Intel Retiree Medical Plan and Sheltered Employee Retirement Medical Account

2026 Plan Document and Summary Plan Description

The information provided in this booklet is the Plan Document and Summary Plan Description (the "SPD") for the Intel Retiree Medical Plan (IRMP) medical and vision plans, and the Sheltered Employee Retirement Medical Account (SERMA). *Intel reserves the right to amend, reduce, suspend, or terminate IRMP, SERMA or any benefit included herein at any time.* Nothing in this booklet can be modified or changed in any way by the oral representation or statements of any party.

ABOUT THIS SUMMARY PLAN DESCRIPTION

This document provides information and describes the general features and benefits offered under IRMP and SERMA. The IRMP medical and vision options are available to eligible Intel Corporation ("Intel") retirees and their eligible dependents. SERMA is a Health Reimbursement Arrangement, subject to IRS rules, that provides credits for eligible Intel retirees to purchase health insurance.

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Section 1 – Overview

1.1 Introduction

The Intel Retiree Medical Plan (IRMP) provides access to medical and vision coverage options, as well as a retiree health reimbursement account, the Sheltered Employee Retirement Medical Account (SERMA), for eligible Intel retirees.

1.2 Medical and Vision Coverage Options

If you retire from Intel as a US employee and have satisfied the eligibility requirements, Intel offers the following medical and vision coverage options:

- IRMP Anthem High Deductible Health Plan (HDHP) – *Non-Medicare eligible*
- IRMP Anthem Medicare Preferred (PPO) 15P – *Medicare eligible*
- IRMP Anthem Medicare Preferred (PPO) 25P – *Medicare eligible*
- VSP Basic Plan
- VSP Plus Plan

1.3 Health Reimbursement Arrangement

The Sheltered Employee Retirement Medical Account (SERMA)

If eligible, SERMA will be established for you, your surviving spouse/domestic partner, and surviving eligible dependent child(ren). SERMA may be used to offset, in full or in part, your IRMP monthly premiums for medical and/or vision coverage until you exhaust your SERMA account. SERMA may also be used to reimburse yourself for eligible non-Intel sponsored health insurance premiums paid for you, your spouse/domestic partner, and your eligible children until you exhaust your SERMA account.

Section 2 – Administrative

2.1 Enrollment Conditions

Submission of your health benefit elections online or through the contact center stipulates that you apply for enrollment (or changes in enrollment) in accordance with the rules for retiree healthcare coverage as outlined in this Summary Plan Description.

Your enrollment in the IRMP and use of SERMA also stipulates that you understand that enrollment is subject to the terms and provisions of this IRMP and SERMA Plan Document and SPD, and that you have read the materials provided to you and are aware of the conditions of enrollment and changes.

In the event of fraud (e.g., submission of fraudulent claims) or intentional misrepresentation of fact (e.g., enrollment of an individual who is not an eligible dependent), coverage may be rescinded.

2.2 Newborns and Mothers Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

2.3 Plan Information

The Employee Retirement Income Security Act of 1974 (ERISA) requires that you be provided with the following benefit plan information. This section provides general and administrative information about all the plans and programs described in this booklet.

Benefit Plan Information

Plan Sponsor or Employer	Intel Corporation Attn: Manager, Health Benefits Services 4500 S Dobson Rd., MS OC2-263 Chandler, AZ 85248
Employer Identification Number	94-1672743
Plan Year Ends	December 31

NOTE: If you need information about the Plan and cannot locate it in this SPD, please call the Intel Health Benefits Center at: 877-GoMyBen (466-9236), 5 a.m. to 5 p.m. Pacific.

How the Plan Is Administered

The plan administrator, or anyone so delegated by the plan administrator, has sole, discretionary authority to grant or deny benefits, to make findings of fact in any benefit determination, and to interpret the terms of the IRMP and SERMA.

To find out which benefits are subject to insurance contracts and service agreements between Intel and the companies, see **Important Benefit Facts** within this section. These companies will make all determinations concerning your claims for a benefit based upon the terms of the contracts and agreement.

Your Plan Administrator

Your plan administrator for the IRMP and SERMA is the Benefits Administrative Committee (BAC). You may contact the plan administrator at:

Intel Corporation
Plan Administrator, BAC
Attn: Health Benefits Services
4500 S Dobson Road
M/S OC2-263
Chandler, AZ 85248
Intel_Health_Welfare_Plan_Administrator@intel.com

How the IRMP and SERMA Are Funded

IRMP Anthem HDHP, vision, and SERMA are self-funded. IRMP is financed by contributions from plan members and Intel Corporation. Retiree contributions are held in trust. Intel makes periodic contributions from its general assets to the trust or may pay plan expenses directly from its general assets. The two IRMP Anthem Medicare Preferred (PPO) options are insured. Members pay the cost of premiums.

The trustee for the retiree medical trust is:

The Bank of New York Mellon
026-0017
135 Santilli Hwy.
Everett, MA 02149

Important Benefit Facts

The following table lists ERISA plan name and number and provides you specific information about how the Plan is funded.

Plan Information	Funding Medium	Who Pays the Cost?
Intel Retiree Medical Plan – Anthem HDHP and VSP Basic or VSP Plus Plan Number: 526	These IRMP options are self-funded. Intel Retiree Health and Welfare Benefit Trust c/o The Bank of New York Mellon 026-0017 135 Santilli Hwy. Everett, MA 02149 Additionally, Intel may pay the cost of these benefits directly through its general assets.	Medical/Vision – You and Intel share the cost of coverage.
Intel Retiree Medical Plan – ▪ Anthem Medicare Preferred (PPO) 15P ▪ Anthem Medicare Preferred (PPO) 25P Plan Number: 526	These IRMP options are Insured.	Intel has contracted with the insurer to administer and pay all eligible claims incurred under the terms of the Plan.
Sheltered Employee Retirement Medical Account (SERMA) Plan Number: 526	This option is self-funded. Intel pays the cost of these benefits directly through its general assets.	Intel

The Intel Health Benefits Center

The Intel Health Benefits Center assists plan members with questions related to IRMP and SERMA. For questions or urgent issues requiring immediate escalation (such as urgent access to care) call the Intel Health Benefits Center at: 877-GoMyBen (466-9236), Monday through Friday 5 a.m. to 5 p.m. Pacific.

Program Phone Numbers and Websites

Supplier	Customer Service
IRMP Anthem HDHP	800-811-2711 www.anthem.com/ca/intelretiree/
IRMP Anthem Medicare Preferred (PPO) 15P **IRMP Anthem Medicare Preferred (PPO) 25P**	800-811-2711 www.anthem.com/ca/intelretiree/
Express Scripts (RX) IRMP HDHP only	800-468-3510 www.express-scripts.com
VSP (Vision)	800-877-7195 www.vsp.com (Locate a VSP doctor or obtain information on how to use your VSP benefits)
Intel Health Benefits Center (SERMA)	877-GoMyBen (466-9236), Monday through Friday 5 a.m. to 5 p.m. Pacific www.intel.com/go/myben

2.4 Employment Retirement Income Security Act (ERISA)

This section provides important information regarding the Employee Retirement Income Security Act of 1974 (ERISA), which describes certain federally mandated rights.

ERISA Rights

As a plan member in the IRMP (medical or vision) or SERMA, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan members shall be entitled to the information, benefits, and rights listed below.

Receive Information about Your Plan and Benefits

You are entitled to the following:

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, 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 US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each plan member with a copy of this summary annual report.

Continuous Group Health Plan Coverage

You are entitled to continued healthcare coverage for your spouse, or dependents if there is a loss of coverage under the plan because of a qualifying event. Your spouse 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 Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Once you have used all your mandatory appeal rights, you have two years from the date of our appeal decision to bring an action in federal court under section 502(a)(1)(B) of ERISA. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file a suit in federal court. If plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file a suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the 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, US Department of Labor, listed in your telephone directory or:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
US 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 Pension and Welfare Benefits Administration.

Contact your Plan Administrator

For questions about the IRMP or SERMA:

Intel Corporation
Plan Administrator, BAC
Attn: Health Benefits Services
4500 S Dobson Road, M/S OC2-263
Chandler, AZ 85248
Intel_Health_Welfare_Plan_Administrator@intel.com

Agent for Service of Legal Process

Intel Corporation – Intel Retiree Medical Plan
c/o C T Corporation System
330 N Brand Blvd, Suite 700
Glendale, CA 91203

2.5 Coverage History Notice

Intel provides you with a notice of coverage history upon retirement or termination of employment if you are enrolled in the Intel Corporation Health & Welfare Plan. The coverage history notice may be needed if you are Medicare eligible and you elect to enroll in Medicare Part D plan. You may need to provide this notice to avoid paying higher monthly premiums if you enroll in Medicare Part D plan later. If you are unable to locate your coverage history notice, please contact the Intel Health Benefits Center at: 877-GoMyBen (466-9236), Monday through Friday, 5 a.m. to 5 p.m. Pacific.

2.6 Unclaimed Funds

As a condition of entitlement to a benefit under the IRMP and SERMA (the "Plan"), participants and beneficiaries must keep the Plan informed of their current mailing address and other relevant contact information. If the Plan is unable to locate any individual otherwise entitled to a benefit payment after exercising reasonable efforts to do so (as determined in the sole discretion of the Plan Administrator), the individual is not entitled to a benefit hereunder and forfeits any rights to any benefits.

In addition, as a further condition to any benefit entitlement under the Plan, any person claiming the benefit must present for payment the check evidencing such benefit within one year of the date of issue. Where a check is not received or is lost, it is the beneficiary's responsibility to notify the Plan Administrator within one year of the date of service and request that a new check be issued. If any check for a benefit payable under the Plan is not presented for payment within one year of the date of issue of the check, the Plan shall have no liability for the benefit payment, the amount of the check shall be deemed a forfeiture. Where it is administratively feasible, forfeited funds revert to the respective Plan trust or bank account.

2.7 When a Third Party is Responsible for your Medical Expenses (Reimbursement and Subrogation)

You, individually and on behalf of your enrolled eligible dependent(s), as a condition of receiving any benefits, agree that if a health plan sponsored by Intel Corporation provides health services that are the result of any act or omission of any other party, the following will apply:

- The plan shall have all the rights that you or your eligible dependent(s) must recover against any person or organization, to the full extent of all the benefits provided by the plan and any other amounts it is entitled to. The plan may, within its sole discretion, take action to preserve its rights, including filing a suit in your name.
- You and your eligible dependent(s) assign to the plan an amount equal to the benefits paid by the plan against any recovery you or your eligible dependent(s) are entitled to receive. The plan is also granted a lien on any such recovery.
- The plan's rights extend to any sources of recovery, including, but not limited to, payments from any uninsured, underinsured, no-fault, or any other motorist or other insurance coverage, or any worker's compensation award or settlement, or any other type of payments from a third party. The plan's right to recover shall also apply to settlements or recoveries with respect to a decedent, minor, and incompetent or disabled person.
- You or your eligible dependent(s) shall not do anything to prejudice the plan's right to recover, including making any settlement that reduces or excludes the benefits provided by the plan. In addition, the plan shall be entitled to recover reasonable attorneys' fees incurred in collecting any recovery proceeds held by you or your family members.
- The plan has the right to recover the full amount of benefits provided without regard to any of the following: any fault on the part of you or your eligible dependent(s); any attorney's fees or costs incurred by or on behalf of you or your eligible dependent(s); or whether or not you or your eligible dependent(s) have been fully compensated for all injuries or conditions.
- Any failure to follow these or other terms of the plan would cause irreparable and substantial harm, for which no adequate remedy at law would exist, and the Plan shall be entitled to invoke such equitable remedies as may be necessary to enforce the terms of the plan, including, but not limited to, specific performance, restitution, the imposition of an equitable lien or constructive trust, as well as injunctive relief.
- Within its sole discretion, the plan has the right to reduce the amount it seeks to recover for the benefits it has paid to you or your eligible dependent(s). Any such decision shall not waive the plan's right to full reimbursement at any other time or grant you or your eligible dependent(s), or any other party, any right to such reduction.

Section 3 – IRMP Eligibility and Enrollment

3.1 IRMP Eligibility

When you retire from Intel in the US, and meet eligibility requirements, you may be able to participate in the IRMP. You must retire as a US employee under the following retirement eligibility definitions:

- Be at least 55 years old and complete at least 15 years of eligible service.
- Be at least 65 years old with no minimum years of service requirement.
- Satisfy the requirements of the Rule of 75, which means the combined total of your age plus your years of service (both calculated in completed, whole years) is equal to or greater than the number 75.

If both you and your spouse/domestic partner are retirees of Intel and are eligible, each of you can be covered individually under IRMP. However, only one of you may enroll your eligible dependent child(ren).

If you return to work at Intel or any of its designated affiliates or subsidiaries after your retirement, both you and your eligible dependents will be eligible to participate in the health plan for active employees. Active employees and their dependents are not eligible to be enrolled in IRMP nor utilize SERMA.

3.2 Eligible Dependent

Your eligible dependents may enroll in the IRMP medical or vision options even if you do not enroll.

Eligible dependents are defined and limited to the following:

- Your legally married spouse as per the laws of any US or foreign jurisdiction has the legal authority to sanction marriages.
- Your eligible domestic partner. Your eligible domestic partner is defined as the person you are in committed relationship, is 18 years or older, not related to you, has resided with you for greater than a year, and shares a mutual obligation of support for the necessities of life.
- Your eligible child, or eligible domestic partner's child, until the child's 26th birthday. An eligible "child" means an individual who is a son, daughter, stepson or stepdaughter, an adopted child, eligible foster child. Custody of a child is not sufficient for eligibility. An adopted child includes an individual who is lawfully placed with you or your domestic partner for legal adoption. An eligible foster child is an individual who is placed with you or your domestic partner by an authorized placement agency or by a judgment, decree, or other order of any court of competent jurisdiction.

  A child's coverage continues to the end of the month of their 26th birthday. The child's coverage is automatically dropped at midnight on the last day of the month of their 26th birthday.

3.3 Surviving Dependent Eligibility

If you die, either as an active employee who was eligible for retirement or as a retiree, your surviving eligible dependents may enroll or continue coverage in IRMP. However, if your surviving spouse remarries or your domestic partner enters a new domestic partner relationship following your death,

he or she will not be able to enroll his or her new spouse/domestic partner in IRMP coverage.

3.4 Special Eligibility Circumstances

Disabled Dependent

If an enrolled and otherwise eligible dependent child is permanently disabled by a physical or mental condition before his or her 26th birthday, the dependent can remain enrolled in the IRMP medical or vision plans regardless of age, if all the following conditions are met:

- You continue to be enrolled in an IRMP plan and cover the dependent under the same plan, unless you qualify for split eligibility.
- The physical or mental condition(s) must result in significant and severe functional limitations that prevent the dependent from supporting him or herself through gainful employment and should be expected to continue indefinitely without significant improvement.
- The dependent must depend on you for primary financial support. Primary financial support is defined as contributing more than one-half toward your dependent's financial support in a calendar year.
- You must provide medical proof of disability (either Social Security Administration documentation or Intel's Disabled Dependent Questionnaire detailing the disability and expected duration of disability). You may be required to provide proof of your dependent's continued disability at reasonable intervals—as requested by Intel.

You will be notified 30 days before your dependent's 26th birthday to submit a completed Disabled Dependent Questionnaire. If you do not respond by submitting the Disabled Dependent Questionnaire before your dependent's 26th birthday, coverage will be terminated at midnight the last day of the month of your dependent's 26th birthday.

If your disabled dependent loses coverage under another health plan, you may enroll your disabled dependent within 30 days after the loss of such coverage, provided the other coverage was in force prior to your dependent's 26th birthday.

You must complete and return a Disabled Dependent Questionnaire within the 30-day timeframe for the coverage to take effect.

Your Responsibility

It is your responsibility to verify that your dependents meet eligibility at the time of enrollment and while they are enrolled in the IRMP as defined by the terms and conditions of the IRMP. If you enroll a dependent and they do not meet the eligibility requirements, or if you do not drop a dependent when they no longer meet eligibility requirements, you will be required to repay Intel for any medical expenses paid for by the IRMP (as far back as administratively possible) by the ineligible dependent, offset by premiums paid toward this ineligible coverage. You will not receive reimbursement for any premiums paid for ineligible dependents.

If your covered dependent loses eligibility under the IRMP, he or she may be eligible for COBRA coverage. Contact the Intel Health Benefits Center within 30 days of the event that results in loss of coverage to make applicable coverage changes.

3.5 Split Enrollment for IRMP Medical Coverage

If you are Medicare eligible and your dependent is not, or vice-versa, you may enroll in the IRMP medical coverage as follows:

	Your Plan Options	Eligible Dependent Plan Options
If ***you are*** Medicare eligible and your ***eligible dependent is not***	▪ IRMP Anthem Medicare Preferred (PPO) 15P or IRMP Anthem Medicare Preferred (PPO) 25P	▪ IRMP Anthem HDHP
If ***you are not*** Medicare eligible and ***your eligible dependent is***	▪ IRMP Anthem HDHP	▪ IRMP Anthem Medicare Preferred (PPO) 15P or IRMP Anthem Medicare Preferred (PPO) 25P

3.6 Enrollment

To enroll in the IRMP medical or vision options, contact the Intel Health Benefits Center within 30 days of one of the following:

- Your retirement date,
- The date your Intel Group Health Plan COBRA coverage ends, or
- An applicable change-in-status event date (see "Change-in-Status Events" in the "Changing Your Coverage Elections" section below).

If you do not enroll within 30 days of one of the events listed above, your next opportunity to enroll will be during the IRMP Annual Enrollment period (typically in October or November) with coverage effective on January 1 of the following year.

You have two ways to make your IRMP enrollment elections:

- **Phone:** Intel Health Benefits Center is available to take your call at: 877-GoMyBen (466-9236), Monday through Friday, from 5 a.m. to 5 p.m. Pacific.
- **Website:** www.intel.com/go/myben, available 24 hours per day, seven days per week.

3.7 Changing Your Coverage Elections

Under the IRMP, you can add or drop medical/vision coverage for yourself or your eligible dependent(s) when any of the following occur:

- Annual Enrollment.
- If you experience a change-in-status event (see below).
- When you deplete your SERMA account.

Change-in-Status Events

The following are the change-in-status events under which benefit elections can be changed mid-year:

- Marriage, divorce, legal separation, or annulment.
- Enter into or dissolve a domestic partnership.

- Death of your eligible dependent.
- You, your spouse/domestic partner, or child gains or losses other healthcare coverage, including COBRA coverage.
- You or your eligible dependent(s) become entitled to Medicare or Medicaid or lose Medicare or Medicaid entitlement.
- You or your eligible dependents(s) enroll in Medicare Part A and/or Part B.

All election changes must be consistent with the change-in-status event. If you, your spouse/domestic partner or eligible child experience a change-in-status event, you must enroll or drop coverage within 30 days of the event date. Coverage becomes effective on the date of the event. If you wait longer than 30 days, you will not be allowed to make an election change until Annual Enrollment or a subsequent change-in-status event.

When you Become Medicare Eligible

If you and/or your eligible dependent(s) are enrolled in IRMP medical coverage and become Medicare eligible **due to turning age 65**, you will receive notice from the Intel Health Benefits Center informing you of your IRMP options.

If you and/or your eligible dependent(s) are enrolled in IRMP medical coverage and become Medicare eligible **prior to turning age 65**, you must notify the Intel Health Benefits Center so that you can review your IRMP coverage options.

If you and/or your eligible dependent(s) are not enrolled in IRMP medical coverage and become Medicare eligible/enrolled, this is considered a qualified change-in-status event that allows you to enroll in IRMP.

3.8 When Benefits Begin

IRMP Anthem HDHP and Vision

IRMP coverage becomes effective on the earliest of the following dates:

- January 1 of the year immediately following an election during Annual Enrollment.
- The first of the month following your retirement date, if you enroll within 30 days of your retirement date.*
- The day after your COBRA coverage sponsored by Intel ends, if you enroll within 30 days of your COBRA coverage end date.*
- The date of a change-in-status event, if you enroll within 30 days of your change-in-status event.*

* Effective date will be impacted if Retiree is eligible and enrolls in the Anthem Medicare Preferred (PPO). The Anthem Medicare Preferred (PPO) coverage begin date is determined by the date of enrollment. Therefore, all eligible dependents coverage begin date will be impacted. See section below regarding Anthem Medicare Preferred (PPO) coverage effective date for additional details.

