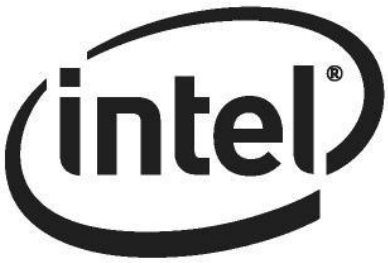

Intel Retiree Medical Plan
and
Sheltered Employee Retirement Medical Account

2016 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 modify, change, or discontinue anything provided or defined under the IRMP and the SERMA program, at its sole discretion, by appropriate action of its board of directors or other persons designated by the board. 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 the IRMP and SERMA. The IRMP medical and vision plans are plans available from Intel Corporation (“Intel”) to eligible retirees and their eligible dependents. This document also provides information about SERMA, an administrative and accounting mechanism that helps eligible Intel retirees purchase health insurance.

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Section 1 –Overview

The Intel Retiree Medical Plan (IRMP) gives you access to medical coverage options and vision coverage options upon retiring from Intel. A retiree health reimbursement account (the Sheltered Employee Medical Retirement Account) is also established for eligible Intel retirees.

IRMP & SERMA Overview

If you retire from Intel as a U.S. employee and have satisfied the eligibility requirements, Intel offers two ways to help you get healthcare coverage:

1. **The Intel Retiree Medical Program (IRMP):**
   Intel offers retirees and their eligible dependents the option to purchase medical and vision coverage through the IRMP.

   An Intel Catastrophic Rx Health Reimbursement Account (HRA) is also available to Medicare eligible Intel Retirees who are **enrolled** in a Medicare Part D Plan to provide more financial protection and extra peace of mind regarding prescription expenses. No enrollment or election is necessary for this benefit, but you must be enrolled in a Medicare Part D Plan to use the Catastrophic Rx HRA.

2. **The Sheltered Employee Medical Retirement Account (SERMA)**:
   If eligible, a SERMA will be established for you, your surviving spouse and surviving eligible dependent child(ren). You may use SERMA credits to pay for IRMP medical and/or vision coverage premiums or you may use SERMA to reimburse yourself for other eligible health insurance premiums paid by you for you and your eligible dependents.

The **Aon Retiree Health Exchange** is available to help all Intel retirees find the right healthcare options and perhaps save money with a plan comparable to the IRMP. The Aon Retiree Health Exchange is a private health insurance exchange for individual coverage options that provides tools, resources, and ongoing personalized support.

Resources available at this one-stop shop are free for you and your family. If you have questions please contact the **Intel Health Benefits Center** by calling **(877) GoMyBen** (466-9236).

Maximize the Value of Your SERMA

The IRMP may not be the best plan for all retirees. Retirees who are not Medicare eligible (typically under age 65), who are healthy, can often purchase health insurance that costs much less than the comprehensive coverage offered by the IRMP. Insurance companies can distribute the risk over a larger population of covered members, thereby lowering member premiums.

You can maximize the value of your SERMA by understanding your available options:

- For retirees who are not eligible for Medicare (typically under age 65), research the cost of coverage you can purchase elsewhere, as this may be the least expensive option for you
- For retirees eligible for Medicare, understand your Medicare eligibility and coverage options
- Know when you will need coverage and what level of coverage you will need.

You may use your SERMA to pay premiums for IRMP coverage or non-IRMP coverage. How you choose to use your SERMA, e.g., premiums for IRMP or other health insurance, covering eligible dependents or yourself only, will impact how long your SERMA balance will last.

Section 2 – IRMP Eligibility and Enrollment

IRMP Eligibility

When you retire from service with Intel U.S., an eligible Intel subsidiary or an eligible Intel owned entity that is designated as a participating company by the plan administrator, and meet eligibility requirements, you will be able to participate in the IRMP. To meet the eligibility requirements, you must retire as a U.S. employee, and meet one of 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 or domestic partner are retirees of Intel and are eligible, each of you can be covered individually under the IRMP. However, only one of you may enroll your eligible dependent child(ren).

If you return to work at Intel or any of its affiliates or subsidiaries after your retirement, both you and your eligible dependents will be eligible to participate in the applicable health plan for active employees. Active employees and their dependents are not eligible for the IRMP.

