and temporarily suspending or limiting the trading of anyone who continues to do so after receiving a warning. Trading restrictions may be imposed by the Plan's current investment funds. To find out if there are any restrictions under a fund, you should read the current prospectus and other available information for that fund.

VOTING AND SIMILAR RIGHTS

All voting, tender and similar rights for any investment funds in which you invest your Plan accounts are passed through to, and may only be exercised by you. The proxy statement and accompanying materials will be sent to you with instructions on how to vote or otherwise exercise your rights.

COMPLIANCE WITH 404(C) REGULATIONS

The Plan is designed to comply with ERISA Section 404(c) by providing you with a number of investment options and a wide choice of fund information, including each fund's operating expenses, investments and share value/performance. The Plan Administrator is responsible for making sure the Plan complies with Section 404(c). Since you make investment choices for your account, the plan's fiduciaries are not responsible for losses that may result from following your investment instructions.

ACCESS TO YOUR ACCOUNT BALANCES WHILE EMPLOYED

Although the Plan is intended to provide income for retirement, you may need your money while you are still working. However, in granting special tax advantages to programs like the Plan, the government limits how you may withdraw funds. This section explains what methods of withdrawal are available to you in various situations.

LOANS FOR ACTIVE EMPLOYEES

Loans for active employees are generally available from the Plan for any reason. Call Fidelity Customer Services at 800-835-5097 or go online at www.401k.com to initiate a loan and/or to determine the loan amount available. Taking a loan may cause you to incur both a set-up fee and an annual maintenance fee. Also, depending on the source of the amounts you are borrowing, a spousal waiver may be required before a loan can be granted.

The following rules apply to 401(k) Plan loans:

- You may borrow from your account the lesser of: (1) $50,000, reduced by your largest outstanding loan balance during the twelve month period prior to the date of the loan; or (2) 50% of your vested account balance. The minimum amount that may be borrowed is $1,000.
- At the time of your loan, the trustee will notify you of the amount of the loan, the interest rate to be charged and the repayment schedule. You will be charged interest on your loan based on the average rate being offered for similar loans of similar risk by three banks or other commercial lending institutions in the geographical location of your work address. The interest is not tax deductible.
- You generally cannot have more than two outstanding loans at any one time. *(Note: Legacy IMS 401(k) participants with three loans outstanding at the time of the plan merger may continue to have three outstanding loans per the original loan terms in effect as of December 31, 2017. However, such participants must pay off at least two of the outstanding plan loans in order to take out a new plan loan and will thereafter be limited to a maximum of two plan loans.)*
- You have up to five years to repay a general purpose loan.
- You have up to 15 years to repay a primary residence loan. A primary residence loan requires documentation, such as a purchase agreement.
- Loan repayments will be made through post-tax payroll deductions and will be deposited in the investment funds of your current contributions.
- If your loan becomes delinquent and is not brought current within 30 days of written notice, the loan may be considered a taxable distribution under the Plan.
- Loans are generally available from all accounts other than the QINC Transfer Account.

Prepayment of Loan

You may prepay your outstanding loan in full at any time. Partial loan repayments are not allowed. Call Fidelity Customer Services at 800-835-5097 or go online at www.401k.com to receive more information about prepaying your outstanding loan.

If You Leave the Company with an Outstanding Loan

The rules applying to loans are complex. You should check with a financial advisor or accountant when deciding how to receive a payout from your account.

Generally, if you have a plan loan when you leave the company, you may repay your loan in full at that time.

You also have the option of requesting recurring loan repayments using ACH by setting this up online with Fidelity. Please contact Fidelity Customer Services at 800-835-5097 to request this option.

If your outstanding loan is not paid in full, the amount you (or your beneficiary) receive will be reduced by the amount of the unpaid balance, plus accrued interest. This means you will be responsible for any required taxes or penalties that may be applicable to the unpaid loan balance.

IN-SERVICE DISTRIBUTIONS

Applying for a Withdrawal

To request a withdrawal, call Fidelity Customer Services at 800-835-5097.

Upon reaching age 59-1/2, you can generally request payment of all or a portion of your vested account balance as an "in-service distribution" even if you continue to work. In-service distributions can generally be made without early withdrawal penalties; however, they will be subject to applicable income taxes unless timely rolled over to an IRA. *(Note: the in-service distribution option is new for legacy Quintiles 401(k) participants effective with the IQVIA plan merger.)*

In addition, certain other in-service distribution alternatives may be available if you are 100% vested in: (i) amounts held in certain legacy Quintiles 401(k) Profit Sharing Accounts, (ii) accounts transferred to the legacy IMS 401(k) from the Cegedim 401(k) or Synavant Plans, or (iii) QINC Transfer Account if the amount has accumulated for at least two years or you have been a participant for five or more plan years. Please contact Fidelity Customer Services at 800-835-5097 for additional information regarding legacy in-service distribution alternatives for these accounts. Note, distribution from your QINC Transfer Account will be subject to the written consent of your spouse. If you receive a distribution from these accounts prior to attaining age 59-1/2, you will also generally be subject to an additional tax of 10% unless you qualify for an exception.

Please consult your tax advisor about the tax consequences of such a withdrawal to you. For more information on in-service distributions, contact Fidelity.

HARDSHIP WITHDRAWALS

Generally, you may make a hardship withdrawal of a portion of your Employee Deferral Account, Employee Roth Deferral Account, Employee and/or Roth Catch-up Accounts, and Employee Rollover and/or Roth Rollover Accounts, if applicable, regardless of your age. This is provided the amount requested is necessary to meet an immediate and heavy financial need. You must have exhausted all other possible means of available resources, such as loans from non-Plan sources, savings accounts and liquidation of other assets before obtaining a hardship withdrawal. An immediate and severe financial reason can be one or more of the following:

- Purchase of a principal residence (excluding mortgage payments).
- Payment of post-secondary tuition and related fees for the next 12 months for you or an eligible dependent.
- Prevention of eviction from your principal residence or foreclosure on the mortgage of your principal residence.
- Payment of medical expenses that are not reimbursed through your medical plan.
- Payments for burial or funeral expenses for your deceased parent, spouse or child.
- Expenses for the repair of damage to your principal residence that would qualify for the casualty loss deduction under section 165 of the Internal Revenue Code (determined without regard to whether the loss exceeds 10% of your adjusted gross income).
- In addition, hardship withdrawals may also be permitted by the IRS on a selective basis in conjunction with certain natural disasters as declared by FEMA and adopted by the Plan from time to time.