Anthem Medicare Preferred (PPO) Coverage Effective Date

- The effective date of coverage for the Anthem Medicare Preferred (PPO) options is the first of the month following the date you complete your enrollment election and are approved for enrollment by Medicare. Medicare must approve all enrollment submissions. Anthem will review your enrollment request and then send to Medicare to confirm eligibility. You will receive an enrollment confirmation letter upon Medicare acceptance.

WARNING: Medicare allows prospective enrollment only; it does not allow retro enrollment into Anthem Medicare Preferred (PPO). Therefore, your coverage effective date will be based on the timing of when you enroll and are approved by Medicare.

If you or one of your dependents is Medicare eligible, here are a few more things to consider:

- To ensure NO GAP in coverage, complete your IRMP Anthem Medicare (PPO) election PRIOR to the last day of the month in which your ACTIVE or COBRA coverage ends, or the first of the month in which you turn age 65.
- If you are currently enrolled in the IRMP HDHP, your coverage will end the last day of the month prior to your 65th birthday.
- Your coverage effective date for the Anthem Medicare Preferred (PPO) is dependent on the date you enroll and the date you are approved by Medicare. Per Medicare requirements, your coverage effective date is the first of the month following your enrollment date. For example, if you complete your election on March 20, and you are approved by Medicare, your coverage will be effective April 1.
- You may elect COBRA, if eligible, to cover the gap period. Note, it is your responsibility to cancel your COBRA to ensure you do not have double coverage based on your IRMP medical effective date.

When IRMP Medical and Vision Benefits End

IRMP benefits cease at midnight Pacific, on the earliest of the following dates:

- December 31 of the year in which you elect to discontinue your coverage during Annual Enrollment.
- The last day of the month of a change-in-status event.
- The date Intel terminates your/your dependent's coverage for nonpayment of required premiums.
- The date Intel terminates any benefit program or specific coverages. Plan termination will not affect any benefits payable prior to the termination date.
- The date Medicare/IRMP Anthem Medicare Preferred (PPO) terminates coverage.
- The date of your/your dependent's death for the individual who has died.
- The date you return to work at Intel or begin employment at an Intel subsidiary or affiliate.
- For your dependent, the last day of the month your dependent(s) no longer meets the eligibility definition for the plan.
- The last day of the month that you drop your coverage in the IRMP.

If you return to work at Intel and then retire again from Intel, you must enroll in the IRMP within 30 days of re-retirement.

For a specific plan information of the Anthem Medicare Preferred (PPO), go to www.anthem.com/ca/intelretiree/ and review the Evidence of Coverage Guide or call 800-811-2711.

3.9 Payment for Coverage

Premiums must be paid to ensure IRMP coverage is continued. If premiums are not received within 30 days following the first of the month in which the premium is due, coverage will be canceled effective midnight on the last day of the fully paid month (or the date of initial enrollment if payment was never made).

Medicare Part A and Part B premiums must also continue to be paid to ensure continued coverage in the IRMP Medicare Preferred (PPO) option. For a specific plan information of the Anthem Medicare Preferred (PPO), go to www.anthem.com/ca/intelretiree/ and review the Evidence of Coverage Guide or call 800-811-2711.

If coverage is canceled for this reason, you and your eligible dependent(s) may not re-enroll in the IRMP until the next Annual Enrollment period (typically in October or November), or until you experience a change-in-status event (other than for loss of coverage associated with nonpayment of health premiums). For more information, refer to the Enrollment section.

IRMP premium rates may be adjusted annually due to changes in actual claims and administrative fees, claim utilization, benefits coverage levels, and healthcare cost trends.

Section 4 – IRMP Anthem HDHP - Non-Medicare Medical (typically under age 65)

4.1 Overview

If you retire from Intel and meet the eligibility requirements for the IRMP before you or your eligible dependent(s) are eligible for Medicare (in most cases prior to age 65), each of you will be eligible to enroll in the IRMP Anthem High Deductible Health Plan (HDHP).

Coverage under IRMP Anthem HDHP includes medical, mental health, and prescription drug benefits. It does not include routine vision or dental coverage.

You pay the entire cost of covering yourself and your eligible dependent(s), if enrolled. The IRMP Anthem HDHP monthly premiums are available on the My Health Benefits website at www.intel.com/go/myben or by calling the Intel Health Benefits Center at 877-GoMyBen (466-9236).

For specific information on the plan, please refer to How the IRMP Anthem HDHP Works section.

4.2 Split Family Enrollment

If you are Medicare eligible and your dependent is not, or vice-versa, the Medicare eligible person can enroll in an IRMP Anthem Medicare Preferred (PPO) option and the non-Medicare eligible person can enroll in the IRMP Anthem HDHP.

4.3 How the IRMP Anthem HDHP Works

If you are an IRMP Anthem HDHP member, you will receive covered benefits for preventive care as well as treatment that is deemed medically necessary. Under the IRMP Anthem HDHP, you may receive services from in-network or out-of-network providers. Covered benefits begin after you meet your plan deductible. After the deductible is satisfied, covered services will be paid at a percentage of allowable cost for in-network or a lower percentage of allowable cost for out-of-network.

Deductibles

A deductible is the dollar amount an individual or family must pay before reimbursements from the medical plan begin.

Coinsurance

The coinsurance is the specific percentage of an allowed expense that is paid by the member once the deductible has been satisfied. An allowed expense is the contracted amount for network providers and the Maximum Allowable Amount (MAA) for out-of-network providers. See the Benefits Chart section for details.

IMPORTANT: If you use out-of-network services, you may be responsible for paying the difference between the actual billed amount for out-of-network services and the allowed expense (e.g., MAA) in addition to the coinsurance amount. The amount you pay over the maximum allowed expense will not be included in your out-of-pocket maximum.

In-Network and Out-of-Network Cost Comparison Example:

Example:	In-Network Provider	Example:	Out-of-Network Provider
Billed Amount	$150	Billed Amount	$150
Allowed expense based on contract amount	$100	Allowed expense based on MAA	$100
Difference: Provider discount	$50	Difference: Patient Responsibility	$50
Coinsurance (10% of $100, after deductible is met)	$10	Coinsurance (40% of $100, after deductible is met)	$40
Total Patient Responsibility	$10	Total Patient Responsibility	$90 (Coinsurance plus difference between allowable and billed amount)

4.4 About the Anthem Provider Network

Anthem is the claims administrator for the IRMP Anthem HDHP. Members enrolled in the IRMP Anthem HDHP have access to the Anthem provider network.

In-Network Benefit

To receive in-network benefits, you and/or your eligible dependent(s) must use Anthem network providers. Anthem network providers include an entity that has directly or indirectly contracted with Anthem to arrange, through contracts with providers of services and/or supplies, for the provision of covered services and/or supplies. You receive the highest level of coverage at the lowest cost by receiving your care from any of the providers or facilities in the Anthem network. You can receive care from any of the providers or facilities in the Anthem network without a referral, although some services may require authorization by the health plan (please see Prior Authorization Requirements section). **It is your responsibility to verify the provider you select is an in-network provider.** A provider directory is available from Anthem at 800-811-2711 or at www.anthem.com/ca/intelretiree/.

Primary Care Physician (PCP)

You are encouraged to select a Primary Care Physician (PCP). A PCP or Personal Doctor gives you a valuable resource and a personal health advocate. PCPs maintain the physician-patient relationship with members who select them, and aid members in coordinating medical and hospital services and the overall healthcare needs of members.

If you choose a PCP, it is important to establish a relationship with your new PCP as soon as possible. Your PCP will:

- Manage all your routine medical needs.
- Refer you to specialists, if needed.
- Refer you for any laboratory or hospital services you need.

If you need surgery or hospitalization, your PCP coordinates the hospital or surgical pre-certification requirements, as described in the Hospital Preadmission Certification and Continued Stay Review section.

Obtaining In-Network Benefits Away from Home

When you or covered family members are away from home, you still may take advantage of the lower in-network fees. The Anthem network includes participating providers nationwide. Anthem Concierge can help you locate participating doctors and facilities wherever you are. For assistance, call 800-811-2711.

4.5 Out-of-Network Benefits

You will receive benefits if you choose to seek services through a non-Anthem network provider, but services are covered at the lower out-of-network benefit level. After the deductible is satisfied and you submit a claim form, covered services will be reimbursed at MAA.

Covered services at the out-of-network level are not identical to those at the in-network level. Refer to the Benefits Chart and Covered Medical Services sections for more detailed benefit information.

You must submit your request for reimbursement for out-of-network claims within one year of service or you forfeit your benefit.

4.6 Out-of-Pocket Maximum

Whether you receive in-network benefits or out-of-network benefits, once you have paid a certain amount of covered medical expenses in any given year, the plan will pay most covered benefits at 100 percent. The amount you pay to reach this level of coverage is called the out-of-pocket maximum.

Refer to the Benefits Chart and Covered Medical Services sections for more detailed benefit information.

Your prescription coinsurance applies to your out-of-pocket maximum. For your convenience, Express Scripts and Anthem will coordinate your prescription drug expenses and help manage your out-of-pocket maximum. For exclusions to the out-of-pocket maximum calculations, see table below.

4.7 Covered Services Exclusions to Out-of-Pocket Maximum Calculations

	In-Network Benefits	Out-of-Network Benefits
Charges above the MAA and charges that are otherwise excluded under the plan	X	X

4.8 Maximum Lifetime Benefit

There is no lifetime limit on the dollar value of in-network benefits.

4.9 IRMP Anthem HDHP Benefits Chart

The following charts summarize information about the IRMP Anthem HDHP plan benefits. It provides an abbreviated comparison between in-network and out-of-network.

Plan Provisions	IRMP Anthem HDHP In-Network	IRMP Anthem HDHP Out-of-Network
Deductible Wherever coinsurance percentages are payable by you, you must first meet the deductible.	▪ $2,050 Individual ▪ $4,050 Individual + Child(ren) ▪ $5,050 Individual + Spouse/Domestic Partner/Family ▪ Combined in-network and out-of-network deductible	
Out-of-Pocket (OOP) Maximum	▪ $3,050 Individual ▪ $6,050 Individual +Child(ren) ▪ $7,550 Individual + Spouse/Family ▪ Combined in-network and out-of-network coinsurance and deductibles apply towards OOP maximum	
Pre-existing Condition Limitation	▪ Does not apply	▪ Does not apply
Medical Services Lifetime Maximum Per Member	▪ Unlimited on the dollar value of benefits	▪ Unlimited on the dollar value of benefits
In-Hospital Preadmission Certification Continued Stay Review and Surgical Precertification	▪ Handled by Anthem provider	▪ Covered member must ensure authorization is obtained from Anthem
Member Cost Share	▪ Applicable coinsurance after deductible has been met unless otherwise noted	▪ Applicable coinsurance after deductible has been met, unless otherwise noted, and subject to maximum allowed amount (MAA)
Primary Care Physician: Office Visit Services (including medical eye care via ophthalmologist), Adult Medical Care, Injections	10%	40%
Preventive Care Services: Preventative Care Routine Immunizations and Injections	100% covered	40%
Specialist Physician Services, Referral Physician Services, Allergy Testing and Treatment	10%	40%

Plan Provisions	IRMP Anthem HDHP In-Network	IRMP Anthem HDHP Out-of-Network
Acupuncture and Naturopathic Services by a licensed practitioner	▪ 10% ▪ Acupuncture limited to 30 visits per calendar year; combined in- and out-of-network	▪ 40% ▪ Acupuncture limited to 30 visits per calendar year; combined in- and out-of- network
Chiropractic Services	▪ 10% ▪ Limited to 30 visits per calendar year; combined in- and out-of-network	▪ 40% ▪ Limited to 30 visit per calendar year; combined in- and out-of-network
Second Surgical Opinion	▪ No charge (after deductible)	▪ No charge (after deductible) subject to maximum allowed amount
Outpatient Laboratory and X-ray Services (including preadmission testing) in Physician's Office or in Dedicated Lab/X-ray Facility	10%	40%
Inpatient Hospital Services: Semiprivate Room and Board Inpatient Hospital Services, Operating and Recovery Room, Oxygen, Laboratory and X-ray Services, Drugs, Medications, Special Care Unit, Operating/Room Oxygen, Internal Prosthetics, Anesthesia and Respiratory/Inhalation Therapy, Hemodialysis, Radiation Therapy and Chemotherapy, Rehab Services, Physician/Surgeon Charges **NOTE:** *Preadmission Certification is required*	10%	40%
Outpatient Hospital/Surgical Services, Physician/Surgeon Charges, Operating and Recovery Room, Anesthesia and Respiratory/Inhalation Therapy, Hemodialysis, Radiation Therapy and Chemotherapy, Laboratory and X-ray Services **NOTE:** *Precertification may be required for some services.*	10%	40%

Plan Provisions	IRMP Anthem HDHP In-Network	IRMP Anthem HDHP Out-of-Network
Hospital Emergency Room	10%	10%
Urgent Care Facility	10%	10%
Ambulance	10% emergent 40% non-emergent	10% emergent 40% non-emergent
Services for Infertility: Office Visit and Diagnosis	10%	40%
Outpatient Physical, Occupational, and Speech Therapy (Short Term Rehabilitative Therapy)	10%	40%
Pulmonary Therapy	10%	40%
Dialysis Treatment	10%	40%
Cardiac Rehabilitation Outpatient Therapy	10%	40%
Men's Family Planning Services: Office Visit, Vasectomy	10%	40%
Women's Family Planning Services: Office Visits Depo-Provera	10%	40%
Hearing Services: Hearing Examination, Hearing Aid	10%	40%
Vision Training/Therapy	10%	40%
Nutritional Counseling	10%	40%
TMJ Services	10%	40%
Transplant Services	10%	40%
Travel and Living Expenses	Combined in-network and out-of-network benefit of $10,000 lifetime maximum for expenses incurred in conjunction with authorized medical services and/or a transplant; prior authorization is required.	
Weight Reduction Services	10%	40%

Plan Provisions	IRMP Anthem HDHP In-Network	IRMP Anthem HDHP Out-of-Network
Tobacco Cessation Services	10%	40%
Orthotics	10%	40%
Durable Medical Equipment **NOTE:** *Prior Authorization may be required*	10%	40%
	▪ Wigs 100% covered after deductible/limited to $3,000 per year ▪ Combined in- and out-of-network	
External Prosthetic Appliances	10%	40%
Other Healthcare Facilities (e.g., skilled nursing facilities (SNF), inpatient physical rehabilitation facility) **NOTE:** *Preadmission Certification is required*	10%	▪ 40% ▪ SNF Maximum benefit of 100 days per calendar year
Home Healthcare	10%	40%
Hospice	10%	40%

Mental Health Chart

Plan Provisions	IRMP Anthem HDHP In-Network	IRMP Anthem HDHP Out-of-Network
Deductible	Combined with Medical deductible	Combined with Medical deductible
Mental Health Inpatient or alternative care** **NOTE:** *Preadmission Certification is required.*	10%	40%
Mental Health Outpatient	10%	40%
** Inpatient = confinement in a 24-hour supervised, skilled nursing setting. Alternate care = less intensive level of service than inpatient that may include partial hospitalization, day hospital treatment, residential treatment centers, and intensive outpatient programs.		

Chemical Dependency Chart

Plan Provisions	IRMP Anthem HDHP In-Network	IRMP Anthem HDHP Out-of-Network
Chemical Dependency Inpatient or alternate care** **NOTE:** *Preadmission Certification is required.*	10%	40%
Chemical Dependency Outpatient	10%	40%
** Inpatient = confinement in a 24-hour supervised, skilled nursing setting. Alternate care = less intensive level of service than inpatient that may include partial hospitalization, day hospital treatment, residential treatment centers, and intensive outpatient programs.		

4.10 Prescription Drugs Chart

Plan Provisions	IRMP Anthem HDHP	
	Retail (34-day supply)	Mail/Walgreens/Costco (90-day supply)
Generic	10%	10%
Preferred Brand		
Non-Preferred Brand		
OUT-OF-NETWORK – If you use a non-network pharmacy, you will pay the appropriate retail copay/coinsurance plus any amount above the allowable prescription drug cost.		

Contact Express Scripts for more information about prescription drug benefits. Prescription drug benefits are provided under an agreement with Express Scripts.

Prescription Drug Cost Examples

Examples prior to meeting deductible compared to after meeting deductible.

Example Drug Name and Strength	Your Cost	Retail Pharmacy (Up to 34-day supply)	Costco/Walgreens/Mail (90-day supply)
Humilog 10 ml vial (Brand Formulary)	Before deductible is met	$253.82	$761.47
	After deductible is met	$25.38	$76.14
Atorvastatin 80 mg (Generic)	Before deductible is met	$11.44	$30.29
	After deductible is met	$1.14	$3.02

Formulary Drug List

A formulary is a list of brand-name and generic medications that are preferred by your plan based on efficacy, safety, and cost. Express Scripts uses an independent group of individuals, including pharmacists, called the Pharmacy and Therapeutics Committee (P&T), which reviews this list to help ensure that it includes medications for most medical conditions that are treated on an outpatient basis. With your plan's prescription drug benefit program, you will have access to many commonly prescribed generic and brand-name drugs. You will usually pay a lower copayment for medications on a formulary.

Medications can be added to or removed from the formulary, and this typically occurs on a quarterly basis after a regularly scheduled meeting of the independent Pharmacy and Therapeutics Committee (P&T). Updates needed to address situations such as a new drug coming to the market or a drug recall from the manufacturer may occur more often.

When a drug is deleted from the formulary list, it becomes a non-preferred drug. Express Scripts notifies patients when certain drugs are removed from the formulary.

To get the most up-to-date formulary information, including possible preferred alternatives for a drug that is non-preferred, please call Express Scripts Member Services at: 800-899-2713 or visit Express Scripts' website at www.express-scripts.com. If you are a first-time visitor to www.express-scripts.com, please take a moment to register using your member ID number and a recent retail or **Express Scripts Pharmacy** prescription number.

How to Request Preferred Drugs on the Formulary Drug List

To take advantage of lower cost preferred drugs, follow these steps when discussing your treatment with your physician:

- Present the Formulary Drug List to your physician on your next visit.
- Ask if your medication can be prescribed from the list.

Your Express Scripts Card is Important

If you lose your Express Scripts card or if it is stolen, you need to report the loss to Express Scripts right away. Express Scripts does not automatically issue additional cards when a new spouse or domestic partner is added to your coverage. Additional cards can be ordered by calling Express Scripts or by downloading the Express Scripts mobile app (compatible with most mobile devices), which has a virtual ID card that can be used at any participating pharmacy.

If you fill a prescription at an out-of-network pharmacy or do not have your Express Scripts card with you when you have a prescription filled, you must pay the full cost of the prescription and submit a reimbursement form to Express Scripts within one year of the date the prescription was filled.

Express Scripts will reimburse you the network pharmacy discounted price for the prescription, less your coinsurance (after deductible). Because the amount charged can exceed the network pharmacy discounted price, the cost to you could be significantly higher than if you had used your prescription drug card at a pharmacy in the Express Scripts network.

For your convenience, this benefit is coordinated directly between Express Scripts and Anthem.

How the IRMP Anthem HDHP Prescription Drug Benefit Works

IRMP Anthem HDHP Prescription Drug Benefit: Applicable coinsurance after deductible has been met.			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Retail Pharmacy (Up to 34-day supply)	10%	10%	10%
Express Scripts Pharmacy (Mail Order)/Walgreens/ Costco (Up to 90-day supply)	10%	10% Coinsurance after deductible	10%

Express Scripts Pharmacy/Mail Order

Express Scripts Pharmacy is a mail-order pharmacy service. You may receive up to a 90-day supply of your medication delivered to your home.

Express Scripts Pharmacy provides 24/7 access to benefit specialists who can answer your prescription medication questions and specialist pharmacist who can answer questions you have about your treatment, help you manage your medications, and support your doctors in helping make sure that all your medications work safely for you. Specialist pharmacists have extensive training in the medications used to treat specific chronic conditions.