Surviving Dependent Eligibility

If you die, your surviving eligible dependents may continue coverage in the IRMP. However, if your surviving spouse remarries following your death or same-sex domestic partner (herein referred to as domestic partner) enters a new domestic partnership or becomes legally married; he or she will not be able to add his or her new spouse or domestic partner or new spouse or domestic partner's children as a dependent in the IRMP.

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, not to exceed six years) 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.

Enrollment

To enroll and begin coverage 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 end date of your Intel Group Health Plan COBRA coverage
- 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 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 7 a.m. to 5 p.m. (Pacific).
- **Web** – www.intel.com/go/myben – Available 24 hours per day, seven days per week.

Eligible Dependent

To enroll your eligible dependent(s) in the IRMP medical or vision plans, you must also be enrolled in the plan. However, in the event of your death, your eligible dependent(s) are eligible to enroll in the IRMP medical or vision plans.

Eligible dependents are limited to the following:

- Your legally married spouse as per the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages.
- Your eligible same-sex domestic partner* (hereafter referred to as domestic partner) and eligible dependent children of your domestic partner. Please see the section below on Domestic Partnership Enrollment Process.
- Your eligible child until the child's 26 birthday. An eligible "child" means an individual who is a son, daughter, stepson or stepdaughter, an adopted child, eligible foster child, or those children made eligible by a Qualified Medical Child Support Order (QMCSO). An adopted child includes an individual who is lawfully placed with you for legal adoption. An eligible foster child is an individual who is placed with you by an authorized placement agency or by a judgment, decree, or other order of any court of competent jurisdiction.

*Domestic Partner Eligibility

The IRMP includes coverage for same sex domestic partners for a transition period described below. With the exception of tax treatment – as required by the Internal Revenue Service (IRS) – and the enrollment process, all other definitions of eligibility and general administration of the IRMP apply equally to enrolled domestic partners as they do to legally married spouses.

Who is eligible for Domestic Partner coverage?
Same-sex Domestic Partners of U.S. Intel employees and eligible dependent children of Domestic Partners are eligible to enroll in the IRMP in states where same-sex marriage was just recently recognized for a transition period only. After the transition period, Domestic Partners and their children are no longer eligible for coverage in the IRMP.

What is the transition period?
The transition period allows time for same-sex Domestic Partners to plan for obtaining other coverage for their Domestic Partner (and the Domestic Partner's children if applicable) or to marry. Once legally married, a new spouse & eligible dependents may be enrolled in the IRMP. Domestic Partner coverage is available until December 31, 2016 if you reside in one of the following states: Alabama, Arkansas, Georgia, Kentucky, Louisiana, Michigan, Mississippi, Missouri, Nebraska, N. Dakota, Ohio, South Dakota, Tennessee and Texas.

To complete the enrollment process, you must enroll and submit the certification of domestic partnership within 30 days of the date your domestic partner becomes eligible. The certification of domestic partnership and domestic partner Information are available online at www.intel.com/go/myben or by calling the Intel Health Benefits Center at (877) GoMyBen (466-9236) Monday through Friday 7 a.m. to 5 p.m. (Pacific).

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, as long as all of 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 day before 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.

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 Indemnity with Rx IRMP Indemnity without Rx	IRMP Cigna Coinsurance Plan
If ***you are*** Medicare eligible and your ***eligible dependent is not***	IRMP Cigna Coinsurance Plan	IRMP Indemnity with Rx IRMP Indemnity without Rx

Proof of Continuous Coverage

Proof of Continuous Coverage is documentation of 18 months of continuous health care coverage without a break in coverage of 63 days or more.

NOTE: Enrollment after age 65 requires Proof of Continuous health care coverage, such as an individual health insurance policy, employer plan, Medicare Part A, B and D, COBRA, VA or TRICARE. Non-comprehensive Medicare coverage (e.g., enrollment in Parts A or B only, and/or Part A or D only) **does not** count as acceptable continuous health care coverage for purposes of enrolling in the IRMP after age 65.

When Proof of Continuous Coverage is required for IRMP Medical plan, it must be received by the Intel Health Benefits Center within 30 days of the change-in-status event date to enroll in the IRMP. The following details when proof of continuous coverage is and is not required to enroll in the IRMP.