You may only withdraw the amount necessary to meet your immediate need, and documentation of your need must be provided. Call Fidelity Customer Services at 800-835-5097 to initiate a hardship withdrawal.

If your withdrawal is approved, the following rules apply:

- You may request only the amount needed to meet your financial hardship.
- The minimum hardship withdrawal is $1,000.
- No hardship withdrawal amounts may be rolled over into another retirement plan or individual retirement account.

Taxes on Hardship Withdrawals

Because the Plan is designed for long-term savings, if you are under age 59-1/2, the IRS imposes a 10% early withdrawal excise tax applicable to hardship withdrawals, in addition to ordinary income tax on pre-tax elective deferrals. There are exceptions to the 10% excise tax. Tax laws that apply to plan withdrawals and distributions are complex and change from time to time. You should check with a financial advisor or accountant when deciding how to receive a payout of your account.

DISTRIBUTIONS WHEN YOU LEAVE THE COMPANY

If you leave the company for any reason (whether as a result of retirement, disability, death or any other reason), you have to make a decision about your plan account balances. In general, you can:

- Transfer balances to another tax deferred plan or a conduit individual retirement account (IRA) or Roth IRA, if applicable.
- Take a cash payment of the full amount, less any required income taxes on regular pre-tax contributions. You may still owe additional income taxes on your payment, and possibly a 10% penalty tax for early withdrawal.
- Take your account balances in a series of periodic installment payments over a reasonable period of time not exceeding your life expectancy or the joint life and last survivor expectancy of you and your designated beneficiary.
- Leave it in the plan until you reach age 72, with the option to withdraw it at any earlier time. You can only leave it in the plan if your account balances are more than $1,000.

If you plan to transfer your funds to another tax-deferred plan or IRA, be sure to read the important information in the special tax notice that will be provided to you after you terminate employment when requesting a distribution or rollover of your vested account balance.

The federal income tax aspects of payments from the 401(k) Plan are complex and subject to change. In addition, applicable tax treatment under state and local law may differ. You may wish to consult your tax advisor regarding the financial impact of any distributions that you receive from the 401(k) Plan.

Note: See "Payment of QINC Transfer Account and Innovex Transfer Account" on page 183 for more about payment of those accounts.

IF YOU RETIRE FROM THE COMPANY

You will be considered to have "retired" if one of the following occurs:

- Your employment with the company ends on or after age 65.
- Your employment with the company ends on or after age 55 and after completion of at least five years of continuous employment.
- Your employment with the company ends on or after age 55 only with respect to the balance held in your Profit Sharing Account.
- You are considered disabled under the provisions of the company's Long-Term Disability Plan or are eligible for Social Security disability.
- Defer payment to age 72.

If you "retire" and your account balance (including the balance in your rollover contributions account) is more than $1,000, you can choose to defer distribution of your account balance until you reach the age of 72. You will have the option to withdraw your account balance (in whole) at any earlier time.

WHEN YOU DIE

If you die before terminating employment with the company, your accounts will become fully vested on your date of death and, consistent with your designated beneficiary's election, all amounts credited to your accounts (except for amounts in your QINC Transfer Account or Innovex Transfer Account, if any) will be paid as soon as administratively possible to your designated beneficiary.

If you die after terminating employment with the company, the portion of your account balances that was vested as of your termination date (less any payments that you may have previously received) will be paid as soon as administratively possible to your designated beneficiary, subject to the applicable survivor annuity rules.

In general, your beneficiary (or beneficiaries) will receive the balance in your account in a single lump sum after your death. However, if you were receiving installment payments at the time of your death, your beneficiary may choose to continue receiving any installment payments that remained unpaid as of your date of death.

These payments will be subject to applicable income taxes and also may be subject to estate taxes.

PAYMENT OF QINC TRANSFER ACCOUNT AND INNOVEX TRANSFER ACCOUNT

The distribution of your QINC Transfer Account and Innovex Transfer Account, as applicable, is subject to the joint and survivor annuity rules of the Internal Revenue Code. It is intended that payment of these accounts will be made at the same time as payment of your other accounts. Your QINC Transfer Account and the vested portion of your Innovex Transfer Account shall be paid as follows, unless you elect otherwise in writing as described below, and, if you are married, your spouse consents in writing:

1. If you are married, a joint and survivor annuity providing monthly payments for your life and, upon your death, continuing monthly payments to your surviving spouse for the remainder of his or her life in an amount equal to a certain percentage of the monthly amount previously paid to you. Effective January 1, 2008, you may elect either a Qualified Joint Survivor Annuity ("QJSA") option with continuing monthly payments to your surviving spouse equal to 50% of the monthly amount previously paid to you or a Qualified Optional Survivor Annuity ("QOSA") with continuing monthly payments to your surviving spouse equal to 75% of the monthly amount previously paid to you. If you elect one of the joint and survivor annuity options, the Plan will purchase an annuity contract for you from an insurance company. The monthly amount of the benefit and the reduced survivor benefit that would be provided under this annuity contract will vary depending upon the amount in your account, the ages of you and your spouse, and the interest that will be credited to the annuity contract by the insurance company.
2. If you are unmarried, a life annuity providing payments for your lifetime. If you elect a life annuity, the Plan will purchase an annuity contract for you from an insurance company. The monthly amount of the benefit will vary depending upon the amount in your account, your age, and the interest that will be credited to the annuity contract by the insurance company.

If you are married, you will be paid under option (1), which is the joint and survivor annuity, unless you elect to receive a lump sum distribution and your spouse agrees in writing to your election. Your spouse's agreement to an alternate form of payment must be made at the time of your retirement (or when you are otherwise due payment) and must either be witnessed by a Plan representative or acknowledged before a notary public. You will be provided a form on which you can elect the form of payment and obtain a spousal waiver.

WHEN YOU REACH AGE 72

In general, you must begin taking distributions from your account balance by April 1 following the year in which you reach age 72 or when you retire, whichever is later. Unless you choose to receive your account balance in a single lump sum, each year thereafter you will receive an additional amount no later than December 31, until your entire account balance is distributed.

IF YOUR ACCOUNT BALANCE IS LESS THAN $1,000

If your account balance (including any rollovers you have made to the plan) is less than $1,000, you or your beneficiary will automatically receive a cash payment of all your account balances (except for amounts in your QINC Transfer Account or Innovex Transfer Account, if any, which may require spousal consent) after you retire, die or otherwise leave the company. However, you may elect to do a direct rollover of this payout beforehand.

APPLYING FOR BENEFITS

To begin payout of your account balance after you leave the company, you must apply for payment. To request a distribution, call Fidelity Customer Services at 800-835-5097.