For help setting up or mailing Express Scripts Pharmacy mail order, please go to www.express-scripts.com or call 800-899-2713.

Dispensing Limitation

If you request a brand drug when a generic is available and "Dispense as Written" (DAW) is not specified by your doctor, you will be responsible for paying the generic copayment plus the difference in cost between the brand name and the generic medication.

Quantity Limits

Certain prescriptions of drug therapies are only covered in certain quantities. These quantity limits are based on approved FDA prescribing guidelines and safety information, clinical guidelines, and uses that are considered reasonable, safe, and effective. Drugs covered under the Plan are routinely reviewed to ensure that their drug limits meet these clinically appropriate guidelines. The quantity limits currently in place under the Plan include, but are not limited to, medications for migraine, impotence, and emergency contraceptives.

If, after clinical review, your physician feels it is necessary for you to have a quantity greater than that allowed under the Plan's quantity limit guidelines, please have your physician contact Express Scripts at: 800-899-2713 to request a prior authorization review.

Prior Authorization Review Program

Certain prescriptions or drug therapies are only covered for specific conditions and/or diagnoses, or under specific circumstances. Such prescriptions or drug therapies must be prior authorized by Express Scripts to ensure that they meet these specific criteria before they are approved for payment. This prior authorization criterion is a separate condition for the coverage of prescriptions or drug therapies – which must otherwise meet all other applicable terms and conditions for coverage under the Plan. Should you present a prescription at an Express Scripts network pharmacy or through Express Scripts Pharmacy and the prescription requires authorization, the pharmacist will receive a message from Express Scripts to have your physician contact Express Scripts directly. This will initiate the prior authorization process. Typically, the authorization process is completed within 24 hours, but in some cases may take up to three days. Once your prescription is authorized by Express Scripts, then the authorization is valid for up to 12 months for most drugs.

The drugs that currently require prior authorization include but are not limited to medications for erectile dysfunction, weight loss, growth hormone deficiencies, and narcolepsy along with attention deficit disorder and acne medications for members over certain ages.

If you have a question regarding an Express Scripts drug authorization request, call: 800-899-2713; select the Express Scripts option to speak directly with an Express Scripts representative.

Drug Utilization Review Program

The Drug Utilization Review Program will detect if you or your enrolled dependents have had other prescriptions filled that, if taken with the newer prescription, could present a potential health risk. If a problem is detected, Express Scripts transmits the message to the pharmacist. This program is initiated automatically when you use a network pharmacy or Express Scripts by Mail and there is no additional cost to you for this service.

Preferred Drug Step Therapy

Coverage under the Preferred Drug Step Therapy Program requires that a member try a generic drug or lower-cost brand-name alternative drug before higher cost non-preferred drugs, unless special circumstances exist. Express Scripts' Pharmacy and Therapeutics Committee has reviewed and approved the clinical basis for the Preferred Drug Step Therapy Program.

Coverage of Specialty Medications

Most specialty medications (prescriptions typically requiring injection or special handling) will only be covered when ordered through Express Scripts' specialty care pharmacy, Accredo Health Group. If you use a pharmacy other than Accredo to purchase specialty medications, you will be responsible for their full cost.

Accredo deals exclusively with providing medications to treat complex conditions. The high-quality services of Accredo include:

- Toll-free access to specially trained pharmacists 24 hours a day, seven days a week.
- Personalized counseling from our dedicated team of registered nurses and pharmacists.
- Expedited, scheduled delivery of your medications at no extra charge.
- Refill reminder calls.

- Free supplies to administer your medication, such as needles and syringes.

To set up a prescription with Accredo, call toll-free at: 800-501-7260 between 8 a.m. and 11 p.m. Eastern, Monday through Friday.

4.11 Elective Surgery

Elective surgical procedures are procedures that are not considered emergencies in nature and may be delayed without undue risk.

- **In-Network**: If you need elective surgery, your provider will contact Anthem to obtain pre-certification approval.
- **Out-of-Network:** You are responsible for ensuring that Anthem is contacted, and that approval is obtained before any elective surgery is performed. Failure to do so will result in either denied benefits or reduced benefits and penalties.

4.12 What is an Emergency?

An emergency is typically defined as a sudden illness, or any condition that, in the judgment of a reasonable person, if not treated immediately, may result in serious long-term medical complications, loss of life, or permanent impairment to bodily functions.

Emergency services are required in life-threatening emergencies when symptoms are severe and occur suddenly and unexpectedly, and immediate medical attention is necessary. Included are conditions that produce the following:

- Loss of consciousness or seizure
- Uncontrolled bleeding
- Severe shortness of breath
- Chest pain
- Broken bones
- Sudden onset of paralysis or slurred speech
- Accidents

What to do in an Emergency

All life-threatening emergencies will be covered at the in-network benefit level if certain steps are followed, as described below. If you have a medical emergency, you should seek care immediately:

- **In-Network:** Whenever possible, emergency services must be obtained through your provider. If you are not able to contact your provider before seeking care, you, the attending physician, or a family member must contact Anthem within 48 hours of receiving emergency care for the service to be covered at the in-network benefit level. Emergency services obtained outside the Anthem Network will be considered for in-network coverage if Anthem, on review, determines that treatment without prior approval of Anthem was medically necessary in order to prevent serious medical complications, permanent disability, or death.

NOTE: Continued follow-up treatment after an emergency service will be covered in-network only if it is rendered or coordinated by your provider or the health plan medical director (or designee).

- Out-of-Network: For emergency hospital admissions, you must contact Anthem at 800-811-2711 within 48 hours to receive the maximum level of benefit provided for out-of-network benefits or Medicare eligible benefits.

If you do not contact Anthem, your submitted claim will be reviewed to determine if the emergency hospital visit was medically necessary. If so, you will be responsible for any applicable deductible and coinsurance amount. If the emergency hospital visit is determined not to be medically necessary, that service will not be covered.

Emergency Hospital Admission

In the case of emergency inpatient admission, Preadmission Certification is not required. However, you must notify Anthem within 48 hours of the emergency hospital admission to receive the maximum reimbursement.

If you do not contact Anthem within 48 hours after an emergency hospital admission, you will not be considered pre-certified for any surgical procedure or hospital admission and will be subject to either denied benefits or reduced benefits. Your submitted claim will be reviewed to determine if the services, hospital admission, and length of stay were medically necessary. If determined to be medically necessary, your benefits will be paid at the out-of-network level.

4.13 Hospital Preadmission Certification and Continued Stay Review

- **In-Network:** If you need hospitalization, your network provider will obtain authorization from Anthem for network inpatient care.
- **Out-of-Network:** You are responsible for seeing that Preadmission Certification and Continued Stay Review requirements are fulfilled. Failure to do so will result in a possible reduction of benefits in addition to the required deductibles and coinsurance.

Preadmission Certification and Continued Stay Review refer to the process used to certify the medical necessity and length of any hospital confinement (emergency and non-emergency). Preadmission Certification and Continued Stay Review are performed through a hospital utilization review program administered by Anthem for medical hospital admissions and mental health or substance abuse treatment hospitalizations.

4.14 Prior Authorization Requirements

Prior Authorization is required for the services listed below. Requirements are subject to change. Please contact Anthem directly to verify current pre-certification rules.

Inpatient Care - Institutional

- Elective Admissions
- Emergency Admissions (require notification within 24 hours of admission)
- OB Related Admissions (complications, excludes childbirth)
- Organ and Tissue Transplant
- Bone Marrow and Stem Cell Transplant
- Stem cell/Bone Marrow transplant (with or without myeloablative therapy)

- Bariatric Procedures
- Newborn Stays Beyond Mother
- Skilled Nursing Facility (SNF)
- Rehabilitation Facility Admissions

Mental Health

- Inpatient BH/SA (including residential care)
- Partial Hospitalization
- Intensive Outpatient Therapy
- Applied Behavioral Analysis (ABA)

Other

- Ambulance (non-emergency transport)
- Durable Medical Equipment (contact Anthem for details)
- Private Duty Nursing
- Home Healthcare
- Home Infusion Therapy
- Oral, Pharyngeal and Maxillofacial Surgical Treatment for Obstructive Sleep Apnea or Snoring
- Surgical Treatment of Obstructive Sleep Apnea and Snoring
- Advanced radiology—CT/MRI/MRA/MRS/PET and Cardiology
- MSK (musculoskeletal)
- Travel and living expenses
- Wigs

Outpatient Hospital Services

- Bariatric Procedures (weight reduction)
- Bone Marrow and Stem Cell Transplant
- Stem cell/Bone Marrow transplant (with or without myeloablative therapy)
- Donor Leukocyte Infusion

Surgery Benefits

- Blepharoplasty
- Chin Implant, Mentoplasty, Osteoplasty Mandible
- Insertion/Injection of Prosthetic Material Collagen Implants
- Panniculectomy and Lipectomy/Diatasis Recti Repair
- Rhinoplasty

4.15 Medical Case Management

If you or your eligible spouse/domestic partner or dependent experience catastrophic injuries, conditions requiring long-term hospitalizations, or other serious conditions, you may be offered a service called case management.

Case management is a service that provides assistance to individuals with treatment needs that extend beyond the acute care setting. The goal of case management is to ensure that patients receive appropriate care in the most effective setting possible, whether at home, as an outpatient, or as an inpatient in a hospital or specialized facility.

If you and your attending physician consent, the case manager appointed by the case management company will help coordinate services. You or the case manager can terminate the case management relationship at any time.

4.16 24-Hour Information Line

Helpful, reliable health information is available from any phone, anywhere in the US. You can speak with a registered nurse any hour of the day or night. You can also choose from hundreds of recorded programs from the Health Information Library.

4.17 Second and Third Surgical Opinions

Based on medical information, your medical coverage may require a second surgical opinion. If it is not required, you can still request a second opinion, which will be covered at 100%, after deductible, if provided by a network provider. A third opinion is available when covered and the first and second opinions differ. The second and third opinion must be obtained from one of three physicians or surgeons recommended by your medical coverage.

If your medical coverage requires a second or third opinion, and you do not obtain the required opinion, you will not be pre-certified for the surgical procedure and will be subject to either denied or reduced benefits.

If you do not obtain the requested second or third opinion, your submitted claim will be reviewed to determine if the medical procedures, hospital admission, and length of stay were medically necessary. If the medical services, hospital admission, and length of stay are determined not to be medically necessary, those services will not be covered.

4.18 Travel

Travel and Lodging Expenses

Reasonable travel and lodging expenses for patients and an adult companion are covered for:

- Organ transplants
- In-network services if the covered service is deemed appropriate and member is unable to obtain services from an in-network (INN) provider within 50 miles from patient's home.
- Abortion or transgender services when such treatment is not permitted in a member's home state.

Travel and lodging expenses will not be covered for out-of-network care unless the care is directed by the medical plan medical director (or designee).

Travel and lodging expenses for organ transplant are subject to a lifetime maximum of $10,000; amounts above the lifetime maximum may be covered if deemed appropriate and approved by your claims administrator.

Travel and lodging expenses for in-network services not available within a reasonable distance from a patient's home, and abortion or transgender services when not permitted in a member's home state are subject to a $3,000 per occurrence limit.

Travel and lodging expenses require prior authorization; contact your health plan.

Benefit payments related to health travel and lodging expenses that is not for medical care, or payments in excess of medical care, as defined under Internal Revenue Code § 213(d) are generally subject to income tax, income tax withholding, and employment tax, and must be reported on your

Form W-2 in Boxes 1, 3, and 5. For a complete list of IRS qualification requirements and applicable taxes, visit irs.gov.

Worldwide Coverage for Emergency and Urgent Care

You are eligible for in-network benefits when seeking care for an emergency anywhere in the world. You will need to pay for the care and submit a copy of the bill and claim form to Anthem to receive reimbursement. Also check with Anthem on emergency care notification requirements.

- **International Personal Travel In-network coverage:** Not available outside of the US (except in the event of an emergency).
- **Out-of-network coverage:** Coverage is available wherever you are when you seek care.
- **Emergency care:** You are eligible for in-network benefits when seeking care for an emergency anywhere in the world. You will need to pay for the care and submit a copy of the bill and claim form to the claims administrator to receive reimbursement. Also check with your specific medical plan on emergency care notification requirements.

4.19 Health Savings Account*

A Health Savings Account (HSA) is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a High Deductible Health Plan (HDHP). Eligibility requirements apply. If you are eligible, you can open an HSA with the HSA administrator of your choice. Intel has partnered with Fidelity as an HSA administrator for your convenience. If you choose Fidelity for your HSA, Intel will cover the Fidelity HSA monthly administration fees while you or your eligible surviving spouse/domestic partner are enrolled in the IRMP Anthem HDHP. For more information, call Fidelity at 888-401-7377.

* The HSA is not an Intel-sponsored benefit or an ERISA welfare benefit plan. Some state's tax laws do not conform to federal HSA tax rules; Please consult with your tax advisor for complete and current information on HSAs.

Section 5 – IRMP Anthem HDHP Covered Medical Services

5.1 Overview

The following is a list of covered medical services for the IRMP. Only those services, supplies, and treatments that are identified as covered medical services are covered. Please refer to the benefits chart for additional details. Covered services and supplies shall be rendered in the least intensive professional setting that is appropriate for the delivery of the services and supplies. Covered medical services must otherwise meet all other applicable terms and conditions for coverage under the Plan for benefits to be payable. If you are disabled, certain denied medical services may be accommodated through the Americans with Disabilities Act (ADA).

5.2 Covered Medical Services

Acupuncture

Acupuncture services are covered for pain associated with a medical condition or nausea (e.g., nausea from chemotherapy, post-operative nausea, or nausea of early pregnancy).

Allergy Services

The office visit copayment or coinsurance applies for any visit in which clinical services are rendered by the physician (or designee). The office visit copayment applies for injections received in a physician's office when no other health service is received (for example allergy immunotherapy).

Ambulance

Emergency transportation consists of either a local professional ambulance or an air ambulance used to transport the patient from where the illness or accident begins to the nearest hospital qualified to provide treatment of that illness or injury. In the case of air ambulance service, the prescribing and receiving physicians must certify that use of any lesser transportation service would have jeopardized the life of the patient or that no alternative transportation was available. Other transportation is covered when approved by the health plan medical director (or designee).

Non-emergency ambulance services are subject to medical necessity reviews. Emergency ground ambulance services do not require pre-service review. Pre-service review is required for air ambulance in a non-medical emergency. When using an air ambulance in a non-emergency situation, the claims administrator reserves the right to select the air ambulance provider. If you do not use the air ambulance the claims administrator selects in a non-emergency situation, no coverage will be provided.

You must be taken to the nearest facility that can provide care for your condition. In certain cases, coverage may be approved for transportation to a facility that is not the nearest facility.

Coverage includes medically necessary treatment of an illness or injury by medical professionals from an ambulance service, even if you are not transported to a hospital. Ambulance services are not covered when another type of transportation can be used without endangering your health. Ambulance services for your convenience or the convenience of your family members or physician are not a covered service.

Other non-covered ambulance services include, but are not limited to, trips to:

- A physician's office or clinic.
- A morgue or funeral home.

If provided through the 911 emergency response system ambulance services are covered if you reasonably believed that a medical emergency existed even if you are not transported to a hospital.

Important information about air ambulance coverage. Coverage is only provided for air ambulance services when it is not appropriate to use a ground or water ambulance. For example, if using a ground ambulance would endanger your health and your medical condition requires a more rapid transport to a hospital than the ground ambulance can provide, this plan will cover the air ambulance. Air ambulance will also be covered if you are in a location that a ground or water ambulance cannot reach.

Air ambulance will not be covered if you are taken to a hospital that is not an acute care hospital (such as a skilled nursing facility or a rehabilitation facility), or if you are taken to a physician's office or to your home.

Hospital to hospital transport: If you are being transported from one hospital to another, air ambulance will only be covered if using a ground ambulance would endanger your health and if the hospital that first treats you cannot give you the medical services you need. Certain specialized services are not available at all hospitals. For example, burn care, cardiac care, trauma care, and critical care are only available at certain hospitals. For services to be covered, you must be taken to the closest hospital that can treat you. Coverage is not provided for air ambulance transfers because you, your family, or your physician prefer a specific hospital or physician.

Breast Reconstruction, Breast Prostheses, and Complications of Mastectomy

For members who are receiving benefits in connection with a partial or radical mastectomy and who elect breast reconstruction, the following coverage is also provided:

- All stages of reconstruction of the breast on which the mastectomy has been performed,
- Surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- Prostheses and treatment of physical complications of mastectomy, including lymphedemas.

Coverage will be provided in a manner determined in consultation between the attending physician and the patient.

Benefits for breast reconstruction and breast prostheses are subject to deductibles and coinsurance limitations consistent with those established for other benefits under the Plan.

Chiropractic Services

Chiropractic care includes charges for detection and correction of nerve interference in the vertebral column. Diagnostic laboratory and X-ray charges related to your chiropractic care are included under your chiropractic coverage.

Qualifying Coronavirus Preventive Services

Qualifying coronavirus preventive services, including immunizations, that receive specified recommendations from the CDC are covered with applicable deductibles and coinsurance waived whether provided by an in-network or out-of-network provider. Note: cost-sharing may be imposed for office visits that are billed separately from the qualifying coronavirus preventive service.

Dental Services

Charges in connection with dental services or treatment only if the charges are:

- In connection with accidental injury of sound natural teeth.
- Oral surgery for treatment of disease or injury of the jaw.
- Covered medical services for the treatment of temporomandibular joint (TMJ) syndrome.

Dental X-rays, supplies, and appliances and all associated expenses, including hospitalizations and anesthesia, are only covered for the following:

- Transplant preparation.
- Initiation of immunosuppressive(s).
- The direct treatment of acute traumatic injury, cancer, or cleft palate.

Dental services for accidental damage are only covered medical services when they are received from a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.) and the dental damage is severe enough that initial contact with a physician or dentist occurred within 72 hours of the accident.

Benefits are available only for treatment of a natural tooth. The physician or dentist must certify that the injured tooth is not a dental implant and functions normally in chewing and speech.

Diagnostic and Therapeutic Radiology Services

Coverage for diagnostic laboratory and diagnostic and therapeutic radiology services including:

- Diagnostic X-ray, consisting of radiology, ultrasound, nuclear medicine, and magnetic resonance imaging.
- Diagnostic laboratory and pathology tests.
- Diagnostic medical procedures consisting of EKG, EEG, and other electronic diagnostic medical procedures.
- Pre-admission/pre-surgical tests which are made prior to a plan member's inpatient or outpatient surgery.
- Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy).

Benefits under this section include only the facility charge and the charge for required services, supplies, and equipment.

Durable Medical Equipment

Durable Medical Equipment (DME) includes the short-term rental, or, the purchase, at the Plan's sole discretion, of durable equipment which is used solely for medical purposes. You must rent or purchase the DME from a vendor identified by the health plan. Such items must be able to withstand repeated use by more than one person, customarily serve a medical purpose, generally not be useful in the absence of illness or injury and must not be disposable (unless directly required to operate an approved DME).

Such equipment includes, but is not limited to, crutches, hospital beds, wheelchairs, respirators and intermittent positive pressure breathing machines, oxygen tents, walkers, inhalators, dialysis machines, and suction machines.

Coverage for DME does not include exercise equipment, equipment that is not solely for the use of the patient, comfort items, routine maintenance, or DME for the convenience of the patient.

Consumable supplies are not covered, except for ostomy supplies and those that are necessary for the function of authorized DME.

Coverage for wigs and hairpieces will be covered for hair loss resulting from disease or treatment of certain medical conditions. Covered conditions include, but are not limited to, chemotherapy and radiation treatments for cancer, alopecia areata, endocrine and metabolic diseases. Documentation will be reviewed on a case-by-case basis and will require a doctor's recommendation including an overall history of the medical problem.

Emergency Services

Coverage is provided for medical, surgical, hospital, and related healthcare services and testing. Services also include ambulance service required for serious accidents, sudden illness, or any condition that, in the judgment of a reasonable person, if not treated immediately, may result in serious long-term medical complications, loss of life, or permanent impairment to bodily functions. Emergency services are required in life-threatening emergencies, where symptoms are severe, occur suddenly and unexpectedly, and immediate medical attention is necessary.