Your 65th birthday (eligible for Medicare):
You can enroll in the IRMP *without* proof of continuous health care coverage, provided you enroll in an IRMP plan within 30 days of the date you become eligible for Medicare due to your 65th birthday. This is your last opportunity to enroll in the IRMP without proof of continuous health care coverage.

Your eligible dependents can also enroll in the IRMP effective on the date you become eligible for Medicare due to your 65th birthday provided you enroll your eligible dependents within 30 days of your 65th birthday. Your eligible dependents *will* be required to provide proof of 18 months of continuous health care coverage without a break in coverage of 63 days or more.

Your spouse's or eligible domestic partner's 65th birthday (eligible for Medicare):

- Your spouse or eligible domestic partner can enroll in the IRMP *without* proof of continuous health care coverage; provided you are enrolled in the IRMP and you enroll your spouse or eligible domestic partner within 30 days of your spouse or eligible domestic partner's 65th birthday. This is their last opportunity to enroll in the IRMP without proof of continuous health care coverage.
- You can also enroll in the IRMP effective on the date your spouse or eligible domestic partner's 65th birthday, provided you enroll within 30 days of their 65th birthday. In order to enroll, you are required to provide proof of 18 months of continuous health care coverage without a break in coverage of 63 days or more.

Important Information you Need to Know if you Choose Not to Enroll in IRMP – Medical Plan upon Retirement

Medicare Eligible (typically age 65 and over):
If you or your dependent(s) choose not to enroll upon your retirement or upon becoming eligible for Medicare or drop IRMP- medical plan coverage after reaching age 65, you must provide proof of 18 months of continuous health care coverage (e.g., a letter or certificate reflecting your coverage dates from you or your spouse's *employer* health plan, TRICARE, VA or COBRA coverage), without a break in coverage of 63 days or more, in order to enroll in IRMP.

Enrollment in Medicare Parts A, B, and D will be considered proof of continuous coverage.
Non-comprehensive Medicare coverage **does not** meet the proof of continuous health care coverage requirement for enrolling in the IRMP-medical plan after age 65. The following examples would be considered acceptable proof of continuous coverage:

- Enrollment in Medicare Parts A and B and D
- Enrollment in Medicare Parts A and B and proof of Part D creditable coverage (i.e. VA Prescription benefit/TriCare)

Non Medicare (typically under age 65):
If you or your dependent(s) are under age 65 and choose not to enroll upon your retirement or after COBRA coverage sponsored by Intel ends, you must provide proof of 18 months of continuous health care coverage, without a break in coverage of 63 days or more (e.g., a letter or certificate reflecting your coverage dates from you or your spouse's *employer* health plan, TRICARE, VA or COBRA coverage), in order to enroll in the IRMP- medical plans.

Changing Your Coverage Elections

Under the IRMP, you have the opportunity to 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:

- Marriage, divorce, legal separation, or annulment
- You enter into or terminate a domestic partnership (in accordance with the terms and conditions of the certification of domestic partnership)
- Death of your eligible dependent
- You, your spouse or domestic partner or child gains or loses other health care coverage, including COBRA coverage
- You, your eligible dependent(s) become entitled to Medicare or Medicaid or lose Medicare or Medicaid entitlement

All election changes must be consistent with the change-in-status event. If you, your spouse or domestic partner or eligible child experience a change-in-status event, you must enroll or drop coverage within 30 days of the event date. In order to enroll, except for marriage or loss of other health care coverage, you must submit proof of 18 months of continuous health coverage, without a break in coverage of 63 days or more 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) have purchased coverage in an IRMP medical plan and become Medicare eligible while enrolled, you will receive notice from the Intel Health Benefits Center informing you that your enrollment will be automatically switched to the Medicare IRMP Indemnity and your premium rates will reflect the change effective the first of the month in which you become eligible for Medicare. In addition, note that Medicare will be considered your primary coverage and the IRMP medical plan is secondary. These premiums are effective the date you or your eligible dependent(s) become eligible for Medicare only if the Intel Health Benefits Center receives the completed Enrollment Change Form within 30 days of the date you or your eligible dependent(s) become eligible for Medicare.