BENEFICIARIES AND ALTERNATE PAYEES

The direct rollover rules also apply to payments to a surviving spouse or to a former spouse who is an "alternate payee" under a court order.

- If you are a surviving spouse, you may elect to have your distribution paid as a direct rollover to an IRA or as a lump sum. If you elect a lump sum payment, you may keep it or roll it over yourself into an IRA, but generally you cannot roll it over into another qualified plan.
- If you are an alternate payee and former spouse, you are eligible for a lump sum payment. You may elect that the payment be a direct rollover or paid to you. If you elect to have the payment made to you, you may roll over the payment into an IRA or another qualified plan that accepts rollovers.
- If you are a beneficiary or alternate payee other than the spouse for distributions after December 31, 2009, a non-spouse beneficiary who is a "Designated Beneficiary" may choose a direct rollover, and roll over all or any portion of his or her distribution to an individual retirement account that the beneficiary establishes to receive this distribution.

The 10% early withdrawal penalty does not apply to a distribution made to a beneficiary or an alternate payee. In the event of the death of a beneficiary with an account, a lump sum distribution will be made to his or her estate.

OTHER PLAN INFORMATION

The following is important information about the 401(k) Plan, including:

- Forfeitures.
- W-2 Reporting.
- Things that can affect your benefit.
- Transferring to an IQVIA affiliate.
- Qualified Domestic Relations Order (QDRO).
- Top-heavy provisions.
- Break in Service.
- If you leave the company and are rehired.
- Leaves of absence.

FORFEITURES

If you terminate employment, your account balances that are not vested are forfeited at the Accounting Date coinciding with or following the day on which your employment ends. Any amounts forfeited do not go back to the Employer, but first are used to pay expenses of Plan administration, including reducing future employer matching and profit sharing contributions to the Plan, and then used to reinstate forfeited amounts as described below.

The remaining forfeitures, if any, are then allocated to the accounts of remaining participants on the Allocation Date coinciding with or following the Accounting Date such amounts are forfeited. Reinstatement of amounts forfeited or allocations of forfeitures shall be made to the type of account from which such forfeitures came, so that, for example, forfeitures from a participant's Profit Sharing Account shall be used to reinstate other Profit Sharing Accounts or allocated across all Profit Sharing Accounts. Allocations of forfeitures across all of a particular type of account shall be made in accordance with the rules for allocating contributions to such accounts. Under no circumstances will participants share in additional forfeitures after termination of employment.

Amounts forfeited will be reinstated in the following situations:

1. The Participant either was not paid his or her entire vested account balance or was not vested in his or her account balance and returns to the employment of the Employer without incurring five consecutive Breaks in Service.
2. The Participant was paid his or her entire vested account balance, returns to the employment of the employer without incurring five consecutive Breaks in Service, and, within the period beginning on the day of his or her return and ending five years from that date, repays to the Plan in cash an amount equal to the vested account balance paid to him or her. Participants are responsible for notifying the Plan Administrator that they have returned to the employment of the Employer. Upon such notice, the Plan Administrator shall notify Participants who are reemployed and are eligible for this reinstatement right that such reinstatement of forfeited amounts is contingent upon repayment.

In either situation, reinstatement shall be made as of the Allocation Date coinciding with or following the Participant's return and repayment, if any. If you were fully vested when you terminated, you do not have the opportunity to repay your distribution.

W-2 REPORTING

The amount shown on your W-2 Form as taxable income has been reduced by any pre-tax contributions you make to the Plan. The amount of your Plan contributions will be printed in a separate box.

THINGS THAT CAN AFFECT YOUR BENEFIT

Benefits may be denied, lost or stopped, or you may not be eligible for benefits, under the following circumstances:

- You are not eligible to participate in the plan if under age 18 or not working for a Participating Employer.
- If you receive a benefit payment that is larger than it should be, you must repay the excess to the plan.
- Some plan fees may be charged directly to your account. See "The Investment Funds" on page 179 for more information on the payment of these fees.
- Certain costs of running the plan (such as the trustee's and the other service providers' fees) may be charged against all participants' accounts on a pro-rata basis.

TRANSFERRING TO AN IQVIA AFFILIATE

If you transfer to another US company affiliated with IQVIA and continue to be eligible to participate in the Plan, your participation will continue uninterrupted. If your employment is transferred to an affiliate outside of the US, contributions to your account will stop. You may make investment fund changes, and your account will continue to share in investment performance. You may be eligible to receive a final distribution from the Plan when you no longer work for a US IQVIA company.

QUALIFIED DOMESTIC RELATIONS ORDER

The Plan may be required to pay all or part of your account balances to an alternate payee pursuant to a qualified domestic relations order ("QDRO"). A QDRO is a special order issued by the court, in a divorce, child support or similar proceeding which requires the plan to pay all or part of your accounts to an alternate payee to satisfy your obligation under the QDRO. An alternate payee is your spouse, former spouse, child, other dependent or someone else other than you or your beneficiary. You will be notified if the 401(k) Plan receives a QDRO that relates to your plan accounts or receives a written notice that a prospective alternate payee intends to pursue a QDRO related to your plan account. In either event, the plan may suspend payment of all of your benefit to ensure that funds will be available to pay the alternate payee as provided in the QDRO. Fidelity now provides the Fidelity QDRO Center which is a website dedicated to handling QDROs at https://qdro.fidelity.com)

TOP-HEAVY PROVISIONS

If the Plan should become "top-heavy," you may qualify for benefits in addition to those already discussed, and your benefits may vest at a faster rate. A plan is top heavy if more than 60% of the account balances have been accumulated for the benefit of employees defined as "key employees." Key employees are primarily officers and owners of the company. You will be informed if the plan becomes top-heavy.

BREAK IN SERVICE

Sometimes your service with the company is interrupted or broken. A Break in Service typically occurs when you have worked less than 1,000 hours in the calendar year (except for maternity or paternity leave as mentioned below).

You will have a Break in Service:

- On the last day you work for the company if you resign, are discharged, retire or die.
- If you are disabled and do not return to work when your disability ends, or the date you retire, whichever occurs first.

- If you are on a military leave of absence and do not return to work within the specified period of time as required by the law pertaining to veterans' re-employment rights.
- If you are on maternity or paternity leave and you did not work at least 500 hours in the same calendar year.
- If you are on an authorized leave of absence or layoff and do not return to work by the first anniversary of the date your leave or layoff began or on the date your leave or layoff ends (whichever occurs first).

Break in Service rules are complex. The above explanation is only a summary. If you have questions regarding Break in Service rules, please contact your Human Resources Representative.