Included are conditions that produce:

- Loss of consciousness or seizure.
- Uncontrolled bleeding.
- Severe shortness of breath.
- Chest pain.
- Broken bones.
- Sudden onset of paralysis or slurred speech.

External Prosthetic Appliances

Coverage is provided for the purchase and fitting of external prosthetic appliances which are used as a replacement or substitute for a missing body part and are necessary for the alleviation or correction of illness, injury, or congenital defect.

External prosthetic appliances include:

- Artificial arms and legs.
- Hearing aids.
- Terminal devices, such as a hand or hook.

Replacement or repair, as appropriate, of external prosthetic appliances is covered if necessitated by such circumstances as normal anatomical growth, physical changes which render the device ineffective, or excessive wear. Whether to repair or replace external prosthetic appliances will be at the sole discretion of the Plan. If more than one prosthetic device can meet your functional needs, benefits are available only for the most cost-effective prosthetic device.

Family Planning Services

The following covered family planning services include:

- Medical history
- Physical examination
- Related laboratory tests, medical supervision, and counseling in accordance with generally accepted medical practice, including medical services connected with surgical therapies (vasectomy or tubal ligation)
- Depo-Provera
- Oral contraceptives (covered under prescription benefits)
- Intrauterine devices (IUD) insertion and removal

Gender Confirmation Surgery

Coverage for gender-affirming services will be determined based on recognized clinical standards and medical necessity, as assessed by the claims administrator. This benefit is only covered under the IRMP Anthem HDHP. Benefit may be subject to tax.

Hearing Care

Office visits to determine hearing loss are covered. Analog and digital hearing aids are covered items.

Home Healthcare

Benefits are available only when the Home Healthcare Agency services are provided on a part-time, intermittent schedule and when skilled home healthcare is required. Skilled home healthcare is skilled nursing, skilled teaching, and skilled rehabilitation services when all the following are true:

- They are delivered or supervised by licensed technical or professional medical personnel to obtain the specified medical outcome and provide for the safety of the patient.
- They are ordered by a physician.
- They are not delivered for the purpose of assisting with activities of daily living, including but not limited to dressing, feeding, bathing, or transferring from a bed to a chair.
- They require clinical training to be delivered safely and effectively.
- They are not Custodial Care.

Home healthcare services are provided when you or an eligible plan member requires skilled care and you or an eligible plan member:

- Are home-bound due to a disabling condition.
- Are unable to receive medical care on an ambulatory outpatient basis.
- Do not require extended daily attendance by a professional nurse or require confinement in a hospital or other healthcare facility, such as a skilled nursing facility.

Home Healthcare Services Include:

- Part-time or intermittent visits by professional nurses and other healthcare professionals
- Intravenous medications

Physical, occupational, and speech therapy provided in the home are subject to benefit limitations, see Rehabilitative Therapy.

Hospice Care

Hospice care must be recommended by a physician. Hospice care is an integrated program that provides comfort and support services for the terminally ill. Hospice care includes physical, psychological, social, and spiritual care for the terminally ill person, and short-term grief counseling for immediate family members.

Benefits are available when hospice care is received from a licensed hospice agency. The following hospice care includes:

- Inpatient care for terminally ill patients (generally a patient with six months or less to live).
- Services of a physician.
- Healthcare services at home, including nursing care, use of medical equipment, rental of wheelchairs and hospital-type beds, and homemaker services.
- Emotional support services.
- Physical and chemical therapies.
- Bereavement counseling sessions for family members.
- Respite care (up to 40 hours total).

If you are a Medicare eligible Retiree your Hospice benefits will be provided by Medicare. You must receive care from a Medicare-certified hospice provider.

Hospital Services

The following hospital services include:

Covered expenses for room and board are limited to the semi-private (a room with two or more beds) room rate. Private room, intensive care, coronary care, and other specialized care units of a facility are covered when such special care or isolation is consistent with professional standards for the care of the patient's condition. When room and board for other than semi-private care is at the convenience of the patient, payment will be made only for semi-private accommodations.

Hospital Ancillary Services

The following ancillary services include:

- Care and services in an intensive care unit
- Administered drugs
- Medications, biologicals, fluids, and chemotherapy
- Special diets
- Dressings and casts
- General nursing care
- Use of operating room and related facilities
- X-rays, laboratory, and other diagnostic services
- Anesthesia and oxygen services
- Inhalation therapy
- Radiation therapy
- Blood and blood products
- The collection and storage of autologous blood (self-donated blood) up to six weeks prior to surgery
- Such other services customarily provided in acute care hospitals

Infertility Services

Services for infertility only include diagnostic services to establish the cause or reason for infertility, and to treat an underlying medical condition in a manner not otherwise excluded under the Plan.

Internal Prosthetic Appliances

Coverage for internal prosthetic appliances includes the purchase, maintenance, or repair of permanent or temporary internal aids and supports for defective body parts and family planning, specifically:

- Intraocular lenses
- Artificial heart valves
- Cardiac pacemakers
- Artificial joints
- Other surgical materials such as screw nails, sutures, and wire mesh

Maternity Care

Covered maternity care services are only payable for covered female retirees, eligible covered female spouse/domestic partners, and covered female dependent children.

Benefits for pregnancy will be paid at the same level as any other condition, sickness, or injury. This includes all maternity-related medical services for prenatal care, postnatal care, delivery, and any related complications.

The hospital length of stay for the mother or newborn child shall not be less than 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery unless the attending provider, after consultation with the mother, determines an earlier discharge is appropriate. The attending provider cannot be required by the health plan to obtain authorization for prescribing a length of stay, which is within these limits.

Services rendered in a birthing facility for low-risk births following an uncomplicated pregnancy are eligible provided the physician in charge is acting within the scope of his license and the birthing facility meets all legal requirements. The facility must have an agreement with a hospital for rapid transport in the event of an emergency.

Mental Health and Chemical Dependency Treatment

The mental health and chemical dependency benefits offer you confidential and convenient access to professional counseling. All mental health and chemical dependency services are strictly confidential and provided in accordance with applicable federal and state laws. Unless a retiree chooses to notify Intel, all contact with counselors is treated in confidence. Anthem provides Intel only basic data regarding the number of calls processed and the number of cases currently being addressed through counseling or through clinical treatment.

Coverage is provided to help you resolve issues such as:

- Alcohol and/or drug dependency
- Physical or mental abuse
- Eating disorders or other forms of obsessive behavior
- Anxiety or depression

Covered services include inpatient facility care and outpatient psychotherapy and counseling. Mental healthcare in a hospital is covered at the semi-private room and board rate. Your coverage will also pay any charges for professional and other services and supplies required for medical care and treatment from the facility.

Naturopath Services

Office visits to a licensed naturopath are covered. Surgical procedures and injections performed by a naturopath are not covered. In addition, medicine, herbs, supplements, and vitamins dispensed by a naturopath are not covered.

Newborn Care

Newborn services are covered (including facility charges) for routine well-care (including immunizations and circumcision) of a newborn child prior to discharge from the hospital nursery, if the mother is eligible and enrolled in the Plan and the child is enrolled in the plan.

Non-Durable Medical Supplies

The following coverage will be provided under the pharmacy benefits: disposable insulin needles/syringes and disposable blood/urine, glucose/acetone testing agents.

Nutritional Counseling

Covered medical services provided by a registered dietician in an individual session for plan members with medical conditions that require a special diet. Some examples of such medical conditions include:

- Diabetes mellitus
- Congestive heart failure
- Severe obstructive airway disease
- Gout
- Coronary artery disease
- Renal failure
- Phenylketonuria
- Hyperlipidemias

Oral Surgery

Oral surgery is covered if there is a medical diagnosis (e.g., tumor in the mouth) or if the surgery requires hospitalization, or if the condition is due to an accident (e.g., broken jaw).

Orthotics

Coverage for orthotics (excluding shoes) is provided when prescribed by a physician. Replacements are covered only if needed to change the prescription, not when the device is lost or damaged. Orthotics for excluded conditions is not covered (e.g., orthotics for fallen arches or flat feet).

Outpatient Services

Outpatient services include diagnostic and/or treatment services; administered drugs, medications, biological, and fluids; and inhalation therapy. Services also can include certain surgical procedures, anesthesia, blood and blood products, and the collection and storage of autologous blood (self-donated blood) up to six weeks prior to surgery, and recovery room services.

Benefits under this section include only the facility charge and the charge for required services, supplies, and equipment.

Physician Services

Physician services include diagnostic and treatment services including office visits (e.g., well-woman, well-baby), pre- and post-natal care, routine immunizations, allergy tests and treatments, lab and X-ray, periodic health assessments, hospital care, consultation, and surgical procedures.

Podiatry

The Plan will pay for certain surgical podiatry services, including incision and drainage of infected tissue of the foot, removal of lesions of the foot, removal or debridement of infected toenails, and treatment of fractures and dislocations of bones of the foot. Podiatry services not covered are those procedures considered to be a part of a routine foot care, such as treatment of corns, calluses, non-surgical care of toenails, fallen arches, and other symptomatic complaints of the feet.

Podiatry is the medical specialty concerned with the diagnosis and/or medical, surgical, mechanical, physical, and adjunctive treatment of the diseases, injuries, and defects of the foot.

Prescription Drugs Benefits

Prescription drug coverage is provided for medically necessary, Food and Drug Administration (FDA) approved drugs and medicines for the treatment of a condition obtainable only by a physician's prescription on an outpatient basis. In addition, any prescribed drug or medicine must otherwise meet the applicable prior authorization criteria used by the Plan. Please note that the Plan may not cover drugs and medicines that have not been specifically approved by the FDA for the use prescribed by your physician. For more information, also see the following sections:

- Benefits Charts
- Out-of-Pocket Maximum
- General Exclusions and Limitations
- Prior Authorization Review Program

Mail Order Program

Maintenance medications, including medications for birth control or long-term health conditions such as high blood pressure, ulcers, or diabetes, can be filled through the mail order program (Express Scripts Pharmacy) or at a preferred retail pharmacy. You receive a 90-day supply of medications and pay the appropriate copayment/coinsurance. Prescriptions filled through Express Scripts Pharmacy will be mailed to the plan member's home address.

Covered Prescription Drugs

The following prescription drugs are covered:

- Federal Legend drugs
- Insulin
- All needles and syringes (insulin needles and syringes, non-insulin needles and syringes)
- Diabetic Supplies (e.g., lancets and strips)
- Contraceptives, oral or other, whether medication or device, regardless of intended use, unless administered in a physician's office
- Tretinoin, all dosage forms (e.g., Retin-A), for individuals through age 25 years, if medically necessary
- Any other drug which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber
- DESI drugs
- Self-Injectable(s)
- Crinone
- Legend tobacco deterrents
- Drug therapy for the treatment of male erectile dysfunction due to an organic medical

condition (subject to managed drug limits of up to eight treatments per month)

- Legend vitamins
- Certain prescription drugs that are excluded from the Plan may be covered for specific diagnoses

If you have a question regarding your prescription drug coverage, call: 800-899-2713 to speak directly with an Express Scripts representative.

You decide what level of benefits you will receive when you seek care. You can receive a higher level of prescription drug benefits by utilizing Express Scripts network pharmacists.

Retail Benefits

Dispensing limit: Amount normally prescribed by a physician, but not to exceed a 34-day supply per copayment. You may purchase up to a 34-day supply at retail and up to a 90-day supply at a preferred retail pharmacy (Walgreens or Costco). You receive an identification card that you present to an Express Scripts pharmacist when you have a prescription filled. The card identifies you and your enrolled spouse/domestic partner as Express Scripts program members. You can use your Express Scripts card at Express Scripts pharmacies. Out-of-network pharmacies do not accept the card.

When you present your Express Scripts card at a network pharmacy, you pay the appropriate copayment for each prescription filled. If you need assistance in locating a network pharmacy, you can contact Express Scripts at: 800-899-2713.

Mail Order Benefits

Plan members simply fill out an Express Scripts mail order form, enclose original prescription(s) from a physician for a 90-day supply and up to three refills (to a maximum of a 12-month supply) and mail to Express Scripts Pharmacy. You pay the appropriate copayment for each prescription filled. You can pay by check or credit card. The processing time for a new prescription is about 14 days. To expedite the processing of refills, you can order by phone by calling Express Scripts at: 800-899-2713 or order online from the Express Scripts website: www.express-scripts.com.

Private Duty Nursing

To be covered, the physician in charge of the case must certify that the patient's condition requires care, which can only be provided by a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.). Private duty nursing applies only for care given in the patient's home and when not part of the home healthcare benefit.

Reconstructive Surgery

Charges incurred for reconstructive surgery only if occasioned by:

- Accidental injury sustained while covered.
- A congenital anomaly in a child that results in a functional deficit. This does not include conditions related to growth, such as malocclusion.
- Reconstruction of a breast following partial or radical mastectomy while covered (please refer to covered medical services under Breast Reconstruction, Breast Prostheses).

Rehabilitative Therapy

Rehabilitative therapy, including physical, speech and occupational therapy is covered on both an inpatient and outpatient basis. Coverage is available only for short-term rehabilitation following injuries, surgery, acute medical conditions, or acute exacerbation of chronic conditions.

Speech therapy by a qualified speech therapist is covered if performed to restore speech that has been impaired because of an injury or illness such as a stroke, head injury, vocal cord injury; or because of impairment caused by congenital defect for which corrective surgery was performed.

Occupational therapy is covered only for the purpose of training the patient to perform the activities of daily living.

Cardiac therapy is provided at two phases. Phase I begins during or just after the acute event (e.g., bypass surgery, myocardial infarction, angioplasty). It includes nursing services, physical therapy and teaching the patient how to deal with his/her condition. Phase II is a hospital- based outpatient program after inpatient hospital discharge. It is physician directed with active treatment and EKG monitoring at a frequency of three times per week for approximately 12 weeks. Memberships to a gym or exercise programs do not quality as cardiac rehabilitation under the plan.

Skilled Nursing Facility

Services for an inpatient stay in a licensed institution other than a hospital (e.g., skilled nursing facility or inpatient rehabilitation facility) are covered for plan members who are convalescing from an injury or illness that requires an intensity of care or a combination of skilled nursing, rehabilitation, and facility services that are less than those of a general acute hospital but greater than those available in the home setting. The institution must maintain on the premises all facilities necessary for medical treatment, provide such treatment for compensation under the supervision of physicians, and provide nursing services. Benefits are available for: Services and supplies received during the inpatient stay and room and board in a semi-private room (a room with two or more beds). The plan member is expected to improve to a predictable level of recovery. Benefits are available when skilled nursing and/or rehabilitation services are needed daily.

Tobacco Cessation Services

Covered treatments include acupuncture, hypnotherapy, biofeedback, and nicotine neutralization injection, when provided by a covered practitioner.

Temporomandibular Joint (TMJ) Syndrome

The following coverage for physician services includes:

- Diagnostic and treatment services of covered physicians and other healthcare professionals, including office visits
- Periodic health assessments
- Hospital care
- Consultation
- Surgical procedures

Transplant Services

Covered medical services for the following organ and tissue transplants when ordered by a physician include the organ recipient's medical, surgical, and hospital services, immunosuppressive medications, and organ procurement costs required to perform any of the following human-to-human organ or tissue transplants:

- Kidney
- Liver
- Heart
- Liver/small bowel
- Heart/lung
- Bone marrow
- Lung
- Small bowel
- Cornea
- Pancreas
- Kidney/pancreas

Reasonable travel and living expenses are also covered for the patient and an adult family member if approved by the health plan medical director (or designee).

Covered organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a donor having a blood relationship to the recipient. Organ procurement costs include organ transportation, compatibility testing, and, where a live donor is involved, donor transportation, hospitalization, and surgery. Coverage for donor transportation, hospitalization, and surgery necessary for the performance of a covered transplant, once compatibility has been established, shall not be limited to a donor having a blood relationship to the recipient. Charges associated with the purchase of an organ or organ tissue are not covered.

- **When the donor is covered by the IRMP:** Any medical insurance provided for the recipient and covering the donor will be the primary payer and the IRMP will be the secondary payer. If the recipient of the organ transplant does not have medical coverage that would cover the donor, the IRMP will be the primary payer.
- **When the recipient is covered by the IRMP:** The Plan will be the primary payer for both the recipient and the donor. However, if you are covered by the IRMP and want to receive out-of-network benefits, a separate deductible, coinsurance, and out-of-pocket maximum will apply to each individual. The family maximum will apply only if the donor and recipient are both covered by the IRMP.

Travel and Living Expenses

Reasonable travel and living expenses for patients and an adult family member are covered as described in section 4.18 Travel.

Travel Immunizations

Covered services include any immunization required for personal travel that is appropriate based on your intended destination.

Vision Therapy

Vision therapy if the following conditions apply:

- Provided by a licensed provider
- Convergence insufficiency
- General binocular vision disorder
- Accommodative disorder
- Strabismus
- Exotropia
- Exotropia
- Ocular motor dysfunction
- Amblyopia

Weight Reduction Services

Weight reduction programs are generally not a covered medical service. However, services may be covered if you are referred for weight reduction services by your provider and authorized by the Health plan medical director (or designee). Gastric Bypass surgery requires predetermination and pre-certification for medical necessity prior to scheduling the member's procedures.

Well-Adult Care

Well adult care includes routine physical examinations, as determined by your physician, lab work, and immunizations. Exams for women include pap smears, pelvic and breast exams, mammograms, urinalysis, and hemoglobin count. Exams for men include prostate exam and prostate-specific antigen (PSA) lab work.

Section 6 – IRMP Anthem HDHP Exclusions and Limitations

6.1 IRMP Anthem HDHP Exclusions and Limitations

IRMP medical coverage excludes the items below as well as charges for services associated with non-covered benefits, unless specifically covered in the Covered Medical Services section.

- **Alternative Treatments:** Forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health unless such treatment is otherwise specifically noted as a covered medical service under the plan.
- **Certain Physical Examinations:** Physical, psychiatric, or psychological testing and examinations required for school, sports, or judicial or administrative proceedings or orders, for purposes of medical research, or to obtain or maintain a license of any type.
- **Comfort or items of convenience:** Supplies, equipment, and similar incidental services and supplies for personal comfort.

  Examples include: Air conditioners, air purifiers and filters, batteries and battery chargers, dehumidifiers, humidifiers, and home remodeling to accommodate a health need (such as, but not limited to, ramps and swimming pools). Hospital services do not include personal or comfort items such as personal care kits, television, telephone, and other articles that are not for the specific treatment of illness or injury.
- **Corrective Eye Surgeries including, but not limited to laser surgery, radial keratotomies, and other refractive eye surgery:** Charges incurred for surgical techniques performed for the correction of myopia or hyperopia, including but not limited to laser surgery, refractive eye surgery, keratomileusis, keratophakia, or radial keratotomy (plastic surgeries on the cornea in lieu of eyeglasses), and all related services.
- **Cosmetic Procedures:** Services are considered cosmetic procedures when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from the impairment does not classify surgery and other procedures to relieve such consequences as a reconstructive procedure.

  Unless otherwise noted, cosmetic procedures include, but are not limited to, plastic surgery, scar, or tattoo removal or revision procedures (such as salabrasion, chemosurgery, and other such skin abrasion procedures), pharmacological regimens, nutritional procedures or treatments, skin abrasion procedures performed as a treatment for acne, breast implant replacement when implant was cosmetic, treatment of benign gynecomastia, medical and surgical treatment of excessive sweating (hyperhidrosis), vein stripping, ligation, sclerotherapy, upper lid blepharoplasty, wigs (except what's specifically covered under the Plan), physical conditioning programs such as athletic training, body-building, exercise, fitness, flexibility, and diversion or general motivation.
- **Custodial Care:** Charges incurred for custodial care domiciliary care or rest cures, provided primarily to assist in meeting activities of daily living may be provided by persons without special skill or training, regardless of where the services are rendered (e.g., in an inpatient or outpatient setting). It may include, but is not limited to, help in getting in and out of bed, walking, bathing, dressing, eating, and taking medication, as well as ostomy care, hygiene, or incontinence care, and checking of routine vital signs.