If you and/or your eligible dependent(s) are already enrolled in the IRMP medical plan, and the Enrollment Change Form is received by the Intel Health Benefits Center after 30 days from the date you or your eligible dependent(s) become eligible for Medicare, the premium change is effective on the first of the month following the month when the Intel Health Benefits Center receives your or your spouse's or domestic partner's Enrollment Change Form.

When IRMP Medical and Vision Benefits Begin

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 make your election within

30 days of your retirement date
- The day after your COBRA coverage sponsored by Intel ends, if you make your election within 30 days of your COBRA coverage end date
- The date of a change-in-status event, if you make your election within 30 days of your change-in-status event

When IRMP Medical and Vision Benefits End

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

For Yourself:

- 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, if you elect to stop coverage within 30 days of a change-in-status event
- The date Intel terminates your 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 of your death
- The date you return to work at Intel or begin employment at an Intel subsidiary or affiliate

For your eligible dependent(s):

- December 31 of the year in which you elect to discontinue coverage for your dependent(s) during Annual Enrollment
- The last day of the month of a change-in-status event,
- The last day of the month your dependent(s) no longer meets the eligibility definition for the plan
- The date Intel terminates the your dependent(s) coverage for nonpayment of a required premium
- 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 of your eligible dependent(s) death
- The date you return to work at Intel or begin employment at an Intel subsidiary or affiliate
- 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.

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 cancelled effective midnight on the last day of the fully paid month (or the date of initial enrollment if payment was never made).

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 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 Enrollment section.

IRMP premium rates may be adjusted annually, for example, based on actual claims and administrative fees, claim utilization, benefits coverage levels, and health care cost trends.

Section 3 - IRMP Medical Non-Medicare Plan (typically under age 65)

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 Cigna Coinsurance plan.

Coverage under IRMP Cigna Coinsurance includes medical, mental health, chiropractic, and prescription drug benefits. It does not include vision or dental coverage.

You pay the entire cost of covering yourself and your eligible dependent(s), if enrolled. The Cigna Coinsurance monthly premiums are available on the *My Health Benefits* Web site 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 Plan Works section.

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 receive Medicare-eligible benefits, and the non-Medicare-eligible person will be eligible to enroll in the Cigna Coinsurance plan.

How the IRMP Cigna Coinsurance Plan Works

If you are a Cigna Coinsurance plan member, you will receive covered benefits for both preventive and medically necessary treatment. Under the Cigna Coinsurance plan you may receive services from in-network or out-of-network providers. Covered benefits begin after you meet an individual or family plan deductible for in-network and a separate deductible for out-of-network. After the deductible is satisfied, covered services will be paid at 80 percent of allowable cost for in-network or 60 percent of allowable cost for out-of-network.

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

Deductibles

A deductible is the dollar amount an individual must pay before any charges are reimbursed by the medical plan. When accessing medical care, you must first satisfy an annual deductible equal to the first $600 individual or $1,200 family for in-network and an additional $600 individual or $1,200 family deductible for out-of-network of eligible medical expenses you incur in a calendar year.

Prescription drug copayments and coinsurance do not count toward your deductible.

Coinsurance Payments

The coinsurance amount is a percentage of the allowable charge of covered services. You will be required to first pay the annual deductible before the plan will begin to pay claims. Once you have met your deductible, you will pay the applicable coinsurance amount for covered services. The coinsurance payment varies depending on whether you are accessing in-network or out-of-network benefits. See the Benefits Chart section for details.

IMPORTANT: If you utilize out-of-network services, you may be responsible for paying the difference between the actual billed amount for out-of-network services and the eligible expense (e.g., reasonable and customary amount) in addition to the coinsurance amount. The amount you pay over reasonable and customary 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 R&C	$100
Difference: Provider discount	$50	Difference: Patient Responsibility	$50
Coinsurance (20% of $100, after deductible is met)	$20	Coinsurance (40% of $100, after deductible is met)	$40
Total Patient Responsibility	$20	Total Patient Responsibility	$90 (coinsurance plus difference between allowable and billed amount)

About the Cigna Provider Network

Cigna is the claims administrator for the Cigna Coinsurance plan. Members enrolled in the plan have access to the Cigna Open Access Plus (OAP) provider network.