IF YOU LEAVE THE COMPANY AND ARE REHIRED

If you leave the company but are later rehired without incurring five consecutive breaks in service, your vesting percentage will generally be the same percentage that it was when you left the company. Company matching contributions that were forfeited will be reinstated provided you were not paid your entire vested account balance. If you were paid your entire vested account balance, then you must repay the gross amount back in order for the non-vested forfeitures to be reinstated.

(If you are a legacy Quintiles 401(k) Participant that is rehired and your original hire date was on or before January 1, 2006, then you are 100% vested in the matching contributions.)

LEAVES OF ABSENCE

A Break in Service may be prevented if you are granted an authorized leave of absence or if your absence is due to military service or maternity or paternity leave. If you do not return to the employ of the Employer at the expiration of your leave of absence, you will be considered to have terminated employment on the date of the expiration of your leave of absence.

Maternity and Paternity Leaves of Absence

If you are absent from work for the birth or adoption of a child, and worked at least 500 hours in the same calendar year, it will not be considered a Break in Service and you will receive credit for vesting service during that year.

Military Leaves of Absence

If you take a leave of absence for military service, special Break in Service rules apply. If you are a veteran and are reemployed under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), your qualified military service may be considered service with the company. You may have other special rights or benefits if you die or become disabled while on active duty.

If you think you may be affected by these rules, please contact your Human Resources Representative for more information.

OTHER BENEFITS

Summary Plan Description

Not Subject to ERISA

Please note that the benefits described in this section are not subject to ERISA.

Work worth doing isn't meant to be done 24/7. IQVIA invests in a broad range of other benefits designed to support you and your interests outside the workplace, helping you balance your personal and professional lives. These benefits include:

- Healthy You Employee Well-being Program
- Hinge Health
- Omada Diabetes Prevention
- Teladoc Medical and Mental Health
- Wellness Coach
- 24/7 Nurse Line
- Aetna Care Management Program
- Aetna AbleTo Emotional Support
- Flu Shots
- Mercer Marketplace 365 HUB
- Time Off
- WorkLife Benefits
- Commuter Benefit Plan
- Statutory Benefits

In addition, you receive other statutory benefits such as Social Security, Medicare, Workers' Compensation and unemployment insurance. All of these benefits are described in this section.

For More Information

For additional information about each of these benefits, visit the IQVIA Benefits Marketplace website, or call or visit the websites listed in each section. Contact information is also available in the *Contacts* section.

IN THIS SECTION SEE PAGE

HEALTHY YOU EMPLOYEE WELL-BEING

Your health and well-being are important to IQVIA. We are focused on building and maintaining a culture of well-being, which means offering benefit programs that help you to take care of your wellbeing and stay healthy. We also give you the tools and resources you need to make the best decisions and take action steps for you and your family to better manage your health care expenses. IQVIA's employee well-being program, Healthy You, includes initiatives aimed at supporting you and your family across four pillars of well-being: Healthy Bodies, Healthy Minds, Healthy Finances, and Healthy Connections.

Here's how:

- U.S. Well-being IQ page (https://quintiles.sharepoint.com/sites/IQ/Employee/Policies_Bnfts_Handbooks/Wellness/Pages/U.S.-Employee-Wellness.aspx) for details on well-being programs and activities Wellness Match Program (WMP)
- Mental Health Support Options
- Well-being newsletters with information, resources and tips
- Healthy Living Webinars
- Nutrition Counseling
- Healthy You Yammer Community
- Well-being Champions
- IQVIA Day for Volunteering
- Employee Resource Groups (ERGs)

The individual carriers may offer/add/revise/remove other internal programs available to IQVIA employees. Those programs are managed and administered by the carriers. We encourage employees to visit the carrier websites for more information on additional programs that may be available to participating members.

Learn More About Healthy You

Go to https://quintiles.sharepoint.com/sites/IQ/Employee/Policies_Bnfts_Handbooks/Wellness/Pages/U.S.-Employee-Wellness.aspx for everything you need to know to get started! Questions? HealthyYou@iqvia.com

HINGE HEALTH

Hinge Health provides support to help conquer back or joint pain without the use of surgery or drugs. The 12-week digital program delivers best practice, evidence-based care for musculoskeletal (MSK) conditions based on three core pillars:

- Exercise therapy
- Behavioral health
- Education

Once enrolled, you will be matched with the right program and care team to meet your needs:

- Prevention Program: An in-app experience with educational information to learn health habits, how to avoid risky behaviors, and exercises designed by physical therapists.
- Acute Program: An app experience paired with a dedicated physical therapist. You complete the exercises in your care plan and work with your dedicated physical therapist.
- Chronic Program: App and sensor technology paired with a dedicated physical therapist and health coach. You will receive a free tablet, sensors, and app that work together right out of the box. You will have 365-day access to a dedicated care team.

Visit **hingehealth.com/IQVIA** to learn whether you are eligible to participate and get started today.

OMADA DIABETES PREVENTION

Using behavioral medicine techniques, Omada is personalized to help participants lose weight and reduce their risk for a number of serious, preventable diseases, including type 2 diabetes and heart disease. With a personalized care plan, access to the latest technology, and daily support from your care team, you can create lasting change. No cost to Regular IQVIA employees who meet the eligibility criteria. Apply at https://go.omadahealth.com/iqvia

TELADOC MEDICAL AND MENTAL HEALTH

Speak to a doctor or therapist through confidential video, messaging, or phone chat 24/7, 365 days a year. Teladoc is available to those who elect an Aetna IQVIA medical plan and provides additional support for non-emergency medical issues or questions, when you are travelling and need medical care, or when your Primary Care Physician, Dermatologist, or Therapist is not available.

Use this convenient service for quick diagnosis and treatment of colds and flu, bronchitis, pink eye, sinusitis, rashes, upper respiratory infections, conjunctivitis, allergies, sprains and strains, as well as for acute or ongoing skin conditions such as psoriasis, skin infection, rosacea, and more. Appropriate deductibles and coinsurance apply. Learn more on www.teladoc.com/aetna.

WELLNESS COACH

Get one-on-one guidance and support from a wellness coach who can help you set goals, stick to them, and, most importantly, see results. Whether you want to reduce stress, eat healthier, lose weight, live tobacco free, sleep better, or focus on preventive health, you'll decide what's important to you and your coach will help you along the way. Log-in to your aetna.com or kaiserpermanente.org account to learn more.