- **Dental Services:** Except as specifically covered, dental care including medical or surgical treatments of a dental condition, all associated dental expenses, including hospitalization, and anesthesia.

  Examples include: Preventive care, diagnosis, treatment of or related to the teeth, jawbones, or gums. Examples include all of the following: examinations, X-rays, supplies, appliances, repairs, extractions, implants, braces restoration, orthodontics, surgical augmentation for orthodontics, periodontics, casts, splints, services for dental malocclusion for any condition, mandibular or maxillary prognathism, maxillary constriction, mirocprognathism or malocclusion, and replacement of teeth. Medical or surgical treatments of dental condition, including hospitalizations and anesthesia. Services to improve dental clinical outcomes. Treatment of congenitally missing, malpositioned, or super numerary teeth, even if part of a congenital anomaly.

- Dietary Supplements, Replacements, and Products: Charges incurred for the following:
  - Dietary, nutritional, and electrolyte supplements, replacements and products, except as authorized by the plan administrator for specific, severe and chronic medical conditions, are not covered under the Plan.
  - Dietary supplements and replacements used for food allergies, lactose intolerance, weight gain or loss, and re-hydration, food of any kind (diabetic, low fat, cholesterol) are not covered under the Plan. Megavitamin/nutrition therapy, oral vitamins, oral minerals, infant formula, donor breast milk (except when sole source of nutrition or inborn error of metabolism), and nutritional counseling are not covered under the Plan.
  - Drugs and medications excluded from Prescription Drug Benefit coverage: Any drug when a written prescription from a physician or other lawful prescriber is not obtained (including over-the-counter items).
  - Anorectics or any drug used for weight loss without prior authorization approval.
  - Tretinoin, all dosage forms (e.g., Retin-A), for individuals 26 years of age or older without prior authorization approval.
  - Anthrax vaccine/injection.
  - Non-legend drugs other than insulin.
  - Charges for the administration or injection of any drug.
  - Therapeutic devices or appliances, including support garments and other nonmedicinal substances, regardless of intended use.
  - Drugs labeled "Caution - Limited by Federal Law" for investigational use or experimental drugs, even though a charge is made to the individual.
  - Biological sera, blood, or blood plasma.
  - Any prescription refilled in excess of the number specified by the physician, or any refill dispensed more than one year from date of the physician's original order.
  - Charges for vitamins (unless legend, prescription vitamins), over-the-counter drugs or contraceptives, whether or not prescribed by a physician and obtainable over the counter.

  - Infertility drugs.
  - Depo-Provera and Norplant when administered in physician's office.
  - Prescription drugs used exclusively for cosmetic purposes or that are not medically necessary.
- **Employment-Related Disease or Injury:** Charges incurred in connection with:
  - Disease or injury sustained while doing any act or thing pertaining to any occupation or employment for remuneration or profit, except for the case of a self-employed dependent.
  - Disease or injury for which benefits are payable in accordance with the provisions of any Workers' Compensation or similar law, except in the case of a self-employed dependent.
  - Disease or injury while attending vocational, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-medically necessary education.
- **Excess of Eligible Expenses:** Charges made in excess of the usual, maximum allowed amount charges, for care or treatment that does not meet the definition of a covered medical service, and for charges in excess of any specified limitation.
- **Experimental or Investigational Services or Unproven Services:** The fact that an Experimental or Investigational Service or an Unproven Service is the only available treatment for a particular condition will not result in the payment of benefits if the service is considered to be experimental or investigational or unproven in the treatment of that particular condition. If you have a life-threatening condition (one which is likely to cause death within one year of the request for treatment) the Plan may, in its sole discretion, determine that an experimental or investigational service or unproven service is not excluded as such under the Plan. For this to take place, the Plan must determine that the procedure or treatment is promising, but unproven, and that the service uses a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health.
- **Foot Care:** Routine foot care (including the cutting or removal of corns and calluses), nail trimming, cutting, or debriding. Hygienic and preventive maintenance foot care.

  Examples include: Cleaning and soaking the feet, applying skin creams in order to maintain skin tone, other services that are performed when there is not a localized illness, injury or symptom involving the foot. Treatment of flat feet. Treatment of subluxation of the foot.
- **Home Birth:** Charges associated with home births are not covered.
- **Infertility Drugs:** Infertility drugs, including injectable drugs and treatments that create a pregnancy, but do not treat a medical condition, are not covered.
- **Infertility Treatments:** Infertility treatments including any assisted reproductive technology (e.g., in-vitro fertilization, artificial insemination, intrafallopian transfer, low tubal transfer, gamete intrafallopian transfer (GIFT) procedures, and zygote intrafallopian transfer (ZIFT) procedures, and frozen embryo implant). Surrogate parenting, donor ovum and semen and related costs, including collection and preparation fees or direct payment to a donor for sperm or ovum donations, monthly fees for maintenance and/or storage of frozen embryos,

and embryo transport.

- **Institution for School, Training, or Nursing Home:** Charges incurred for education including educational therapy and training for learning disabilities or mental retardation. This includes bed and board in an institution, which is primarily a school, or other institution for training. Also excluded are charges for a rest home, or a place for the aged.
- **Mental Health and Chemical Dependency:**
  - Treatment of congenital and/or organic disorders, including, but not limited to, organic brain disease, Alzheimer's disease, and pervasive developmental disorders.
  - Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
  - Services for mental health and chemical dependency that extend beyond the period necessary for short-term evaluation, diagnosis, treatment, or crisis intervention.
  - Treatment of mental retardation, other than the initial diagnosis.
  - Private hospital rooms and/or private duty nursing, unless determined to be a medically necessary service and authorized by the Health plan medical director (or designee).
  - Damage to the facility of a participating provider or to the participating facility caused by member. The actual cost of such damage shall be billed directly to the member.
  - Inpatient services, treatment or supplies rendered without Preadmission Certification, except in the event of an emergency.
  - Wilderness treatment programs.
- **Non-Durable Medical Supplies (DME):** Devices used specifically as safety items or to affect performance in sports-related activities. Outpatient medical supplies and disposable supplies, like elastic stockings, ace bandages, gauze, dressings, syringes, unless specifically stated in the Covered Medical Services section, tubings, nasal cannulas, connectors, and masks unless part of DME. Orthotic appliances that straighten or re-shape a body part (including some types of braces).
- **Nonemergency Confinement:** Charges for hospital room and board and other inpatient services for nonemergency confinement, unless the confinement is authorized by your provider or health plan administrator.
- **Orthopedic Shoes:** Orthopedic shoes, unless prescribed for a congenital anomaly or as covered by Medicare for the Medicare eligible retirees.

- **Rehabilitative Therapy:** The Plan excludes any type of therapy, service, or supply for the treatment of a condition which ceases to be therapeutic treatment and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
- **Reversal of Voluntary Sterilization Procedures:** Reversal of voluntary sterilization procedures, including infertility treatment that would circumvent a voluntary sterilization procedure.
- **Services not Medically Necessary:** Services not considered medically necessary are excluded. Medically necessary services must meet all the following criteria: consistency between symptoms, diagnosis, and treatment; appropriate and in keeping with standards of good medical practice; not solely for the convenience of the member or participating providers; not for conditions that have reached maximum medical improvement or are maintenance in nature.
- **Services Provided by Family Members:** Services performed by a provider who is a family member by birth or marriage, including your spouse, parent, child, brother, sister, or anyone who lives with you. This includes any service the provider may perform on himself or herself.
- Services and Supplies that do not Meet the Definition of a Covered Medical Service: For further information, see Covered Medical Service section.
- **Sleep Disorders:** Sleep therapy, medical and surgical treatment for snoring, except when provided as a part of treatment for sleep apnea and appliances for snoring.
- **Speech Therapy:** Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from stroke, head injury, vocal cord injury, or because of impairment caused by congenital defect for which corrective surgery was performed. Exclusions include therapy related to mental, psychoneurotic, or personality disorders, lisps, or stuttering.
- **Spinal Column Manipulation:**
  - Spinal treatment, including chiropractic and osteopathic manipulative treatment, to treat an illness, such as asthma or allergies.
  - Treatment that ceases to be therapeutic and is instead administered to maintain a level of functioning or to prevent a medical problem from occurring or reoccurring.
  - Maintenance care (treatment for a condition that has reached maximum medical improvement).
  - Services for examination or treatment of strictly non-neuromusculoskeletal disorder and conjunctive physical therapy not associated with spinal or joint adjustment.
  - Laboratory tests, X-rays, thermography, adjustments, physical therapy, or other services not documented as necessary and appropriate, or classified as experimental or in the research stage.
  - Any services or treatment for jaw joint problems.

  - Hypnotherapy, behavior training, sleep therapy and weight programs, educational programs, non-medical self-care or self-help exercise training, or any related diagnostic testing.
  - Hospitalization, manipulation under anesthesia, anesthesia, or other related services.
- **Tests to Determine Unborn Baby's Sex:** Amniocentesis and sonogram when used only to determine the sex of a child.
- **TMJ:** Oral appliances used in the treatment of temporomandibular joint syndrome (TMJ).
- **Transplants:** Organ or tissue transplants or multiple organ transplants other than those listed as Covered Medical Services are excluded from coverage; donor expenses if recipient not covered under the plan; health services for transplants involving mechanical or animal organs; any solid organ transplant that is performed as a treatment for cancer.
- **Travel and Living Expenses:** Travel and living expenses for patients and a family member other than for organ transplant or other than for in-network services deemed appropriate and approved by the appropriate health plan administrator.
- **Veterans Services:** Health services received as a result of active military duty, war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country. Health services for treatment of military service-related disabilities, when you are legally entitled to other coverage and facilities are reasonably available to you.
- **Vision Services:** Cosmetic materials including blended lenses, contact lenses (except as noted), oversize lenses, progressive multifocal lenses, photochromic lenses or tinted lenses, Coated lenses (including scratch resistant and anti- reflective coatings), laminated lenses, any balance remaining on a frame that exceeds the plan allowance, cosmetic lenses, optional cosmetic lenses, UV (ultraviolet) protected lenses, high index lenses, polarized lenses, polycarbonate lenses, edge treatments.
  - Orth-optics or vision training (except as specifically defined under Covered Medical Services) and any associated supplemental testing.
  - Plano lenses (non-prescription).
  - Two pairs of glasses in lieu of bifocals.
  - Replacement of lost or broken lenses and/or frames (originally furnished under this program) except at the normal intervals when service is otherwise available.
- **Weight Management Services:** Except as otherwise authorized by the Plan, expenses related to surgical and non-surgical weight reduction procedures, exercise programs or use of exercise equipment, special diets or diet supplements, Nutri/System Program, Weight Watchers, or similar programs; and hospital confinements for weight reduction programs.

6.2 Miscellaneous Exclusions:

- In the event that an out-of-network provider waives copayments, the annual deductible, or both for a particular health service, no benefits are provided for the health service for which the copayments or annual deductible are waived.
- Any charges for missed appointments, room or facility reservations, except in cases where the participating provider is notified at least 24 hours in advance that the appointment will not be kept, or in circumstances in which the plan member had no control over missing the appointment and could not notify the participating provider at least 24 hours prior to the scheduled appointment Completion of claim forms or record processing.
- Any charge for services, supplies or equipment advertised by the provider as free. Charges by a provider sanctioned under a federal program for reasons of fraud, abuse, or medical competency.
- Health services received after the date your coverage under the Plan ends, including health services for medical conditions arising before the date your coverage under the Plan ends.
- Health services for which you have no legal responsibility to pay, or for which a charge would not ordinarily be made in the absence of coverage under the plan.
- Any charges higher than the actual charge (the actual charge is defined as the provider's lowest routine charge for the service, supply, or equipment).
- Any charges prohibited by federal anti-kickback or self-referral statutes; any additional charges submitted after payment has been made and your account balance is zero.
- Any outpatient facility charges in excess of payable amounts under Medicare.
- Any charges by a resident in a teaching Hospital where a faculty Physician did not supervise services.
- Services provided without cost by any governmental agency, except where such exclusion is prohibited by law.
- Services, treatment or supplies for which no charge would usually be made or for which such charge, if made, would not usually be collected if no coverage existed.
- Services, treatment or supplies to the extent that charges for the care exceed the charge that would have been made and collected if no coverage existed.

Section 7 – IRMP Anthem Medicare Preferred (PPO) (typically age 65+ or disabled)

7.1 Overview

If you retire from Intel and meet the IRMP eligibility requirements and you or your dependent(s) are eligible for Medicare, you may enroll in one of two Anthem Medicare Preferred (PPO) with Senior Rx Medical and Prescription Drug ("Anthem Medicare Preferred (PPO)") options.

The Anthem Medicare Preferred (PPO) options are Medicare Advantage plans.* They are comprehensive health plans offering expanded benefits. Anthem Medicare Preferred (PPO) options include Medicare Part A (hospital benefits), Part B (doctor and outpatient care), and Medicare Part D (prescriptions), as well as other benefits not offered by original Medicare.

Anthem Medicare Preferred (PPO) eligibility requirements*:

- You and your dependents who wish to enroll must be eligible for IRMP
- You must be enrolled in Medicare Part A and Part B
- You must live in the United States

Anthem Medicare Preferred (PPO) coverage includes medical, mental health, chiropractic, and prescription drug benefits. It does not include routine vision or dental coverage.

You pay the entire cost of covering yourself and your enrolled dependent(s). The monthly premiums are available on the My Health Benefits website at www.intel.com/go/myben or by calling the Intel Health Benefits Center at: 877-GoMyBen (466-9236).

* Medicare must approve all enrollment submissions. Anthem will review your enrollment request and then send to Medicare to confirm eligibility. You will receive an enrollment confirmation letter upon Medicare acceptance. Anthem Medicare Preferred (PPO) plan premiums are based on individual enrollment and will be calculated based on the number of Medicare eligible individuals enrolled.

7.2 Plan Information

For additional information, including covered benefits, of the Anthem Medicare Preferred (PPO) options, go to www.anthem.com/ca/intelretiree/ and review the Evidence of Coverage Guide or call 800-811-2711.

7.3 Split Family Enrollment

If you are Medicare eligible and your eligible dependent is not, or vice-versa, the Medicare eligible person will be eligible to enroll in an IRMP Anthem Medicare Preferred (PPO) option and the non-Medicare eligible person will be eligible to enroll in the IRMP Anthem HDHP.

7.4 Medicare Part D Creditable Coverage

Anthem Medicare Preferred (PPO) options include Medicare Part D, prescription coverage. The coverage you get from Anthem Medicare Preferred PPO is at least as good as Medicare Part D—it is creditable prescription drug coverage.

The Medicare Modernization Act (MMA) requires entities whose policies include prescription drug coverage to notify Medicare eligible policyholders whether their prescription drug coverage is creditable coverage, which means that the coverage is expected to pay on average as much as the standard Medicare prescription drug coverage.

Accordingly, you will receive a Notice of Creditable Coverage as an enrollee in an Anthem Medicare Preferred (PPO) option. Keep the notice as you may need it in the event you decide to join a Medicare drug plan later.

NOTE: Please do not send the creditable coverage letters/certificates to Medicare

Section 8 – IRMP Vision

8.1 Routine Vision Care Overview

Routine vision benefits are provided under an agreement with Vision Service Plan (VSP).

- **In-Network:** Make an appointment with a VSP network provider and identify yourself as a VSP patient. If you need assistance in locating a VSP network provider call VSP at: (855) 663-2836. The network provider will contact VSP for authorization and detailed information about your eligibility and plan coverage. VSP pays the network provider directly according to its agreement with the provider. You are only responsible for the fees applicable beyond plan coverage.
- If VSP authorization is not obtained in advance and you visit a network provider as a private patient, the network provider is not obligated to accept VSP fees as full payment for their services but may determine their own charges.
- **Out-of-Network:** Eye exam and prescription eyewear benefits are covered if you do not use VSP providers; however, the out-of-network benefits are lower than in-network benefits.

  If you receive services from an out-of-network provider, you need to follow these steps:

  - Pay the provider in full for services rendered and request a copy of the bill that shows the billed amount for the exam and/or lenses and/or frame.
  - Complete an out-of-network claim form by calling VSP at: 855-663-2836 to request a form.
  - Send a copy of the itemized bill(s) and claim form to:
    VSP
    P.O. Box 385018
    Birmingham, AL 35238-5018

8.2 Treatment of Minor Medical Conditions of the Eye (Primary Eyecare Program)

In-Network Benefit Only

Make an appointment for Primary Eyecare Program services with a VSP Vision network provider and identify yourself as a VSP patient. If you need assistance in locating a VSP network provider, call VSP at: 855-663-2836. The network provider will contact VSP for authorization and detailed information about your eligibility and plan coverage. VSP pays the network provider directly according to its agreement with the provider.

The Primary Eyecare Program provides coverage for the diagnosis and/or treatment of nonsurgical eye-related health conditions. The Primary Eyecare Program also involves management of conditions, which require monitoring to prevent future vision loss. If urgent care is necessary, a VSP network provider may see you immediately.

Examples of conditions that may be treated under the Primary Eyecare Program, include, but are not limited to:	Examples of conditions, which may require management under the Primary Eyecare Program, include, but are not limited to:
▪ Ocular discomfort or pain ▪ Transient loss of vision, flashes, or floaters ▪ Ocular trauma ▪ Diplopia ▪ Recent onset of eye muscle dysfunction ▪ Ocular foreign body sensation pain in or around the eyes, swollen lids ▪ Red eyes	▪ Ocular hypertension ▪ Retinal nevus Glaucoma ▪ Cataract ▪ Pink eye ▪ Macular degeneration ▪ Corneal dystrophy ▪ Corneal abrasion ▪ Inflammation of the eyelids ▪ Stye

The Primary Eyecare Program does not cover surgery or pre- and post-operative services. If you require services beyond the scope of this program, the VSP network provider will refer you to your health insurance provider for treatment.

NOTE: There is no out-of-network benefit for the Primary Eyecare Program under VSP.

8.3 VSP Basic and Plus Vision

Basic Plan Coverage with a VSP Provider		Plus Plan Coverage with VSP Provider	
Benefit	**Copay**	**Benefit**	**Copay**
WellVision Exam Every calendar year		WellVision Exam Every calendar year	
Comprehensive eye exam	$0	Comprehensive eye exam	$0
Retinal screening	$25	Retinal screening	$25
Prescription Glasses	$25 (in-network)	**Prescription Glasses**	$10 (in-network)
Frame		**Frame**	
▪ $150 allowance for a wide selection of frames ▪ $200 allowance at Visionworks or Eyemart Express ▪ $200 allowance for featured frame brands ▪ 20% savings on the amount over your allowance ▪ $80 Walmart/Costco/Sam's Club frame allowance ▪ Every other calendar year	Included in Prescription Glasses	▪ $200 allowance for a wide selection of frames ▪ $250 allowance at Visionworks or Eyemart Express ▪ $250 allowance for featured frame brands ▪ 20% savings on the amount over your allowance ▪ $110 Walmart/Costco/Sam's Club frame allowance ▪ Every calendar year	Included in Prescription Glasses
Lenses		**Lenses**	
Single vision, lined bifocal, and lined trifocal lenses	Included in Prescription	Single vision, lined bifocal, and lined trifocal lenses	Included in Prescription Glasses
Impact-resistant lenses for dependent children		Impact-resistant lenses for dependent children	

Every calendar year	Glasses	Every calendar year	

Basic Plan Coverage with a VSP Provider		Plus Plan Coverage with VSP Provider	
Lens Enhancements		**Lens Enhancements**	
Standard progressive lenses	$0	Standard progressive lenses	$0
UV Coating	$0	UV Coating	$0
Anti-glare coating	$40	Anti-glare coating	$40
		Impact resistant for adults	$10
Premium and Custom progressive lenses	$95 – $175	Premium and Custom progressive lenses	$95 –$175
Average savings of 30% on lens enhancements		Average savings of 30% on other lens enhancements	
Every calendar year		Every calendar year	
Contacts (instead of glasses)		**Contacts (instead of glasses)**	
$150 allowance for contacts	copay does not apply	$200 allowance for contacts;	copay does not apply
Contact lens exam (fitting and evaluation)	Up to $55	Contact lens exam (fitting and evaluation)	Up to $55
Every calendar year		Every calendar year	
Primary EyeCare		**Primary EyeCare**	
▪ Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. ▪ As needed	$15	▪ Your VSP doctor can diagnose, treat, and monitor common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. ▪ As needed	$15
Laser Vision Correction		**Laser VisionCare Preferred Program**	
Average 15% off the regular price; discounts only available from contracted facilities; once per lifetime		▪ $2000 allowance for both eyes for LASIK, PRK, SMILE, Contoura; once per lifetime ▪ Average 15% off the regular price; discounts only available from contracted facilities	N/A
Extra Savings		**Extra Savings**	

Glasses and Sunglasses ▪ Extra $50 to spend on featured frame brands. Go to vsp.com/offers for details. ▪ 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.	**Glasses and Sunglasses** ▪ Extra $50 to spend on featured frame brands. Go to vsp.com/offers for details. ▪ 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.