Cigna Coinsurance allows you the option of selecting a primary care physician (PCP). A PCP gives you a valuable resource and a personal health advocate. You decide each time you need medical care whether to use providers who are in-network or providers who are out-of-network. If you would like to receive in-network benefits, you are responsible for confirming that all providers (specialists, hospitals, labs, etc.) are in-network. **NOTE: Choosing in-network services provide the highest level of benefits at the lowest cost to you**. IRMP Cigna Coinsurance Plan Participating Providers are listed in the Provider Directory, available from Cigna by calling (800) 468-3510 or at www.myCigna.com.

In-Network Benefit

To receive in-network benefits, you and/or your eligible dependent(s) must use Cigna OAP network providers. You receive the highest level of coverage at the lowest cost by receiving your care from any of the providers or facilities in the Cigna OAP network. You can receive care from any of the providers or facilities in the Cigna OAP network without a referral, although some services may require authorization by the health plan (please see Prior Authorization Requirements section). If you choose to self-refer to a doctor or hospital, it is your responsibility to verify the provider you select is an in-network provider. A provider directory is available from Cigna at (800) 468-3510 or at www.myCigna.com.

Primary Care Physician (PCP)

Intel encourages Cigna Coinsurance members 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 health care 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:

- Manages all your routine medical needs
- Refers you to specialists, if needed
- Refers 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.

Choosing or Changing your Primary Care Physician

To choose or change your PCP, contact Cigna Member Services at (800) 468-3510 or on the Web at www.myCigna.com. This is a secure, personalized online web site for accessing health and benefits information specifically for and about you.

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 Cigna network includes participating providers nationwide. Cigna Customer Service can help you locate participating doctors and facilities wherever you are.

Out-of-Network Benefits

You will receive benefits if you choose to seek services through a non-Cigna network provider,

but services are covered at the lower out-of-network benefit level. Covered out-of-network benefits begin after you meet the annual out-of-network $600 individual or $1,200 family deductible. After the deductible is satisfied and you submit a claim form, most medically necessary health care services are reimbursed at 60 percent of the reasonable and customary (R&C) charge.

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.

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 eligible expenses at 100 percent. The amount you pay to reach this level of coverage is called the out-of-pocket maximum. The out-of-pocket maximum for the Cigna Coinsurance plan is $3,000 for an individual; $6,000 for family (includes deductible).

Your prescription copayments and coinsurance apply to your out-of-pocket maximum. For your convenience, Express Scripts and Cigna will coordinate your prescription drug expenses and help manage your out-of-pocket maximum. However, it is your responsibility to provide proof of payment (e.g., Explanation of Benefits, receipt) to accumulate towards the medical out-of-pocket maximum. For exclusions to the out-of-pocket maximum calculations, see table below.

Covered Services Exclusions to Out-of-Pocket Maximum Calculations

	In-Network Benefits	Out-of-Network Benefits
Prescription drug retail surcharge and costs beyond the copayments	X	X
Surgeon's fees paid at 50% because a required second opinion was not obtained		X
The $500 penalty incurred when inpatient hospitalizations are not certified		X
Charges above reasonable and customary rates and charges that are otherwise excluded under the plan	X	X

MAXIMUM LIFETIME BENEFIT

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

Additional Networks

Other organizations administer certain specialized benefits provided by the Cigna Coinsurance plan. Each of these specialty administrators contracts with certain providers. In order to receive in-network benefits, you must seek care from one of these network providers. If you elect to use out-of-network providers for your care, you receive a reduced benefit or benefits may be denied. Both in-network and out- of-network specialized benefits are administered by the specialty networks. Most retirees can access all of these specialty networks. The specialty networks are identified in the Specialty Networks table below.