24/7 NURSE LINE

Talk with a Registered Nurse anytime, for no cost. You could save yourself time and money by preventing a visit to the emergency room. The U.S. medical system can be hard to navigate – with Primary Care, Urgent Care, Pharmacies, Teladoc, and Emergency Department options, you may not always know where to go or who to see for your immediate concern. Aetna's nurse line is available 24/7 to guide you. If you have questions about a health concern or need guidance on where to go for care, call 1-800-556-1555 and select the option to speak to a nurse. You can also email a nurse within your www.Aetna.com account who can send you links to health information. Nurses reply within 24 hours. Nurses with Aetna's nurse line cannot diagnose, prescribe, or give medical advice.

AETNA CARE MANAGEMENT

Get personalized care and support when you need it most

Whether you're managing a chronic condition or dealing with other complex health challenges, Aetna nurses can help. If you're identified for care management, a nurse can work with you to put together a plan, help you understand your benefits offerings, and answer your health-related questions – all at no cost to you.

- One-on-one personalized support: Clinical nurses collaborate with service teams (pharmacist, dietician, and social worker) to help you achieve your health goals and guide you to local resources. Whether you're struggling with emotional concerns or an advanced illness, they'll work with you and your family to provide guidance and support.
- Local support: Aetna's Pharmacist Panel can provide guidance and connect you to more resources. With CVS HealthHUB and MinuteClinic locations inside select CVS Pharmacy and Target stores, you have a broad range of services to keep you and your family healthy.
- Tools, tips and support centers: Through your Aetna member website, you'll be able to locate a doctor, review your personal health record, and watch informational health videos. And for specific health needs, you can explore member resources like the Cancer Support Center, the Maternity Support Center, and the Back and Joint Care Support Center.

To start using care management, go to www.aetna.com and log-in to your account.

AETNA ABLETO EMOTIONAL SUPPORT

AbleTo is part of Aetna's Behavioral Health Plan and is a personalized 8-week virtual emotional support programs that help reduce depression, stress, and anxiety. Get counseling and coaching combined by secure video or phone.

You'll work with two AbleTo specialists for eight weeks (16 sessions):

- Once a week with a licensed therapist, to address emotional challenges like depression, stress and anxiety that can come with a medical diagnosis.
- Once a week with a behavior coach, to identify health goals and develop an action plan.

Appropriate deductibles and coinsurance apply. To get started, call 1-855-773-2354.

FLU SHOTS

Employees and covered family members on IQVIA's medical plans receive a flu shot covered at 100% at an Aetna or Kaiser Permanente network pharmacy.

MERCER MARKETPLACE 365 HUB℠

Imagine you've been told you need a medical procedure to treat a recently diagnosed condition. It's hard to know where to start. How will you find the best doctor, and what will it cost? Where can you get a second opinion? What if you need help resolving a complicated bill or claim issues?

If you enroll in an IQVIA medical plan, you may also choose to enroll in the Mercer Marketplace 365 HUB℠, a voluntary benefit that provides one-on-one support — online and by phone — to help you improve the quality and cost of your care.

By enrolling in the 365 HUB at Mercer Marketplace 365, you will have year-round access to personal health advocacy services, price comparison tools, physician performance ratings, expert medical opinions and more.

Learn more about the 365 HUB, see costs and enroll when you visit the IQVIA Benefits Marketplace website.

FIND AN ADVOCATE

The 365 HUB has a team of registered nurses, medical directors and benefits and claims specialists who work alongside each other to help you. 365 HUB is available to you and your covered family members.

A personal health advocate with expert knowledge about your benefits will help you:

- Find the right doctor.
- Schedule appointments quickly.
- Resolve health care billing and insurance claims disputes.
- Secure elder care with confidence, including answering Medicare questions.
- Work seamlessly with insurance providers.
- Transfer medical records promptly and securely.

COMPARE PRICES

The cost of health care services can vary significantly, even within the same geographic area and health plan.

Health Cost Estimator+ is an easy-to-use online tool offered through the 365 HUB. You'll see what you can expect to pay for a medical procedure at different locations — based on the medical plan you're enrolled in — and can easily compare prices so you can make the right choice for your needs and budget.

COMPARE QUALITY

With the Mercer Marketplace 365 HUB, you can review the quality scores of doctors in your area based on your condition and need. Scorecards include:

- Physician performance scores.
- Quality analysis.
- Experience and outcomes ranking.
- Evaluations based on billions of doctor-patient interactions.

GET EXPERT MEDICAL OPINIONS

Don't hesitate to get another opinion, especially if it's a concerning or serious condition. The 365 HUB gives you and your covered family members access to world class specialists who will review your case and give you an expert opinion on your diagnosis and treatment plan. It's peace of mind at a time when you may need it most. 365 HUB accepts all cases, and sticks with you every step of the way.

TIME OFF

Time away from work is important for your physical and emotional well-being. It's why IQVIA provides paid time off during the year, including holidays, vacation, bereavement leave, military leave, and jury duty.

To learn more information about IQVIA' time off policies, it can be found in the employee handbook on the IQVIA intranet site.

COMPANY HOLIDAYS

Each year, IQVIA offers you ten company-wide holidays. Although the actual dates may vary slightly from year-to-year, company-wide holidays for the following year are announced in advance of January 1. Details are available in the employee handbook on the IQVIA intranet site.

PAID TIME OFF

Exempt Employees

IQVIA provides all exempt employees a discretionary paid-time-off plan. In general, most exempt positions are not eligible for overtime pay.

Employees who are exempt under the Fair Labor Standards Act (FLSA) have the opportunity to take Discretionary Leave, and will not accrue paid time off during the year. Exempt employees working less than 20 hours per week are not eligible for Discretionary paid time off. Discretionary leave provides eligible employees with time off for personal reasons, including vacation or any personal purpose.

Discretionary Leave may not be used in lieu of other types of leaves appropriate for a specific situation, including but not limited to, short term or long-term disability, Family Medical Leave (FML), military leave, jury duty, workers' compensation, sick time and/or bereavement leave.

Non-Exempt Employees

Non-exempt employees will be on a flat accrual vacation schedule.

Full-time employees working 37.5-40 or more hours per week

If you are a non-exempt full-time employee working 37.5 to 40 or more hours per week, you accrue 13.334 hours of vacation time on a monthly basis.

Part-Time Employees Working 30-<37.5 Hours Per Week

If you are a non-exempt part-time employee working 30<37.5 hours per week, you accrue 10.00 hours of vacation time on a monthly basis.

Part-Time Employees Working 20<30 Hours Per Week

If you are a non-exempt part-time employee working 20<30 hours per week, you accrue 6.67 hours of vacation time on a monthly basis.