Section 9 – Sheltered Employee Retirement Medical Account (SERMA)

9.1 Overview

The Sheltered Employee Retirement Medical Account (SERMA) is provided to help eligible retirees and eligible spouse/domestic partner and dependents purchase health insurance. SERMA is a Health Reimbursement Arrangement subject to Internal Revenue Service rules.* If eligible, SERMA will be established for you upon retirement. You must be a US employee retiring from a participating company to be eligible for SERMA. If you are eligible for SERMA, Intel credits your SERMA account with a specific amount based on your years of completed eligible service with Intel. You can use your SERMA for as long as you and your eligible dependent(s) have credits remaining in the account.

SERMA has no cash value; therefore, you cannot receive cash in lieu of SERMA.

Participating companies in SERMA are designated by the Intel Benefits Administrative Committee (BAC). The participating companies are: US Intel Corporation, Intel Massachusetts, Inc., Intel Americas, Inc., Intel Resale Corp., Intel Mobile Communications North America, Inc., Intel Federal LLC, Intel Media, Inc., Intel Foundry Corporation and Intel NDTM US LLC.

* See also IRS Publication 969, section on Health Reimbursement Arrangements - https://www.irs.gov/pub/irs-pdf/p969.pdf

9.2 SERMA Eligibility

If you were hired by an Intel US participating company before January 1, 2014, a SERMA will be established upon your retirement from Intel if you are a US employee of a participating company at the time you retire and meet the SERMA eligibility rules described below.

You are **not eligible** for SERMA if you:

- Are hired on or after January 1, 2014.
- Are rehired on or after January 1, 2014.
- Transferred to an Intel US participating companies from a non-participating Intel subsidiary (e.g., Wind River) or non-participating Intel entity (e.g., Intel China) on or after January 1, 2014.
- Became an Intel US participating company employee because of an acquisition or joint venture. Limited exceptions apply as noted below in "Intel Acquisitions and Joint Ventures."
- Transfer from an Intel US participating company to a non-participating subsidiary or entity (e.g., Intel China) on or after January 1, 2014
  - if you were not retirement eligible upon your transfer.
  - if you were retirement eligible upon your transfer but do not return to the US and retire from a participating company.

The amount of SERMA credits available to you upon retirement is based on your Eligible Service.

Spouse/Domestic Partner who is also an Intel Retiree

If both you and your eligible spouse/domestic partner are retirees of Intel, each of you will have your own SERMA and the amount for each will be based on each individual's Eligible Service.

Eligible Dependents

Eligible Dependents are defined in section 3.3 above.

NOTE: SERMA reimbursements for a domestic partner (and children of a domestic partner) are generally treated as taxable income unless your domestic partner is a tax dependent. See Domestic Partner Taxation section below.

9.3 Eligible Service

For employees hired to a participating company prior to 2014, completed full years of US service, as specified below, count toward "Eligible Service" to calculate SERMA credits. US service is defined as being on US payroll. The amount of credit available upon retirement, as described below, is capped on the 2020 anniversary of your hire date which means there is no Eligible Service after 2020. Eligible Service is determined as follows:

Eligible Service Prior to January 1, 2004

Only completed general full-time years of service as an Intel US employee (including intern) count toward eligible service. Time on Intel Military Leave while you are an Intel US full-time employee is counted as Eligible Service.

Part-time service, Intel Contract Employee (ICE) service, and personal leave time will not count as Eligible Service. Also, medical leave and other leave time (except military leave) over 183 days within a seven-year period will not count towards Eligible Service.

Rehire*: If you left Intel and were rehired by an Intel participating company **prior** to January 1, 2004, your past Eligible Service counts provided you were rehired within **five years** of your termination date.

Eligible Service on or After January 1, 2004

Eligible Service beginning on or after January 1, 2004, includes completed years of US Service:

- General full or part-time
- Intern
- ICE
- All leave of absence time (including personal leave time)

Rehire: If you left Intel and were rehired by an Intel participating company **prior** to January 1, 2014, your past Eligible Service counts provided you were rehired within **two years** of your termination date.

If you had SERMA after originally retiring from Intel and are rehired, your SERMA is suspended during the time you are employed, and you will not earn any additional SERMA credits or interest until you retire again from Intel. Upon your subsequent retirement, you will once again earn interest on your balance and be able to use your remaining SERMA. No additional SERMA credits are available upon your subsequent retirement.

Transfer:

- **Before 2014:** If you transferred to a non-participating entity or subsidiary (e.g., Intel China) before 2014 and later return to a participating company, a SERMA will be established for you based on your Eligible Service if you are a US employee of a participating company upon your retirement.
- **On or after January 1, 2014:** If you transfer to a non-participating entity or subsidiary (e.g., Mobileye or Intel China) and:
  - You were not eligible for retirement from a participating entity or subsidiary upon your transfer, ***you forfeit your Eligible Service*** when you transfer to the non-participating company. You are no longer eligible for SERMA.
  - You were eligible to retire from a participating entity or subsidiary prior to your transfer to the non-participating entity, SERMA will be established for you upon your retirement based on your Eligible Service if you are a US employee of a participating company upon your retirement.

NOTE: If you have eligible service time prior to and after January 1, 2004, the credit amount under each rule above will be added together at the time of your retirement to determine your total SERMA credit balance.

Intel Acquisitions, Hiring Actions, and Joint Ventures

With limited exceptions, years of pre-acquisition employment with a company acquired by Intel or years of employment with an Intel joint venture do not count as Eligible Service. Exceptions are based on, and subject to the applicable transaction agreement and are otherwise subject to the standard SERMA eligibility and calculation rules for acquired employees. The following transactions have provided exceptions to the standard SERMA rules:

- BIIN joint venture that closed July 1988.
- Digital Equipment acquisition that closed May 16, 1998. Employees who meet all the following requirements:
  - Have at least 10 years of combined Digital and general, full-time Intel service after age 45; and
  - Been at least 50 years of age on May 16, 1998, and had vested Digital service on May 16, 1998, equal to or greater than those listed below:

Age	Years of Vested Digital Service
55+	Five (not to exceed 9 years of service)
50-54	Five

  NOTE: Digital acquired employees age 55 or over with vested service of at least 10 years as of May 16, 1998 or those under age 50 as of May 16, 1998 are not eligible for SERMA.
- Ford Microelectronics acquisition that closed June 26, 2000.
- HP hiring action that closed January 31, 2005; employees hired by HP prior to January 1, 2003 are eligible for a starting SERMA balance of $1,500 per year of HP service (fractional years rounded up). No HP service credit applies for those hired by HP on or after January 1, 2003.

In the event of a discrepancy between this information and the official transaction agreements, the official transaction agreements will apply.

9.4 SERMA Credit Amounts

- Effective January 1, 2001, Intel increased the credit amount to **$1,500** for each year Eligible Service. This increase is not retroactive and only applies to employees retiring on or after January 1, 2001. This amount may be adjusted in the future in Intel's sole discretion.
- Effective January 1, 2020, the amount of SERMA credits available upon retirement is capped using Eligible Service up to the 2020 anniversary of your hire date.

9.5 SERMA Contributions and Interest

If you retire from Intel and have Eligible Service, Intel will establish a SERMA for you. The amount of SERMA credit is based each year of Eligible Service. This amount is a one-time credit made to your SERMA after you retire.

The only other contributions to your SERMA are annual interest earned on your SERMA balance. The interest credited is based on the average 12-month T-bill rate for the preceding calendar year. Interest is applied based on the prior year's December 31st balance. If you retire in the middle of the year, interest is pro-rated for the partial year.

9.6 When SERMA Ends

Balance Depleted

SERMA ends when your SERMA balance has been depleted. You remain eligible for IRMP after you exhaust your SERMA balance.

20 Consecutive Years of Non-use

Your SERMA is forfeited when the account has not been used after 20 consecutive years.

Upon Your Death

If you do not have any surviving eligible dependents (spouse/domestic partner or eligible child(ren)), any remaining balance in your SERMA is forfeited. If you have a surviving eligible dependent(s), your eligible dependent is eligible to use your remaining balance in your SERMA. However, if your spouse remarries or your domestic partner enters into a new domestic partnership following your death, your spouse/domestic partner will not be able to use SERMA for a new spouse/domestic partner or new dependent children.

Upon the death of your surviving spouse/domestic partner, or surviving eligible dependent child(ren), the balance remaining in SERMA is forfeited. If Intel determines you have passed, Intel will contact any eligible dependents on record for use of the remaining SERMA balance. If Intel does not have a record of surviving eligible dependents, your SERMA balance is forfeited.

Slayer Exclusion

Notwithstanding any provision of this Section 9.6 or any other provision of the SERMA Plan, a slayer spouse or other eligible dependent will not be entitled to your SERMA balance upon your death, and such SERMA balance shall be available as if the slayer spouse or other eligible dependent predeceased you. For purposes of this provision, a slayer spouse or other eligible dependent means a spouse or other eligible dependent who has been determined by the Plan Administrator, based on all relevant facts, to have unlawfully caused your death. Such spouse or other eligible dependent's conviction of homicide under applicable state criminal law or a finding of such spouse's or other eligible dependent's liability for causing your death under state civil law, or a judicial determination that such spouse or other eligible dependent is not entitled to death benefits under a state slayer statute, shall be considered conclusive evidence that such spouse or other eligible dependent is a slayer for purposes of this provision, but the Plan Administrator may determine that a spouse or other eligible dependent is a slayer without regard to whether such conviction, finding or judicial determination has been obtained.

9.7 SERMA Claims and Appeals

A SERMA claim or appeal regarding 1) eligibility for SERMA, 2) the amount of SERMA credit upon retirement, and 3) reimbursement for eligible expenses are ERISA Post-Service claims. Please see "Section 10 – Claims" and "Section 11 – Appeals" for information on how to file a claim or appeal for SERMA eligibility, or credit amount. Please see "Submit Claims for Reimbursement" below in this Section (Section 9) for more information on how to submit claims for reimbursement for eligible insurance premium expenses. Refer to Chapter 11 for information on appeals of denied reimbursement claims.

9.8 SERMA Balance

When you retire, Intel will establish a SERMA for you or your surviving eligible dependent(s) provided that you meet the SERMA eligibility requirements. The balance will reflect credits for interest based on the average 12-month T-bill rate for the preceding calendar year. You may obtain your SERMA account balance on the My Health Benefits website at: www.intel.com/go/myben, on the SERMA Tile or by calling the Intel Health Benefits Center at: 877-GoMyBen (466-9236).

9.9 Summary of SERMA Eligible Expenses

You may use your SERMA credits in one of two ways:

1. **IRMP Medical/Vision Insurance Premiums** – SERMA may be used to offset, in full or in part, your IRMP monthly insurance premiums for medical and/or vision coverage until you exhaust your SERMA account. See Subsection 9.11 below for more information.
2. **Insurance Premiums Outside IRMP** – SERMA may be used to reimburse yourself for eligible non-Intel sponsored healthcare insurance premiums paid for you, your spouse/domestic partner and your eligible children until you exhaust your SERMA account. See Subsection 9.12 below for more information.

All dependents eligible for reimbursement from SERMA, including domestic partners, must be listed as your dependent on the My Health Benefits website for a SERMA reimbursement to be processed. See Subsection 9.16 below regarding domestic partner reimbursements.

Insurance premium payments eligible for reimbursement include:

- Individual health insurance
- Individual dental insurance
- Individual vision insurance
- Other employer retiree group health plans
- COBRA
- Medicare
- Medigap
- TriCare
- Long-term care

NOTE: SERMA may be used for both IRMP and insurance premiums outside IRMP within the same year.

9.10 Summary of Ineligible SERMA Expenses

Expenses not eligible for SERMA reimbursement include, but are not limited to:

- Automobile insurance premiums.
- **Discount programs** – Amounts toward the purchase of programs which offer discounts on health care services such as doctor's visits or prescription costs.
- **Healthcare Sharing Ministry/Group Share costs** – Only health insurance or IRMP premiums are eligible under the SERMA plan.
- **Health Club or YMCA dues** – Examples include membership and personal trainer fees.
- **Healthcare expenses and services** – Only health insurance premiums or IRMP premiums are eligible under the SERMA plan.
- **Life insurance premiums** – Premiums paid for life insurance, or the repayment for loss of earnings.
- **Long-term care facility fees** – Fees for room and board at long-term care or assisted living facilities.
- **Premiums for active employee group health insurance** – Premiums paid for any type of active employee group health insurance coverage, including premiums for an employer sponsored health plan.
- **Bundled policy, such as health and non-health insurance** – If you are enrolled in a policy that provides coverage for other than healthcare insurance—such as life insurance or Accidental Death and Dismemberment—the healthcare insurance premium cost must be separately stated in the insurance contract or statement. If you do not provide this premium break out, your request for SERMA reimbursement will be denied.

9.11 If You Elect IRMP Enrollment

After you have retired and a SERMA is established for you, you can use credits from your SERMA in increments of 25 percent (e.g., 0, 25, 50, 75, or 100 percent) toward the cost of your, your eligible spouse/domestic partner's and eligible dependent's monthly IRMP premiums. The percentage you elect from your SERMA will apply to the total IRMP premium for you and your eligible dependent(s). You cannot elect a different SERMA percentage for you and your eligible dependent(s).

If you choose an amount other than 100 percent, then you are responsible for paying the remainder of the premium cost, in a timely manner. You will receive monthly invoices from the Intel Health Benefits Center for your share of the monthly IRMP premium payments. However, you may also opt to pay additional months of IRMP coverage in advance within each calendar year in increments of full monthly premiums.

When you elect to use your SERMA, the larger the percentage you choose, the faster your account balance will be depleted. For more information, see Changing Your SERMA Percentage.

You are responsible for paying any portion of your premium that is not paid with SERMA credits. If you use all the credits in your SERMA, you and your eligible dependent(s) can continue to be covered by the IRMP, but you must pay 100 percent of the premiums.

Changing Your SERMA Percentage for IRMP

If you are enrolled in IRMP, you have the opportunity to change the SERMA percentage amount you have elected to withdraw from your account to help pay your IRMP premiums:

- During the Annual Enrollment period (which will generally be held annually in November). The effective date of the percent change will generally be the first of January following the Annual Enrollment period.
- Mid-year. A mid-year change is effective prospectively for the next month's IRMP premium(s) based on when you call to make the change. Call the Intel Health Benefits Center to make a mid-year change to your percentage allocation.

Enrollment Change Forms are available by calling the Intel Health Benefits Center at: 877-GoMyBen (466-9236), Monday through Friday 5 a.m. to 5 p.m. Pacific.

9.12 If You Elect Reimbursement for Health Insurance Premiums Outside of IRMP

Eligible insurance premiums for yourself, your spouse/domestic partner and eligible dependents may be submitted for reimbursement from your SERMA. You may submit for insurance premium reimbursements for the following even if you are enrolled in IRMP.

Insurance premium payments eligible for reimbursement include:

- Individual health insurance
- Individual dental insurance
- Individual vision insurance
- Other employer retiree group health plans
- COBRA
- Medicare

- Medigap
- TriCare
- Long-term care

9.13 Claims for Reimbursement

The My Health Benefits website will provide you tools and resources to allow you to manage your SERMA. You can access the website from www.intel.com/go/myben. The website offers you the convenience of creating a claim form online. Once you enter the site, simply select the Your Spending Account tile at the top of the page and then choose Submit Claims to get started. Claim processing typically takes 10 business days. To get your money faster, sign up for direct deposit.

You can track your claim status and when receipts have been received on the My Health Benefits website.

The SERMA plan year runs from January 1 through December 31 of each year. You may submit a claim for reimbursement of an eligible premium incurred during the plan year as long as:

- You file your claim AFTER your health coverage began (i.e., premium for March paid in February 2016 cannot be submitted for reimbursement until March 1, 2016).
- You file your claim before May 31 of the following year (the run-out period).

Reimbursement Claim Submission Deadline

You can submit claims for eligible insurance premiums for the prior year (January 1 through December 31) until the runout period ends May 31 of the current year. For example, a claim for insurance premium coverage date of July 2025 can be submitted until May 31, 2026.

The runout period provides you extra time to submit your claims. If you do not submit your claims with complete supporting documentation by the May 31 run-out period, your claim will be denied.

Get Your Money Faster with Direct Deposit

You can have your eligible insurance premiums reimbursed electronically through direct deposit. After your claim is approved, the funds will automatically be deposited into your checking or savings account. To sign up, go to the "My Account" page on the Your Spending Account tile and click on the "Your Preferences" link.

Overpayments

You are responsible to repay any SERMA overpayment. Future reimbursement may be reduced by the amount of the overpayment. SERMA may seek additional methods for recouping overpayments, including collections.

9.14 How to Manage Your SERMA

- The My Health Benefits website will provide you tools and resources to allow you to manage your SERMA.
- You can access the website from www.intel.com/go/myben.
- You will need to login with your User ID and password.

- If you are accessing the site for the first time, you will be asked to create a User ID and password to login.
- To create your User ID, select "Register as a New User" and follow the instructions.
- You will be asked to create a password and answer a series of security questions.

Your SERMA Tile will allow you to:

- View your SERMA account balance.
- Learn which medical premium payments are eligible expenses.
- Submit a claim for premium payment reimbursement.
- Track the status of your requests for reimbursement (claims).
- Add or update direct deposit information.
- Set up recurring claim submission and reimbursement.

You may also speak with a service center representative by calling the Intel Health Benefits Center toll-free at: 877-GoMyBen (466-9236) and select Your Spending Account option. Representatives are available from 5 a.m. to 5 p.m. Pacific, Monday through Friday.

9.15 SERMA "Opt Out" Option

Non-Medicare retirees with access to SERMA will not qualify to receive Federal premium tax credits. If you are considering using Federal premium tax credits to reduce the cost of health insurance purchased through an eligible exchange, you should seek advice from a tax advisor.

If you are enrolled in Medicare, you are not eligible for Federal premium tax credits so the SERMA "Opt Out" program does not pertain to you.

If you are not Medicare eligible and you determine that you are eligible for the Federal premium tax credit, you may "Opt-Out" of SERMA for the year. If you take no action, the default is to "Opt In" to SERMA. When you "Opt Out," your SERMA balance is frozen, and you will not be able to use SERMA to pay for Intel or non-Intel sponsored healthcare premiums mentioned above for you or your dependents. Your "Opt-Out" election will continue unless you "Opt-In."

You may choose to temporarily "Opt Out" of SERMA through the following:

- Upon Initial Retirement, within 31 days of your initial retirement, for the remainder of the current calendar year.
- During Annual Enrollment for the following calendar year.
- Prospectively during the year for the following month.

Notify the Intel Health Benefits Center that you want to "Opt Out" of SERMA. Your "Opt Out" election will carry over unless you "Opt In" again. You may "Opt In" again for the following calendar year during the next Annual Enrollment or during the current year on a prospective basis. You may not change your "Opt Out" election retroactively.

There are online tools that help you identify if your income levels are such to qualify for Federal premium tax credits, and the Benefits Advisors at the Aon Retiree Health Exchange can guide you through that process, if needed. If you want to learn more now, these sites are helpful: www.healthcare.gov and kff.org/health-reform.