Provider Network	Cigna Open Access Network
Mental Health and Chemical Dependency	Cigna Behavioral Health
Prescription Services	Express Scripts

IRMP Medical - Cigna Coinsurance Benefits Chart

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

Plan Provisions	IRMP Cigna Coinsurance In-Network	IRMP Cigna Coinsurance Out-of-Network
Deductible Wherever coinsurance percentages are payable by you, you must first meet the deductible.	$600 Individual $1,200 Family	$600 Individual $1,200 Family
Out-of-Pocket (OOP) Maximum	$3,000 individual / $6,000 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 (PAC), Continued Stay Review (CSR), and Surgical Precertification	Handled by Cigna provider	Covered member must ensure authorization is obtained from Cigna HealthCare
Primary Care Physician • Office Visit Services (including medical eye	20% coinsurance after the deductible has been met	40% coinsurance based on Reasonable and Customary (R&C) charges (after deductible)

Plan Provisions	IRMP Cigna Coinsurance In-Network	IRMP Cigna Coinsurance Out-of-Network
care via ophthalmologist) • Adult Medical Care • Injections		
Preventive Care Services • Preventative Care Routine Immunizations and Injections	100% covered	100% covered up to R&C
Specialist Physician Services, Referral Physician Services, Allergy Testing and Treatment	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
Acupuncture and Naturopathic Services by a licensed practitioner	20% coinsurance after the deductible has been met Acupuncture limited to 30 visits per calendar year; combined in- and out-of-network.	40% coinsurance based on R&C after deductible Acupuncture limited to 30 visits per calendar year; combined in- and out-of-network.
Chiropractic Services	20% coinsurance after the deductible has been met. Limited to 30 visits per calendar year; combined in- and out-of-network.	40% coinsurance based on R&C after deductible Limited to 30 visit per calendar year; combined in- and out-of-network
Second Surgical Opinion	No charge	No charge (deductible does not apply)
Outpatient Laboratory and X-ray Services (including preadmission testing) in Physician's Office or in Dedicated Lab/X-ray Facility	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
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 Chemo- therapy, Rehab Services, Physician/ Surgeon Charges ***NOTE:*** *Preadmission Certification is required.*	20% coinsurance after the deductible has been met	40% of R&C after deductible with Preadmission Certification by Cigna HealthCare

Section 3 – IRMP Medical Non-Medicare Plan (typically under age 65)

Plan Provisions	IRMP Cigna Coinsurance In-Network	IRMP Cigna Coinsurance Out-of-Network
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.*	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
Hospital Emergency Room	20% coinsurance after the deductible has been met	20% coinsurance after the deductible has been met
Urgent Care Facility	20% coinsurance after the deductible has been met	20% coinsurance after the deductible has been met
Ambulance	Emergency services: 100% covered; Non-emergency 20% covered after deductible has been met	Emergency services: 100% covered Non-emergency services: 40% coinsurance based on R&C after deductible
Services for Infertility • Office Visit and Diagnosis • Corrective Surgical Treatment (Inpatient)	20% coinsurance after the deductible has been met. Prior authorization required	40% coinsurance based on R&C with PAC for inpatient procedures after deductible
Outpatient Physical, Occupational, and Speech Therapy (Short Term Rehabilitative Therapy)	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
Pulmonary Therapy	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
Dialysis Treatment	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
Cardiac Rehabilitation Outpatient Therapy	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
Men's Family Planning Services • Office Visit • Vasectomy • Depo-Provera	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible

Section 3 – IRMP Medical Non-Medicare Plan (typically under age 65)

Plan Provisions	IRMP Cigna Coinsurance In-Network	IRMP Cigna Coinsurance Out-of-Network
Women's Family Planning Services • Office Visit	100% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
Hearing Services • Hearing Examination • Hearing Aid	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
Vision Training/Therapy	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
Nutritional Counseling	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
TMJ Services	Benefits based on place of service; prior authorization required.	
Transplant Services	Benefits based on place of service; prior authorization required.	
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	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
Tobacco Cessation Services	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
Orthotics	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
Durable Medical Equipment	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
External Prosthetic Appliances	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
Other Health care Facilities (e.g., skilled nursing facilities, inpatient physical rehabilitation facility)	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible with Preadmission Certification (PAC) to a maximum benefit of 100 days per calendar year
Home Health Care	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
Hospice	100% covered	40% coinsurance based on R&C after deductible ***NOTE:*** *Preadmission Certification is required*