Annual Carryover

California, Colorado, Montana, Nebraska, and Nevada Residents: Regular non-exempt full-time and part-time employees may accrue and carry over up to 1.5 times your annual accrual to the next calendar year. Once an employee reaches their 1.5 times annual accrual cap, they will stop accruing paid time off. After an employee uses accrued vacation hours and falls below the 1.5 times annual accrual maximum, their accrual will resume.

All other U.S. Residents: Regular non-exempt full-time and part-time employees in all other states will not be allowed to carry over hours into the next calendar year. Employees should plan to use paid time-off in the year in which it is accrued.

BEREAVEMENT

In the event of a death in your immediate family, IQVIA may provide special consideration of paid work absences. IQVIA will provide up to a total of five (5) days for immediate family. Immediate family is defined as your spouse/domestic partner, children/domestic partner's children, siblings, parents, grandparents, grandchildren and immediate in-laws/step relations (children, siblings, parents, grandparents, and grandchildren).

One (1) day is allowed for the death of extended family members. Extended family is defined as aunts, uncles, nieces, nephews, and first cousins.

If additional time off is needed, employees may also request to use accrued but unused Paid Time Off (if any) or Discretionary leave, as applicable. Note, use of vacation or discretionary time must be requested and approved by your manager in accordance with the Paid Time Off policy.

JURY DUTY

IQVIA supports all regular full-time and part-time employees who are called to serve jury duty.

If you are called to serve, you should give your supervisor as much advance notice as possible, along with an estimation of how long you expect to be out. During your absence, you are responsible for communicating with your manager on a regular basis.

To be compensated for your jury duty absence, an employee must submit a copy of the "Notice to Serve" document to his or her manager prior to the anticipated absence.

MILITARY LEAVE

IQVIA has different military leave policies based on the type of duty you are performing.

Active Duty Leave

If the leave is for active duty, you should contact Lincoln Financial at www.myLincolnportal.com or 800-213-5608 to open a Military Leave. Complete the "Active Duty Military Leave" found at the last page of the Military Leaves of Absence policy in the employee handbook on the IQVIA intranet site, along with a copy of the active duty orders, and submit them to Benefit.Services@IQVIA.com. Be sure to copy your manager. The Benefits Department will then reach out to you to discuss the leave.

- You receive your regular pay less military pay and authorized deductions for the first 6 months of Active Duty Military Leave.
- You are not eligible for holiday pay while on Active military leave.
- You are eligible for IQVIA Active military leave upon date of hire.

Temporary Duty Leave (U.S. Military Reserves or National Guard)

IQVIA will provide you with the leave necessary to fulfill an annual training duty in the United States Military Reserves or National Guard.

To be eligible for this type of military leave, the following guidelines apply:

- You are limited to a maximum of 15 days Temporary Duty leave in any calendar year.
- You are eligible for IQVIA Temporary Duty leave upon date of hire.

SICK TIME

Sick leave may be used for periodic illness or injury, or for the care of an immediate family member (parent, spouse or child) due to his or her illness or injury. Sick leave may also be used for doctor and dentist appointments, and must be taken in .25 hour increments for recording on the time reporting system using the appropriate sick leave attendance code. Sick days cannot be used indiscriminately.

You are responsible for notifying your supervisor of your absence as soon as possible on a sick day, and at least two hours before your expected start time. When a medical or dental appointment is scheduled, you should notify your supervisor as soon as the appointment has been made so that plans can be made to cover your work. Each day you are out sick (unless hospitalized or on an approved leave of absence) you are required to personally notify your supervisor before the beginning of the scheduled work day. For absences of three consecutive days or more, a physician's note substantiating your absence is required upon your return. IQVIA may require medical documentation for any employee absence. Physician's notes may not be completed by physicians that are family members of the employee requesting the leave as it might be perceived as a conflict of interest.

If, due to illness or injury, you are unable to return to work after the fifth (5^{th}) consecutive business day; you are required to notify the IQVIA Disability carrier, Lincoln Financial at www.mylincolnportal.com or by phone at 800-213-5608 to file a disability claim. In the event the absence qualifies for Family Medical Leave (FML), the days absent will be counted towards the employee's FML entitlement.

If you are hospitalized overnight during paid time off, you will receive sick pay instead of vacation or discretionary pay (if eligible), but only with a supporting physician statement.

While sick time is made available to employees, it is not to be abused, and ultimately it is the employee's responsibility to ensure that their work duties are being performed as required, provided that IQVIA will comply with statutory leave rights such as those provided under the Family and Medical Leave Act (FMLA) or similar leave rights as provided by applicable law. Your supervisor is responsible for monitoring the number of sick days you take in any calendar year (January 1 – December 31).

Management will initiate a discussion with employees who have accumulated fifty (50) or more hours of sick time in a calendar year, to discuss the terms of this policy. Should you have a recurring health problem that may continue, information regarding other leave plans, such as FML, will be provided.

Excessive absenteeism occurs above eighty (80) hours of sick time, and may occur earlier, depending on the circumstances. The appropriate coding for sick time for absences above 80 hours will be decided on a case-by-case basis with Human Resources. These absences may be grounds for corrective action up to and including termination of employment. Managers should contact Employee Relations by opening a VIA ticket for assistance if an employee exceeds 80 hours of sick time in a calendar year.

WORKLIFE BENEFITS

IQVIA invests in a broad range of WorkLife benefits designed to support you and your interests outside the workplace. The IQVIA WorkLife offerings provide you with an array of helpful benefits and services, including the following:

ADOPTION ASSISTANCE

The Adoption Assistance Plan provides you with financial assistance for qualified adoption expenses. Unless otherwise required by state law, eligible expenses will be reimbursed up to a per-child maximum of $5,000 and a lifetime maximum of $10,000 per family.

Additional details on the on the IQVIA US Benefits Intranet page.

PERKSPOT DISCOUNT MALL

Through the IQVIA PerkSpot program, you can receive special offers and discounts from a variety of national retailers and service providers. Available features include discounts on personal services, entertainment, attractions, and shopping.

Visit http://iqvia.perkspot.com for more information.

EMPLOYEE ASSISTANCE PROGRAM (EAP)

IQVIA offers the Aetna Resources For Living℠ employee assistance program (EAP), available at no cost to you and members of your household which include dependent children up to age 26, whether or not they live at home.

Services are confidential and available 24 hours a day, 7 days a week.