If you have questions about the option to "Opt Out" of your SERMA, or you wish to "Opt Out," please contact the Intel Health Benefits Center by calling 877-GoMyBen (466-9236). You must call to "Opt Out" as it cannot be completed online.

9.16 Domestic Partners Taxation

Reimbursements from SERMA for a domestic partner and children of a domestic partner are generally treated as taxable income. Intel will provide you with a 1099 for SERMA reimbursements for your domestic partner's (or their children's) eligible expenses that are reimbursed.

However, if your domestic partner is a tax dependent under the IRS rules for healthcare expenditures, you will not be taxed on the value of a domestic partner's reimbursement. The tax rules are complicated, but in general, a domestic partner may receive pre-tax health benefits (SERMA) if:

- The retiree and domestic partner have the same principal place of abode for the entire calendar year;
- The domestic partner is a member of the retiree's household for the entire calendar year;
- During the calendar year, the retiree provides more than half of the domestic partner's total support;
- The domestic partner is not the retiree's (or anyone else's) qualifying child under Code § 152(c); and
- The domestic partner is a US citizen, US national, or resident of the US, Canada, or Mexico.

If your domestic partner meets these criteria, contact the My Health Benefits Center at 877-GoMyBen (466-9236) to complete a qualified domestic partner affidavit so you will be exempt from tax on the SERMA. Please consult with your tax advisor for individual tax questions.

Section 10 – Claims – IRMP Self-Funded Options

10.1 Overview

This Section 10 does not apply to the Anthem Medicare Advantage (PPO) which is insured. For a specific plan information of the Anthem Medicare Preferred (PPO), go to www.anthem.com/ca/intelretiree/ and review the Evidence of Coverage Guide or call 800-811-2711.

10.2 Filing an IRMP Self-Funded Claim (Anthem HDHP, VSP, or SERMA)

- **In-Network:** Generally, you do not need to file claim forms for reimbursement for in-network benefits. However, you need to file a claim form if you have received emergency or urgent care services while traveling and are seeking in-network benefits. If you receive a bill from any in-network provider, contact Anthem at: 800-811-2711 for instructions or VSP Member Services at: 800-877- 7195. ***If you submit a claim, you must do so within one year of the date the service is provided or you forfeit the benefit.***
- **Out-of-Network:** You must submit a claim form each time you use out-of-network or Medicare eligible services. You must submit a request for payment of benefits within one year of the date the service was provided. Claims filed after one year from the date of service will be denied in full. If an out-of-network provider submits a claim on your behalf, you will be responsible for the timeliness of the submission. **If you don't provide this information within one year of the date of service, benefits for that health service will be denied.** This time limit does not apply if you are legally incapacitated. If your claim relates to an inpatient stay, the date of service is the date your inpatient stay ends.
- **SERMA:** For information on filing a reimbursement claim for SERMA, please refer to the SERMA section. To file a claim for eligibility for SERMA or a claim related to the calculation of your SERMA credit amount upon retirement, please see the post-service claim process below.
- If you disagree with how a claim has been paid, see the Appeals Process.

10.3 Claim Forms

Benefit	How to Obtain Claim Forms	Submitted Claim Forms
IRMP Anthem HDHP Claims	You can call Anthem at: 800-811-2711	**Anthem** Use the claim address indicated on the back of your Identification Card.
IRMP Anthem HDHP Prescription	You can call Express Scripts Member Services at: 800-899-2713	**Express Scripts** P.O. Box 14711 Lexington, KY 40512
Vision	You can call VSP Member Services at: 800-877-7195	**VSP Vision** Submit all claims through the VSP website: www.vsp.com
SERMA eligibility or credit amount	Intel Health Benefits Center at: 877-GoMyBen (466-9236)	Speak with representative. An inquiry will be reviewed by the Health Benefits Center. If you disagree with the outcome of your inquiry, you may request that your claim be reviewed by Intel GAM Health & Welfare Program Office
SERMA Reimbursement Claim	Intel Health Benefits Center at: 877-GoMyBen (466-9236) and select "Your Spending Account"	Speak with representative. An inquiry will be reviewed by the Intel Health Benefits Center. If you disagree with the outcome of your inquiry, you may request that your claim be reviewed by Intel GAM Health & Welfare Program Office.

NOTE: If you disagree with how a claim is paid, refer to the Appeals Process.

10.4 Types of Claims and the Claim Determination Process

Any claim for plan benefits will fit into one of several claim types—each with its own process for reviewing a claim and time period in which a determination will be made.

Pre-Service Claims

Sometimes, certain health services must be reviewed by a plan before the plan can provide benefits for those services. This is to ensure that the requested health services meet the plan's criteria for coverage. This process is called "care coordination notification," "prior authorization," or "utilization review." Services that require such review processes, and the procedures for obtaining such authorization, are outlined in the "How the Plan Works" section. Claims submitted to request authorizations for these services are called "pre-service claims," because these services are typically not provided until the plan has authorized them.

Urgent Care Claims

There are some claims for medical care or treatment where waiting for the usual claim determination process to finish could seriously jeopardize your life, health, ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would otherwise subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Claims of this type are called "urgent care claims." These claims will be processed in an

expedited manner, as outlined in the below table.

Post-Service Claims

Some health services either do not require care coordination notification, prior authorization, or utilization review, or you may receive such services before they are reviewed for authorization. These are called "post-service claims." For these, you will receive the health service and then you, your provider, or authorized representative will submit the claim to the plan for payment. SERMA claims are also post-service claims. A claim for SERMA eligibility, or SERMA credits must be submitted within one year of the date of your retirement from Intel.

10.5 Time Periods for Making Claim Determinations

The process for reviewing claims will depend on the claim type, as noted in the table below.

	Urgent Care Claims	Pre-service Claims	Post-service Claims
General time period for deciding your claim	A decision will be made as soon as possible, taking into account the medical exigencies, but no later than 72 hours after receipt of the claim by the Plan.	A decision will be made within a reasonable time, based on your medical circumstances, but no later than 15 days after your claim is received.	A decision will be made within a reasonable time, based on your medical circumstances, but no later than 30 days after your claim is received.
If your plan determines that more time is needed to decide your claim due to matters beyond its control	Your plan may only take more time to decide your claim if additional information is needed (see below).	Before the end of the initial 15 days, the Plan will notify you of the circumstances requiring the extension of time and the date by which it expects to render a decision. The Plan may take up to 15 additional days to decide your claim.	Before the end of the initial 30 days, the Plan will notify you of the circumstances requiring the extension of time and the date by which it expects to render a decision. The Plan may take up to 15 additional days to decide your claim.
If your plan determines that more time is needed to decide your claim because additional information is needed	You will be notified no later than 24 hours after receipt of your claim of the specific information necessary to complete your claim. Once your response is received, your claim will be decided within 48 hours – without regard to whether all of the requested information is provided. If you request, the Plan may, within its sole discretion, provide you	Before the end of the initial 15 days, you will be notified of the need for additional information. The notice will specifically describe the required information, and you will be given up to 45 days to respond. Once your response is received, your claim will be decided within 15 days – without regard to whether all of the requested information is	Before the end of the initial 30 days, you will be notified of the need for additional information. The notice will specifically describe the required information, and you will be given up to 45 days to respond. Once your response is received, your claim will be decided within 15 days – without regard to whether all of the requested information is

	more time to submit information.	provided. If you request, the Plan may, within its sole discretion, provide you more time to submit information.	provided. If you request, the Plan may, within its sole discretion, provide you more time to submit information.

10.6 Concurrent Medical Care Claims

There may be situations where you are receiving an ongoing course of treatment that has been approved by the plan for a specified period of time, or number of treatments. If you, your provider, or authorized representative make a request to extend this course of treatment beyond what has been approved, this is called a "concurrent care claim." Depending on the nature of the treatment you're receiving and your medical condition, a concurrent care claim will be treated as an urgent, pre-service, or post-service care claim.

For concurrent claims that meet the definition of urgent care claims, there are two time periods the plan will follow for making a determination, depending on how long before treatment ends that you request an extension:

- If the request to extend is made at least 24 hours before treatment ends, the plan will provide you with a determination within 24 hours of receipt of the claim.
- If the request to extend is made less than 24 hours before treatment ends, the time period and process for urgent care claims will be followed.

If the plan decides to reduce or terminate a previously approved course of treatment, you will be notified of this determination, and you will be given an opportunity to appeal this decision within a reasonable period of time before your treatment is reduced or terminated. For "how to file an appeal," see the Appeals Process section.

10.7 Communications that Are Not Claims for Benefits, or Are Failed Claims

Certain inquiries will not be considered a claim for benefits. These include:

- Questions concerning an individual's eligibility for coverage under a plan without making a claim for benefits.
- Requests for advance information on the plan's possible coverage of items or services – or advance approval of covered items or services where the plan does not otherwise require prior authorization for the benefit or service.
- Casual inquiries about benefits or circumstances under which benefits might be paid under the terms of the plan.

However, if you or your authorized representative fail to follow the plan's procedures for filing a pre-service claim, but otherwise a) communicate with the plan's claims unit; and b) identify a specific person, a specific medical condition or symptom, and a specific treatment, service or product for which approval is requested, then you or your authorized representative shall be notified of the failure. You will also be notified of the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to you or your authorized representative, as appropriate, as soon as possible, but not later than five days (24 hours in the case of failure to file a claim involving urgent

care) following the failure. Notification may be oral, unless you or your authorized representative request written notification.

10.8 Appointing an Authorized Representative

You may appoint an authorized representative to act on your behalf in submitting a claim for benefits and in appealing an adverse claim determination. Contact the plan administrator to find out the process for authorizing someone to act on your behalf.

If your claim involves urgent care or if you have a pre-service claim in the IRMP, a healthcare professional with knowledge of your medical condition (such as your treating physician) can act as your authorized representative without going through the plan's normal process for authorizing a representative.

If you clearly designate an authorized representative to act and receive notices on your behalf with respect to a claim, then in the absence of any indication to the contrary the plan will direct all information and notifications to which you are entitled to your authorized representative. For this reason, it is important that you understand and make clear the extent to which an authorized representative will be acting on your behalf.

10.9 Notice of Claim Determination

For pre-service and urgent care claims, the plan will notify you or your authorized representative of its determination on your claim—regardless of whether the determination is adverse or not. For post-service claims, you will receive a notice of the plan's claim determination if it is an adverse determination, and you may receive a notice if the claim is granted.

10.10 What is an Adverse Determination?

An adverse determination generally includes any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. However, if the plan has approved a benefit that will be provided over a period of time, such as a series of chemotherapy treatments, and has notified you of the scope of the treatment (such as how long and for how many treatments), the plan will not provide you with a formal notification that the course of treatment is coming to an end, unless the plan decides to reduce or terminate this course of treatment early. You will receive a notice of an adverse determination either in writing or electronically. However, for urgent care claims, you may be initially notified of the claim determination orally. If you are notified orally, within three days you will also be provided with a written or electronic notification of the determination.

For all types of claims, notice of adverse determinations will include the following information that applies to the determination on your claim:

- The specific reason or reasons for the adverse determination.
- Reference to the specific plan provisions on which the determination 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.
- A description of the plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on appeal.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge upon request.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.
- A description of the expedited appeal process if your claim is an urgent care claim.

10.11 Coordination of Benefits

If you or your dependent(s) are enrolled in IRMP and have coverage through another medical plan, benefits (i.e., medical and prescription drug claims) will be coordinated based on the rules in this section. One plan will pay benefits first ("primary" plan), and the other plan ("secondary" plan) may pay additional benefits depending on its coordination-of-benefits provision.

Determining the Primary Plan

If you or your eligible dependent(s) are enrolled in the IRMP and also have coverage through another medical plan, then benefits will be coordinated based on the rules in this section. One plan will pay benefits first (the "primary" plan), and the other plan (the "secondary" plan) may pay additional benefits depending on its coordination of benefits provision. If IRMP is the primary plan, benefits will be paid without regard to the other plan coverage. When the IRMP is the secondary plan, benefits will be limited to the amount normally payable under the IRMP as the primary plan, minus the benefits paid under the other coverage (this is also known as non-duplication of coverage).

- IRMP is the primary plan for the retiree and the secondary plan for an eligible spouse/dependent who also has coverage under another plan.

Examples of Coordinated Benefits

Your spouse is enrolled in his or her employer's medical plan. You and your spouse are also enrolled in IRMP. Your spouse incurs surgical expenses of $1,500 and he or she has already met the deductibles for both plans. Your spouse's plan is the primary plan for your spouse's claim.

Your spouse's plan, the primary plan for his or her coverage, pays 90 percent of the claim or $1,350. The IRMP Anthem HDHP in-network surgery benefit is the same and would pay 90 percent of the eligible expense after the deductible is met when it is the primary plan. Because IRMP Anthem HDHP is secondary for your spouse, the IRMP Anthem HDHP in-network benefit for the claim is reduced by the amount paid by your spouse's plan (the primary plan):

- IRMP Anthem HDHP benefit: $1,350
- Less the benefit paid by the spouse's plan (the primary plan): $1,350
- IRMP Anthem HDHP coordinated benefit: $0, the primary plan paid up to the IRMP Anthem HDHP benefit

How to File Claims if you have Multiple Coverage

If you and your eligible dependent(s) are covered by two plans, claim forms should be sent to the primary plan first. After the primary plan pays, copies of the same bills and the settlement sheet or Explanation of Benefits (EOB) you received from the primary plan should be sent to the secondary plan.

You are obligated to notify the IRMP if you have other coverage. Failure to notify the IRMP will result in the denial of claims for your enrolled eligible dependent(s) until you notify the IRMP of whether other coverage is available for your covered eligible dependent(s).

10.12 Overpayments

You are responsible to repay IRMP any overpayment. For example, an overpayment may occur if:

- All or some of the amount paid by IRMP were not paid by you or your enrolled spouse or dependent or was not legally required to be paid.
- All or some of the payment IRMP made exceeded the benefits under the plan.
- Any other error whereby IRMP overpaid you or your covered spouse or dependent's claim.

If the overpayment is due from another person or organization, you will assist in obtaining a refund of the overpayment.

If you or your enrolled spouse or dependent, or any other person or organization that was paid, does not promptly refund the full amount of the overpayment, IRMP may reduce the amount of any future benefits that are payable. IRMP may use other methods, such as collections, in addition to the right to reduce future benefits.

Offsetting

Anthem, as the claims third-party administrator for IRMP, uses offsetting and cross-plan offsetting to recover overpayments from providers who have agreed to such practice. Offsetting is the practice of recovering overpayments made to a provider by withholding overpaid amounts from subsequent payments to be made to the same provider. Cross-plan offsetting is the practice of recovering overpayments made to a provider for one member by withholding the overpaid amount from subsequent payments to be made to the same provider for another member, who receives benefits under a different group health plan for which Anthem pays claims on behalf of a different employer.

Section 11 – Appeals Process – IRMP Self-Funded Options

11.1 Overview

This Section 11 does not apply to the Anthem Medicare Advantage (PPO). For a specific plan information of the Anthem Medicare Preferred (PPO), go to www.anthem.com/ca/intelretiree/ and review the Evidence of Coverage Guide or call 800-811-2711.

11.2 Filing an IRMP Anthem HDHP, VSP, or SERMA Appeal

If you receive notice of an adverse benefit determination on your claim for benefits under the IRMP Anthem HDHP, VSP vision options, or SERMA, you have up to 180 days from the date you receive the notice to file an appeal.

Different appeals procedures will be followed, depending on whether your claim is an urgent care claim, a pre-service claim, or a post-service claim, see the table below for a summary of types of appeals and procedures. The decision maker for each type of appeal is as follows:

- Your plan supplier will decide appeals in all urgent care claims.
- Your plan supplier will review all pre-service and post-service appeals.
- Intel Health Benefits Services (HBS) will decide appeals for pre-services and post-service claims that involve eligibility or enrollment in the Plan.

The following table summarizes the appeals process for each type of appeal:

	Urgent Care	Pre-existing Claims	Post-service Claims
Who will review your appeal	Depending on the health services involved in your appeal, Anthem, VSP, or Express Scripts will review and decide your appeal.	Depending on the health services involved in your appeal, Anthem, VSP, or Express Scripts will review and decide your appeal unless the issue involves your eligibility or enrollment in the Plan. Intel Health Benefits Services will decide your appeal only if it involves your eligibility or enrollment in the Plan.	Depending on the health services involved in your appeal, Anthem VSP, Business Solver or Express Scripts will review and decide your appeal unless the issue involves your eligibility or enrollment in the Plan. Intel Health Benefits Services will decide your appeal only if it involves your eligibility or enrollment in the plan, SERMA reimbursement or SERMA credit amount.
How to file an appeal	Appeals must be filed directly with the plan supplier. You or your authorized representative can file an appeal either orally or in writing.	You or your authorized representative must file appeals in writing with the plan supplier. Your plan will review your appeal. Eligibility and enrollment appeals	You or your authorized representative must file appeals in writing with the plan supplier. Your plan will review your appeal. Eligibility, or enrollment in any of

	Urgent Care	Pre-existing Claims	Post-service Claims
	All necessary information, including the appeal determination, will be transmitted between the plan supplier and you or your authorized representative, by telephone, facsimile, or other available similarly expeditious method. See the Contact Information Table on page for address and telephone numbers.	will be forwarded to Intel Health Benefits Services. See the Contact Information Table for address and telephone numbers.	the plans, SERMA reimbursement, and SERMA credit amount appeals will be forwarded to Intel Health Benefits. See the Contact Information Table for address and telephone numbers.
Time period for deciding your appeal*	Your appeal will be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for appeal.	Your appeal will be decided within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of your request for appeal.	Your appeal will be decided within a reasonable period of time, but not later than 60 days after receipt of your request for appeal.

* The time period within which a decision on your appeal will be made shall begin at the time you file your appeal in accordance with the procedures in this section, without regard to whether you have submitted all the information necessary to make an appeal determination. However, if you so request, either the plan supplier, or Intel Health Benefits Services may, in their sole discretion, grant you additional time to submit more information on your appeal.

11.3 Procedures for all Appeals

- You or your authorized representative will be able to submit written comments, documents, records, and other information relating to your claim for benefits (and may do so orally or electronically for urgent care appeals).
- You or your authorized representative shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- All comments, documents, records, and other information submitted by you or your authorized representative that relate to your claim will be considered in the appeals process, regardless of whether such information was submitted or considered in the initial benefit determination.
- The appeals process will not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual.
- For adverse benefit determinations that are based in whole or in part on a medical judgment, including determinations regarding whether a particular treatment, drug, or other item is experimental or investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a healthcare professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This healthcare professional shall be an individual who was neither consulted in connection with the adverse benefit determination that is the subject of the appeal, nor is the subordinate of any such individual.
- Identification of any medical or vocational experts whose advice was obtained on behalf of the plan in connection with your adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination, will be provided upon request.

11.4 Appointing an Authorized Representative

You may appoint an authorized representative to act on your behalf in submitting an appeal. Contact the plan or Intel Health Benefits Services to find out about the process for authorizing someone to act on your behalf.

If your appeal involves urgent care, a healthcare professional with knowledge of your medical condition (such as your treating physician) can act as your authorized representative without going through the usual process for your plan, or Intel Health Benefits Services for authorizing a representative.

If you clearly designate an authorized representative to act and receive notices on your behalf with respect to a claim, then in the absence of any indication to the contrary the Plan will direct to your authorized representative all information and notifications to which you are entitled. For this reason, it is important that you understand and make clear the extent to which an authorized representative will be acting on your behalf.

11.5 Notification of Appeal Determination

For non-urgent care appeals, you will be notified in writing of the determination on your appeal. For urgent care appeals, you will be notified of the appeal determination by telephone, facsimile, or other available similarly expeditious method.