Mental Health Chart

Plan Provisions	IRMP Cigna Coinsurance In-Network	IRMP Cigna Coinsurance Out-of-Network
Deductible	Combined with Medical deductible	Combined with Medical deductible
Mental Health Inpatient or alternative care** ***NOTE:*** *Preadmission Certification is required.*	100% covered after the deductible has been met	40% coinsurance based on R&C after deductible
Mental Health Outpatient	20% coinsurance after the deductible has been met	40% coinsurance based on R&C after deductible
**** 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 Cigna Coinsurance In-Network	IRMP Cigna Coinsurance Out-of-Network
Chemical Dependency Inpatient or alternate care** ***NOTE:*** *Preadmission Certification is required.*	100% coverage	40% of R&C after deductible
Chemical Dependency Outpatient ***NOTE:*** *Preadmission Certification is required*	20% coinsurance after the deductible has been met	40% of R&C after deductible
**** 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.**		

Prescription Drugs Chart

Plan Provisions	IRMP Cigna Coinsurance		
	Retail (34 day supply)	**Mail/Walgreens/Costco (90 day supply)**	**Retail Maintenance Medications* (34 day supply)**
Generic	$10	$20	**$20
Preferred Brand	20% coinsurance with $25 min/$60 max	20% coinsurance with $62.50 min/$150 max	**50% coinsurance with $25 min
Non-Preferred Brand	40% coinsurance with $40 min and $100 max	40% coinsurance with $100 min and $250 max	**50% coinsurance with $40 min
** Retail Surcharge applies after the first two purchases of a maintenance (long-term) prescription at a retail pharmacy. Maintenance prescriptions may be purchased without surcharge at Walgreens and Costco Retail pharmacies and through Express Scripts Pharmacy (Mail).* *** The surcharge out of pocket costs beyond the standard mail benefit will not apply towards deductible/out of pocket maximums.*			
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.

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 utilizes 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
- Explain that your copayment is lower when you use a preferred drug on the Formulary Drug 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.

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 copayment. 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.

Prescription drugs do not count toward the in or out-of-network deductible. Prescription drug expenses may count toward your out-of-pocket maximum. For your convenience, this benefit is coordinated directly between Express Scripts and Cigna.

How the IRMP Coinsurance Prescription Drug Benefit Works

IRMP Coinsurance Prescription Drug Benefit All prescription except for maintenance medications			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Retail Pharmacy	$10 up to 34-day supply	20% Coinsurance with $25 min & $60 max up to 34- day supply	40% Coinsurance with $40 min & $100 max up to 34- day supply
Express Scripts Pharmacy (Mail Order)/Walgreens	$20 up to 90-day	20% Coinsurance with $62.50 min & $150 Max up to 90-day supply	40% Coinsurance with $100 min & $250 Max up to 90-day supply

IRMP Coinsurance Prescription Drug Benefit **Maintenance Medications** (Prescriptions you take for three months or more, such as high blood pressure or cholesterol medication.)				
Where	**When**	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Retail Pharmacy	First two times you purchase each prescription (Retail Refill Allowance)	$10 up to 34-day Supply	20% Coinsurance with $25 min & $60 max up to 34-day supply	40% Coinsurance with $40 min & $100 max up to 34- day supply
Retail Pharmacy	Beginning with the third refill	*$20 up to 34-day Supply	*50% Coinsurance with $25 min up to 34-day supply	*50% Coinsurance with $40 min up to 34-day supply
Express Scripts Pharmacy (Mail Order) /Walgreens / Costco	All prescription purchases	$20 up to 90-day Supply	20% Coinsurance with $62.50 min & $150 Max up to 90-day supply	40% Coinsurance with $100 min & $250 Max up to 90-day supply
** Out-of-pocket costs for maintenance medications beyond the standard mail benefit will not apply toward deductible/out of pocket maximums*.				

Retail Refill Allowance

For maintenance drugs, such as blood pressure and cholesterol medications, you will pay more for your prescriptions after the second fill unless you move your prescriptions to Express Scripts Pharmacy (mail order), Walgreens or Costco (preferred retail pharmacies). For generic drugs you will pay $20 copayment, for formulary or non-formulary drugs, you will pay the greater of the minimum or coinsurance of the drug cost. There is no copay maximum for maintenance drugs purchased at non-preferred retail pharmacies.