Emotional Well-being Support

You can access up to six counseling sessions per issue each year. You can also call 24 hours a day for in-the-moment emotional well-being support. Counseling sessions are available face to face, via televideo or online chat therapy. Services are free and confidential. Counselors are always available to help with a wide range of issues including:

- Relationship support
- LGBTQ+ support and resources
- Stress management
- Work/life balance
- Family issues
- Grief and loss
- Depression
- Anxiety
- Substance misuse
- Self-esteem and personal development
- Manager resources and services

Daily Life Assistance

Completing day-to-day needs can make it tough to know where to start. Call the EAP for personalized guidance and get help finding resources for:

- Child care, parenting and adoption
- Summer programs for kids
- School and financial aid research
- Care for older adults
- Caregiver support
- Special needs
- Pet care
- Home repair and improvement
- Household services and more

The EAP also offer care kits related to growing families, child care, caregiving and more.

Legal Services

You can get a free 30-minute consultation with a participating attorney for each new legal topic related to:

- General
- Family
- Criminal law

- Elder law and estate planning
- Divorce
- Wills and other document preparation
- Real estate transactions
- Mediation services

If you opt for services beyond the initial consultation you can get a 25% discount. Services must be related to you or an eligible household member. Work-related issues are not covered. Discount does not include flat legal fees, contingency fees and plan mediator services.

Financial Services

Simply call for a free 30-minute consultation for each new financial topic related to:

- Budgeting
- Retirement or other financial planning
- Mortgages and refinancing
- Credit and debt issues
- College funding
- Tax and IRS questions and preparation

You can also get a 25% discount on tax preparation services. Services must be for financial matters related to you or an eligible household member.

Other Services

- **Identity theft services** — One-hour fraud resolution phone consultation or coaching about ID theft prevention and credit restoration. Services include a free emergency kit for victims.
- **Chat therapy** — Use your counseling sessions to connect with a counselor virtually. Share secure text messages with your counselor whenever you like. Your counselor will respond within one working day up to five days a week.

Online Resources

The EAP's website offers a full range of tools and resources to help with emotional well-being, work/life balance and more. You'll find:

- Articles and self-assessments
- Adult care and child care provider search tool
- Stress resource center
- Video resources
- Live and recorded webinars
- Mobile app

Discount Center

Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel, fitness, nutrition and more.

myStrength

myStrength offers tools to improve your emotional health and help you overcome depression, anxiety, stress, substance misuse and/or chronic pain.

Contacting the EAP

To take advantage of the Resources For Living program or to speak with a counselor, call 1-833-721-2319 (TTY: 711) for unlimited 24/7/365 assistance.

You can also visit www.resourcesforliving.com for user friendly and practical EAP-related information that addresses emotional well-being, health and well-being, and daily living concerns. To log in to the site, enter the following information:

- User Name: IQVIA
- Password: EAP

Your calls and any counseling services are completely confidential to the maximum degree permitted by law.

EMPLOYEE REFERRAL

Under the Employee Referral program, if you refer a person to certain open positions at IQVIA who is eventually hired into a full-time regular position, you may be eligible to receive a referral incentive.

In general, only active, regular full-time and part-time employees are eligible to participate in the Employee Referral program. For more information, search for "Employee Referral" under the My HR/Hiring Talent tab on the IQ homepage.

IDENTITY THEFT PROTECTION

Identity protection through Allstate Identity Protection includes proactive identity and credit monitoring, which protects you against identity fraud. In addition, you have access to full-service identity restoration, in case of fraud. You must enroll in this voluntary benefit during Open Enrollment.

LEGAL ASSISTANCE PLAN

MetLife® Legal offers economical access to attorneys for legal services such as will preparation, estate planning and family law. You, your spouse and your dependents will have access to a nationwide network of 13,000 attorneys. When you enroll, legal advice is a phone call away, and representatives will help you find an attorney in your area. You must enroll in this voluntary benefit during Open Enrollment.

Additional details on the Legal Assistance Plan can be found in the employee handbook on the IQ intranet site.

LIFEKEYS SERVICES

To help you prepare for the future and deal with the death of a loved one, you have access to the Lincoln Financial Group's *LifeKeys* services.

LifeKeys services include:

- Online will preparation
- Information on important life matters through GuidanceResources Online, where you'll find articles, tutorials, videos, and "Ask the Expert" advice on a wide range of topics — including legal, financial, family, and career.
- Protection against identity theft
- Guidance and support for your beneficiaries

PET INSURANCE

Through Nationwide, you can purchase medical insurance coverage for your pet(s). Nationwide Pet Insurance covers a variety of medical problems and conditions related to accidents and illness (including cancer) for dogs, cats, birds, ferrets, rabbits, reptiles and other exotic pets. If you are a dog or cat owner, Nationwide's optional Pet WellCare Protection coverage also reimburses you for regular routine care expenses that are necessary to keep your pets healthy.

To learn more about protecting your pets and to obtain a free quote, contact Nationwide at 855 525-1458 or visit their website at http://www.petinsurance.com.

SUBSIDIZED CAFETERIAS

IQVIA provides subsidized meals in the cafeterias at some U.S. locations and is dedicated to providing healthy food options within the cafeteria and through its catering services.

EDUCATION ASSISTANCE

To help expand your knowledge and skills, and to help you take your career where you want it to go, IQVIA offers an Education Assistance program. You are eligible for the program if you are a regular, employee working at least 30 hours per week and have completed one or more years of continuous service with the company.

When you enroll in a job-related degree program or professional certification courses and/or exams, IQVIA will reimburse 75% of your expenses (including tuition, books and fees), to a maximum of $5,250 per year. You must earn a C or better in each course to receive reimbursement.

IQVIA also offers Student Loan Coaching though EdAssist. Consult with EdAssist experts to develop repayment strategies that my reduce your monthly payments, allow you to repay your loan faster or evaluate consolidation and refinance options.

For detailed information on the Education Assistance program, it can be on the US Benefits page on the IQVIA intranet site.

SERVICE RECOGNITION

At IQVIA, we push the boundaries of human science and data science to solve problems differently. We believe in giving our best, recognizing the importance of teamwork and enjoying what we do. We recognize and celebrate you as you reach service milestones because your service matters to your colleagues, leaders, customers and the patients we ultimately serve.

Employee recognition can be given in many ways, such as saying thank you, giving praise or providing a public acknowledgement, such as through IQVIA's Impact Program. To celebrate long service, eligible employees who reach their 10-year, 15-year, 20-year, 25+ year anniversaries will receive a Workday notification inviting them to direct an IQVIA donation to the charitable organization of their choice through the YourCause platform.

COMMUTER BENEFITS

Save on public transportation costs by making tax-free purchases on metro cards, bus passes, parking fees and more.