In the case of an adverse determination, the notification will include the following information:

- Specific reason(s) for the adverse determination.
- Reference to the specific plan provisions on which the determination is based.
- A statement that you are entitled to receive, upon request and free-of-charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits.
- Your right to obtain information about such procedures and a statement of your right to bring an action under section 502(a) of ERISA.
- If an internal rule, guideline or protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, and that a copy of such rule, guideline, protocol, or other similar criterion will be provided free of charge upon request.
- If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limitation, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

11.6 Contact Information Table – Where to File Your Appeal

Reviewing Organization	Contact Information	Phone Number
Intel Health Benefits Center (for SERMA reimbursement)	Intel Health Benefits website: www.intel.com/go/myben	Call the Intel Benefits Center toll-free at: 877-GoMyBen (466-9236)
Anthem (for the IRMP Anthem HDHP)	Anthem Appeals PO Box 54149 Los Angeles, CA 90054	800-811-2711
Express Scripts	Express Scripts 8111 Royal Ridge Pkwy. Irving, TX 75063-0000	800-637-6438
Vision Service Plan	Vision Service Plan P.O. Box 2350 Rancho Cordova, CA 95741-2356	800-877-7195

Section 12 – COBRA

12.1 Overview

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) is a federal law that enables you or your enrolled dependents to continue medical and dental coverage in the event that you or they lose coverage as the result of certain qualifying events. To receive COBRA coverage, you must enroll in continuation of coverage in accordance with Intel plan provisions and federal regulations governing COBRA.

In considering whether to elect COBRA, please note that failure to continue your group health coverage will affect your future rights under federal law. You can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have a gap of 63 days or more in your health coverage, an election of COBRA may help you avoid such a gap.

As a retiree, you may take advantage of either COBRA continuation coverage sponsored by the Intel Health and Welfare Plan (the active employee health plan referred to as the Group Health Plan). First, if you are enrolled in Intel group health plan benefits, you and your covered eligible dependent(s) may be eligible for COBRA at the time you retire. For information about COBRA continuation coverage due to retirement, refer to COBRA Continuation Coverage in the Intel Pay, Stock and Benefits Handbook.

Second, upon the expiration or termination of your COBRA coverage, you and your eligible dependent(s) may participate in the IRMP. Third, your eligible dependent(s) are enrolled in the IRMP or you have a SERMA balance, your eligible dependent(s) may be eligible for COBRA under the IRMP or SERMA if they lose coverage due to a COBRA qualifying event. This section describes how COBRA continuation coverage applies to retirees and eligible dependents who elect to participate in the IRMP or when you have a SERMA balance.

This section is only a summary of COBRA. For additional information, contact the Intel Health Benefits Center at: 877-GoMyBen (466-9236), Monday through Friday 5 a.m. to 5 p.m. Pacific.

12.2 COBRA Qualifying Event for IRMP or SERMA Participants

If your eligible dependent(s) are enrolled in any of the IRMP option or you have a SERMA balance, your eligible dependent(s) may be entitled to COBRA rights as the result of:

- Divorce
- Dissolution of domestic partnership
- A dependent child ceases to be eligible for coverage under the terms of the plan
- A spouse/domestic partner ceases to be eligible for coverage under the terms of the plan

If you are enrolled in the Intel Group Health Plan upon your retirement, you may be entitled to COBRA rights. However, you are not entitled to any COBRA rights under the IRMP.

12.3 Qualified Beneficiary

A qualified beneficiary is an individual who is covered under a group health plan the day before a qualifying event. Only qualified beneficiaries are entitled to elect COBRA coverage upon a qualifying event. Once you and your eligible dependent(s) begin participation in the IRMP or, you retire and have a SERMA balance, only your eligible dependent(s) can become a qualified beneficiary.

12.4 Length of COBRA Coverage

The table below summarizes the length of continuation coverage your enrolled eligible dependent(s) are entitled to under IRMP or SERMA as qualified beneficiaries.

Qualifying Event	Who	Coverage Period
Spouse/Domestic Partner/Dependent child losing eligibility	Dependents	36 months
Divorce or dissolution of domestic partnership	Dependent(s)	36 months

12.5 Required Notice to Intel

You or your eligible dependent(s) are responsible for notifying Intel within 60 days* of a COBRA qualifying event. To notify Intel, you must call the Intel Health Benefits Center at: 877-GoMyBen (466-9236) Monday through Friday 5 a.m. to 5 p.m. Pacific.

If you fail to notify Intel by calling the Intel Health Benefits Center within 60 days of the qualifying event, your affected eligible dependent(s) may not be entitled to elect COBRA coverage. You must call the Intel Health Benefits Center specifically for this purpose, even if Intel is otherwise notified of your divorce (e.g., you submit a Qualified Domestic Relations Order (QDRO)).

*If the 60-day period ends on a weekend, or business holiday, the notification period will be extended until the first business day following the 60th day.

12.6 Electing and Paying for COBRA Coverage

Upon a COBRA qualifying event and notice to the Intel Health Benefits Center, if your eligible dependent(s) is a qualified beneficiary, he or she will receive a COBRA enrollment form from the Intel Health Benefits Center, a third party contracted by Intel to provide COBRA administrative services. Your eligible dependent(s) must elect COBRA continuation coverage within 60 days of the date coverage would otherwise be lost because of a qualifying event or within 60 days of the date election materials are mailed, whichever is later. If your eligible dependent(s) does not elect COBRA coverage within this 60-day period*, IRMP and SERMA coverage ends in accordance with the provisions outlined in the Enrollment section of this booklet.

*If the 60-day period ends on a weekend, or business holiday, the election period will be extended until the first business day following the 60th day.

For a qualified beneficiary who elects COBRA coverage, the first COBRA coverage premium is due within 45 days of the date COBRA coverage is elected. Thereafter, COBRA premiums must be paid within 30 days of the date it is due.

COBRA premiums include the full applicable premium plus a two percent administrative charge. If your eligible dependent(s) fails to elect or pay for COBRA continuation coverage but continues to use healthcare services past the termination of coverage date, you will be responsible for repayment of all costs.

After the initial COBRA election, COBRA participants have the same rights as IRMP plan members to change their coverage at Annual Enrollment and upon a change- in-status event. For more information, see "Changing Your Coverage Elections" section.

12.7 Termination of COBRA Coverage

COBRA coverage will end at the end of the 36-month period or when certain events occur that automatically terminate coverage. COBRA coverage automatically terminates when any of the following occurs:

- On the date Intel no longer provides group healthcare coverage to any of its regular employees or retirees.
- If any premium for COBRA coverage (except the first) is not paid within 30 days of the due date. Coverage will terminate as of the last date paid, and the Plan will not be responsible for claims incurred following the coverage termination date.
- You must call Intel Health Benefits Center at: 877-GoMyBen (466-9236) Monday through Friday 5 a.m. to 5 p.m. Pacific, to provide notice of the following event that will automatically terminate COBRA coverage:
  - The date any person with COBRA coverage becomes covered (after the date of the COBRA election) **under any other health plan** that does not contain any exclusion or limitation with respect to any pre-existing condition of that person (other than an exclusion or limitation that does not apply to, or is satisfied by, you or your dependent under the Health Insurance Portability and Accountability Act of 1996).

Section 13 – Medical Privacy

13.1 Medical Privacy Overview

Intel has always taken voluntary steps to safeguard your personal information. The US Department of Health and Human Services has also issued the Privacy and Security Rule under the Health Insurance Portability and Accountability Act (HIPAA), and the HITECH Act of the American Recovery and Reinvestment Act of 2009, with additional requirements for health plans.

Under the Privacy Rule, the Intel health "plans" (Intel Health and Welfare Benefits Plan, Intel Retiree Medical Plan, Sheltered Employee Retirement Medical Account, Employee Assistance Plan, Health For Life Wellness Programs, Health For Life Centers, the Health FSA and the Limited Use Health FSA under the Flexible Benefit Plan) have implemented policies and procedures restricting the use and disclosure of your Protected Health Information ("PHI").

Under the Security Rule, the plans have implemented administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentially, integrity and availability of the electronic PHI that it creates, receives, maintains, or transmits.

Intel is the plan sponsor of the plans. Members of Intel's workforce have access to the PHI for administration functions of the plans. Intel shall have access to PHI and electronic PHI from the plans only as permitted under this amendment or as otherwise required or permitted by HIPAA.

You are not required to take any affirmative action to be protected under the Intel HIPAA Privacy or Security policies and procedures. For detailed description of how medical information about you may be used and disclosed, and how you can get access to this information, see the Notice of Privacy Practices posted on My Health Benefits website under Knowledge Center.

The plans may disclose PHI to Intel to the extent necessary for plan administration purposes. Plan administration purposes means administration functions performed by Intel on behalf of the plans, such as quality assurance, claims processing, and auditing, population-based activities designed to improve health or reduce costs such as disease management or wellness programs. Enrollment and disenrollment functions performed by Intel, or a third-party administrator, are performed on behalf of plan participants and beneficiaries, and are not plan administration functions. Enrollment and disenrollment information provided to Intel and held by Intel is held in its capacity as an employer and is not PHI.

Intel will not use or disclose PHI in a manner inconsistent with the HIPAA privacy rules.

Where required by HIPAA, Intel agrees that with respect to any PHI disclosed to it by the plans, Intel shall adhere to the following:

- Not use or further disclose the PHI other than as permitted or required by the plans or as required by law.
- Ensure that any agent, including a subcontractor, to whom it provides PHI received from the plans, agrees to the same restrictions and conditions that apply to Intel with respect to PHI.
- Not use or disclose the PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of Intel.
- Report to the plans any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware.

- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524.
- Make available the information required to provide an accounting of disclosure in accordance with 45 CFR § 164.528.
- Make available PHI for amendment, and incorporate any amendments to PHI, in accordance with 45 CFR § 164.526.
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the plans available to the Secretary of Health and Human Services for purposes of determining compliance by the plans with HIPAA's privacy requirements.
- If feasible, return or destroy all PHI received from the plans that Intel still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to the purposes that make the return or destruction of the information infeasible.
- Ensure that the adequate separation between plans and Intel required by 45 CFR § 504(f)(2)(iii) is satisfied.
- If Intel creates, receives, maintains, or transmits any electronic PHI (other than enrollment/disenrollment information and Summary Health Information, and information disclosed pursuant to a signed authorization, which are not subject to these restrictions) on behalf of the covered entity, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI.
- Intel will ensure that any agents to whom it provides such electronic PHI agree to implement reasonable and appropriate security measures to protect the information.
- Intel will report to the plans any security incident of which it becomes aware.

13.2 Adequate Separation Between Plans and Intel

Intel shall allow only specific parties' access to PHI to the extent necessary to perform the plan administration functions that Intel performs for the plans. In the event that any of these specified parties does not comply with the provisions of this section, the party shall be subject to disciplinary action by Intel for noncompliance pursuant to Intel's discipline and termination procedures.

Intel will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the parties have access to electronic PHI.

Section 14 – Glossary

Annual Enrollment

The annual period of time during which retirees can change enrollment of medical plans and enroll or drop your eligible dependent(s) in the medical plan. It is held annually (usually in the October-November time frame) with all enrollment changes effective January 1 of the following year.

Anthem

The organization contracted to provide claims administration services and access to the Anthem participating providers for the IRMP.

Calendar Year

Begins January 1 and ends December 31.

Claims Administrator

Organizations contracted by Intel (e.g., Anthem, Express Scripts, VSP) that provide administrative services, including claims administration, for the IRMP.

Coinsurance Payments

The share of the charges, usually a percentage, that the plan member and the plan each pay.

Coinsurance Maximum

The coinsurance maximum is the most you pay in coinsurance expenses for covered services in a plan year.

Coordination of Benefits

Rules that determine the order in which health plans must reimburse claims when coverage is provided by multiple health plans. See Section 10 Claims in this booklet for more information.

Copayment or Copay

The fixed dollar fee you pay when obtaining some covered services in the IRMP. The amount of copayment required varies. Please review the appropriate benefit chart (Medicare or Non-Medicare) for more information.

Covered Medical Service(s)

As defined in the Covered Medical Services section.

Covered Providers

Licensed providers are limited to:

- Medical doctors
- Ophthalmologists and Optometrists
- Certified acupuncturists
- Naturopaths
- Osteopaths
- Chiropractors

- Podiatrists
- Physical and occupational therapists
- Midwives
- Speech therapists
- Licensed clinical psychologists

Christian Science practitioners (must be listed in the Christian Science Journal as a Christian Science Practitioner) provided they:

- Practice within the scope of their license
- Practice within the scope of generally accepted medical practices
- Are recognized by the state in which they practice

Licensed clinical social workers and licensed marriage, family, and child counselors are also covered, provided they must either:

- Be licensed or certified by the appropriate governmental authority having jurisdiction over such licensure or certification in the jurisdiction where the provider renders service to a retiree, eligible dependent(s).
- Be a member or fellow of the American Psychological Association if there is no licensure or certification in the jurisdiction where that provider renders service to a retiree, eligible dependent(s).
- Providers who are professionally registered in their state, but do not meet these criteria, will not be covered.

Deductible

The amount an individual or family must first pay before reimbursements from coinsurance for covered benefits are available.

DME

Durable Medical Equipment

Drug Utilization Review Program

A computerized drug monitoring service provided by Express Scripts designed to help promote appropriate drug therapy for you and your enrolled eligible dependent(s) in the IRMP.

Eligible Dependent

A person defined under the eligibility rules for whom you may elect coverage under the IRMP.

EMS – Extended Medical Services Group

Primary Care Physicians (PCP) and specialists who work together under a single contract with Anthem. A PCP who is part of the EMS group can provide referrals only to specialists within the same EMS group. The only exception to this requirement is when a required specialist is not part of the EMS group.

Express Scripts

The organization that administers the pharmacy claims and provides access to a network of contracted pharmacies.

Free-Standing Surgical Facility

An institution that meets all of the following requirements:

- Has a medical staff of physicians, nurses, and licensed anesthesiologists.
- Maintains at least two operating rooms and one recovery room.
- Has immediate access to diagnostic laboratory and X-ray facilities.
- Has equipment for emergency care.
- Has a blood supply.
- Maintains medical records.
- Has agreements with hospitals for immediate acceptance of patients who need hospital confinement on an inpatient basis.
- Is licensed in accordance with the laws of the appropriate legally authorized agency.

Group Health Insurance

An employee/retiree healthcare plan maintained by an employer or union that provides medical care to employees and often to their dependents.

Healthcare Benefits

Includes benefits for medically necessary and appropriate medical services, prescription drugs, vision, chiropractic and mental health and chemical dependency coverage. Through COBRA employees have the ability to continue healthcare insurance should the employee or the employee's dependents lose eligibility for the IRMP.

Health Plan Medical Director (or designee)

A physician charged by the IRMP with responsibility for overseeing the delivery of health services and maintaining utilization review and quality assurance programs.

HIPAA

Health Insurance Portability and Accountability Act of 1996

Home Healthcare Agency and/or Services

A hospital or a nonprofit or public agency which:

- Primarily provides skilled nursing services and other therapeutic services under the supervision of a physician or a registered graduate nurse.
- Is run according to rules established by a group of medical professionals.
- Maintains clinical records on all patients.
- Does not primarily provide custodial care or care and treatment of the mentally ill.
- Is licensed and runs according to the laws.

Hospice

A facility or program that offers home care and/or inpatient care for a terminally ill patient and the patient's family. The program provides supportive care to meet the special needs arising out of physical, psychological, spiritual, social, and economic stresses that are experienced through the final stages of illness and bereavement.

Hospital

Services provided by an institution that meets one of the following criteria:

- Is licensed as a hospital, which maintains on-the-premises facilities necessary for medical and surgical treatment, provides such treatment on an inpatient basis, for compensation, under the supervision of physicians, and provides 24-hour service by registered graduate nurses.
- Is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals and is a provider of services under Medicare, such as a hospital, a psychiatric hospital, or a tuberculosis hospital, as those terms are defined by Medicare.
- Is licensed in accordance with the laws of the appropriate legally authorized agency for an institution that specializes in treatment of mental illness, alcohol, drug dependence, or other related illness and provides residential treatment programs.

Intel Health Benefits Center

Service center for IRMP enrollment, billing and SERMA record keeping. For IRMP and SERMA questions, call the Intel Health Benefits Center at: 877-GoMyBen (466-9236), Monday through Friday 5 a.m. to 5 p.m. Pacific.

Legend Drugs

FDA labeled federal law prohibits dispensing without a prescription.

Maintenance Medication

Also known as long-term drugs are used to treat ongoing and chronic conditions such as cholesterol, asthma, acid reflux, and high blood pressure.

Maximum Allowed Amount (MAA)

Maximum Allowed Amount (MAA) is determined based on the lesser of the provider's normal charge for a similar service or supply; or a percentile of charges made by providers of such service or supply in the geographic area where the service is received. These charges are compiled in a database we have selected.

NOTE: The provider may bill you for the difference between the provider's normal charge and the Maximum Allowed Amount, in addition to applicable deductibles, copayments and coinsurance. Some providers forgive or waive the cost share obligation (e.g., your copayment, deductible and/or coinsurance) that this plan requires you to pay. Waiver of your required cost share obligation can jeopardize your coverage under this plan.

Medicare Approved Charge

The Medicare-approved charge is the maximum amount that Medicare will recognize for a particular service or procedure. When a provider accepts Medicare assignment, it means that he or she agrees to accept the Medicare approved charge for the services as payment in full.

Medicare Part A

Medicare Part A is one of two components of Medicare (Part B is the other, see below). Medicare Part A is hospital insurance and, in most cases, is paid for by Social Security. Medicare Part A covers such services as hospital stays, care in a skilled nursing facility, home healthcare and hospice care.

Medicare Part B

Medicare Part B is one of two components of Medicare (Part A is the other, see above). Medicare Part B is medical insurance and is financed in part by monthly premiums paid by Medicare beneficiaries.

These premiums are subject to increase each year, and you are responsible for satisfying a separate, annual deductible for Part B benefits. Medicare Part B covers such services as physicians' services, diagnostic tests, outpatient hospital services and X-rays.

Medicare Part C/Medicare Advantage

A type of Medicare health plan offered by a private company that contracts with Medicare to provide you with all your Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. If you're enrolled in a Medicare Advantage Plan, most Medicare services are covered through the plan and aren't paid for under Original Medicare. Most Medicare Advantage Plans offer prescription drug coverage. For more information go to medicare.gov.

Medicare Part D

Medicare Part D is a prescription drug benefit for people with Medicare in the United States. It is enacted as part of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). The benefit started on January 1, 2006.

Medicare Eligible Benefits

Coverage provided for both medically necessary treatment and routine wellness care (in accordance with plan provisions and limitations) to participants eligible for Medicare. Reimbursement for covered services begins after the individual or family deductible is met. Payments are based on Maximum allowed amount charges for the applicable geographic area and the course of treatment used. If the Participant is Medicare eligible, Medicare coverage is the primary payer and the IRMP is the secondary payer.

Out-of-Pocket Maximum

The maximum out-of-pocket expenses that a plan member incurs before coverage of allowable expenses are paid at 100 percent. Certain exclusions apply. See appropriate benefits section of this booklet (Section 4 Non-Medicare IRMP and/or Section 7 Medicare IRMP).

PAC

Pre-Admission Certification

Participating Provider

An institution, facility, agency, or healthcare professional who is under contractual agreement with Anthem, Express Scripts, VSP, or Managed Health Network to provide medical coverage or supplies to plan members.

PCP – Primary Care Physician

Generally, a family practitioner, a general practice practitioner, a pediatrician, or an internist who has contracted with a health plan to manage and coordinate your healthcare.

Plan Approved Charge

The amount of the billed charge the plan allows for a covered service.

PPO – Preferred Provider Organization

An organization providing health care that gives economic incentives to the individual purchaser of a health-care contract to patronize certain physicians, laboratories, and hospitals that agree to supervision and reduced fees

Retail Refill Allowance

Allows Express Scripts plan participants to fill a maintenance medication prescription twice at retail pharmacies. This is a trial period to ensure the medication is effective with no adverse side effects. After the second fill, participants will pay a higher cost if they continue to fill maintenance prescription at retail. Participants may fill maintenance prescriptions through mail order to avoid paying the higher cost.

TRICARE

Healthcare program for US military dependents and retirees.

Urgent Care

Care for conditions that need immediate attention from a doctor or nurse but are not critical or life threatening.

VSP

Vision Service Plan, the supplier who administers the Intel Retiree routine vision benefit. A specialty network and claims administrator where you seek care to receive in-network vision coverage under the IRMP vision plan.