- You decide how much to contribute, and the money is deducted from your paycheck automatically, on a tax-free basis. You can change your contribution anytime during the plan year.

- You can contribute from $5 to $280 per month for transit and/or from $5 to $280 per month for parking, pre-tax.
- You must enroll during Open Enrollment.

For More Information

Additional information about the Commuter Benefit Plan can be requested by contacting Mercer Marketplace at 888-264-9180 or http://accounts.mercermarketplace.com.

STATUTORY BENEFITS

In addition to your benefits as a IQVIA employee, don't forget that you also have access to the following:

- Medicare.
- Social Security.
- Workers' Compensation.
- Unemployment Insurance.

MEDICARE

The Medicare program is administered by the United States government and provides health insurance coverage for people age 65 and over (and certain others who meet special criteria). Medicare is partially financed through the payroll taxes deducted from each of your paychecks.

In general, you are eligible for Medicare if one of the following applies:

- You are age 65 or older, a U.S. citizen (or a permanent legal resident) for five continuous years, and you or your spouse (if married) have paid Medicare taxes for at least 10 years.
- You are under 65, disabled and have been receiving either Social Security benefits or disability benefits from the Railroad Retirement Board for 24 months or more.
- You suffer from end stage renal disease or need a kidney transplant.
- You are eligible for Social Security disability benefits as a result of amyotrophic lateral sclerosis (ALS, or Lou Gehrig's disease).

For more information about Medicare, visit the Medicare website at www.medicare.gov.

SOCIAL SECURITY

The Social Security program is administered by the United States government and provides monthly retirement income for eligible retirees (and certain others who meet special criteria). Social Security is partially financed through the payroll taxes deducted from each of your paychecks.

Your eligibility for full Social Security benefits depends on your age and birth year, although you may receive a reduced monthly benefit if you retire before your Social Security retirement age. You also may be eligible for Social Security benefits if you become disabled or if your spouse dies. The amount of Social Security benefit you are eligible to receive will depend on your (or your spouse's) lifetime earnings and your age when benefits begin.

For more information about Social Security, visit the Social Security Administration website at www.socialsecurity.gov.

WORKERS' COMPENSATION

Workers' Compensation is a form of insurance that compensates you if you are injured while employed. This compensation is provided if you voluntarily give up your right to sue for negligence following an accident. Depending on the type of Workers' Compensation you receive, payments can take the form of weekly amounts to replace lost wages, reimbursement or payment of medical expenses relating to your accident, or payments to your dependents in the case of your death.

Workers' compensation laws vary from state-to-state. For more information on the laws that apply to you, visit your state's website and search "Workers' Compensation."

UNEMPLOYMENT INSURANCE

Unemployment insurance is a type of insurance providing you with a minimum level of compensation if you become unemployed. This insurance is a federal-state program jointly financed through the payroll taxes deducted from each of your paychecks.

For most states you are limited to 26 weeks of unemployment compensation benefits. However, extended benefit programs may apply during certain economic conditions. For example, a temporary program may be passed at the federal or state level that extends benefits for a specified period of time.

Unemployment insurance laws vary from state-to-state. For more information on the laws that apply to you, visit your state's website and search "unemployment insurance."

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.

CONTACTS

Benefits	Vendor	Phone Number	Website
401(k)	Fidelity	800-835-5097	www.401k.com
Accident, Critical Illness and Hospital Indemnity Insurance	Aetna	800-607-3366	www.aetnaresource.com/n/IQVIA
Adoption Assistance	Employee Benefit Services	800-526-7094	Visit the employee handbook on the IQ intranet site.
AD&D coverage	Lincoln	800-713-7384 (to initiate a claim) Call Mercer Marketplace for general questions at 888-264-9180	www.mylincolnportal.com/customer/public/login Company Code: IQVIA
BTA coverage	CHUBB	800-336-0627	Visit the IQVIA company intranet, IQ
Commuter Benefit Plan	Mercer Marketplace 365	888-264-9180	http://accounts.mercermarketplace.com App: "Mercer Marketplace Accounts" mercermarketplaceaccounts@serviceaccount.com
Dental coverage	Delta Dental	800-932-0783	www.deltadentalins.com App: "Delta Dental"
Disability coverage	Lincoln	800-213-5608 (to initiate a claim) Call Mercer Marketplace for general questions at 888-264-9180	www.MyLincolnPortal.com Company Code: IQVIA
Discount Mall	PerkSpot	866-606-6057	http://iqvia.perkspot.com
Education Assistance	EdAssist	855-687-7629	https://iqvia.EdAssist.com
Employee Assistance Plan	Aetna	833-731-2319	www.resourcesforliving.com, User Name: IQVIA, Password: EAP
Flexible Spending Accounts	Mercer Marketplace 365/TRI-AD	866-268-0142	www.mercermarketplace365plus.com/IQVIA www.yourflexbenefits.mercermarketplace365.com
Identity Theft	Allstate Identity Protection	800-789-2720	https://www.myaip.com/mercermarketpp
Legal	MetLife Legal	800-821-6400	www.legalplans.com (access code: GETLAW) Visit the employee handbook on the IQ intranet site.

Benefits	Vendor	Phone Number	Website
Life Insurance	Lincoln	800-713-7384 (to initiate a claim) Call Mercer Marketplace for general questions at 877-248-9180	www.MyLincolnPortal.com Company Code: IQVIA
LifeKeys Services	Lincoln Financial	855-891-3684	www.guidanceresources.com First-time user: enter Web ID LifeKeys
Medical coverage	Aetna	800-726-4366	www.aetna.com App: "Aetna"
	Kaiser	800-464-4000	https://healthy.kaiserpermanente.org.
Pet Insurance	Nationwide	855-525-1458	https://my.petinsurance.com
Prescription Drug coverage	Express Scripts	866-790-8276	www.express-scripts.com
	Kaiser	800-464-4000	https://healthy.kaiserpermanente.org.
Vacation Accrual	Employee Benefit Services	800-526-7094	Visit the IQVIA company intranet, IQ Email: Benefit.Services@iqvia.com
Vision coverage	EyeMed	866-939-3633	www.eyemed.com/en-us
Impact Program Recognition Awards	IQVIA	n/a	Visit the IQVIA company intranet, IQ, or the IQVIA Global Employee Recognition website: ■ The full site address is https://quintiles.sharepoint.com/sites/IQ/Employee/Policies_Bnfts_Handbooks/IP/Pages/Home.aspx ■ Note that you must be inside the IQVIA firewall for this link to work