Through Retail Refill Allowance, you may fill a prescription twice at retail–a trial period to ensure the medication is effective with no adverse side effects. After your Retail Refill Allowance period ends you will pay a higher rate if you continue to fill your prescription at a non-preferred retail pharmacy. (You should continue to purchase short-term drugs, such as antibiotics, at your retail pharmacy.)

Mail order and preferred retail pharmacies offer you an opportunity to avoid the higher rates. When you use mail order or a preferred retail pharmacy you may order up to a 90-day supply and pay a $20 copay for generic drugs, or you will pay the greater of the minimum or

coinsurance up to a maximum per prescription for formulary and non-formulary drugs. For example, if you fill a 90-day supply of a generic drug that costs $145, you will only pay $20.

Maintenance Medication

Maintenance medications are used to treat ongoing conditions such as cholesterol, asthma, acid reflux, and high blood pressure. You will pay a higher coinsurance (i.e., a surcharge) for maintenance medication purchased at retail. The additional retail refill surcharge will not count toward your out-of-pocket maximum and you will continue to pay this amount after meeting your out-of-pocket maximum if you continue to refill at retail. To avoid this surcharge you can purchase your maintenance medication through Express Scripts Pharmacy (mail order), or at the preferred retail pharmacies: Walgreens or Costco. By using one of these options, you avoid the surcharge and receive up to a 90-day supply of your maintenance medication prescriptions.

Express Scripts Pharmacy

Express Scripts Pharmacy is a mail-order pharmacy service and it is the preferred way for you to fill your maintenance (long-term) medications. You may receive up maintenance (long-term) medications. 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. Express Scripts specialist pharmacists have expertise in the medications used to treat:

- Diabetes
- High cholesterol
- High blood pressure
- Asthma
- Depression
- Cancer
- Women's Health conditions

Follow these steps to get started using Express Scripts Pharmacy.

*OPTION 1 – **Mail in** your prescription:*
Step 1:
Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to 1 year (as appropriate). Make sure you have a 2-week supply on hand. If not, ask your doctor for a 14-day prescription that you can fill at a participating retail pharmacy while you wait for your mail-order prescription to arrive.

Step 2:
Mail the new prescription using the Express Scripts Pharmacy form. You can use e-check to have payments automatically deducted from your checking account. Or you can use

AutoCharge to have payments automatically charged to the credit card of your choice. You can also pay for individual orders by money order, personal check, or credit card. For more information, visit www.express-scripts.com or call Member Services.

Your medication will usually be delivered within 8 days after we receive your order.

OPTION 2 – Have your doctor fax *your prescription*

Step 1:
Follow Step 1 in the Mail-in section above.

Step 2:
Provide your doctor with your ID number (located on your ID card and ask him or her to call (888)327-9791 for instructions on how to use our fax service. You will be billed later.

Your medication will usually be delivered within 8 days after your doctor faxes the order.

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 & 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 8 p.m. (Eastern), Monday through Friday.

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 Cigna to obtain pre-certification approval.

Out-of-Network: You are responsible for ensuring that Cigna 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.

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 Cigna within 48 hours of receiving emergency care for the service to be covered at the in- network benefit level. Emergency services obtained outside the Cigna OAP Network will be considered for in-network coverage if Cigna, on review, determines that treatment without prior approval of Cigna 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 Cigna at (800) 468-3510 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 Cigna, 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 Cigna within 48 hours of the emergency hospital admission to receive the maximum reimbursement.

If you do not contact Cigna 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. This means that you will be responsible for the first $500 of covered medical services in addition to any required deductible and coinsurance amount. If the services, hospital admission, and length of stay are determined not to be medically necessary, those services will not be covered at all.

Hospital Preadmission Certification and Continued Stay Review

In-Network: If you need hospitalization, your network provider will obtain authorization from Cigna 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 and/or your responsibility for the first $500 of covered medical services, 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 Cigna for medical hospital admissions and mental health or substance abuse treatment hospitalizations.

Prior Authorization Requirements

Cigna must pre-authorize the following:

- **Ambulance**: Non-emergency ambulance requires approval.
- **Durable Medical Equipment**: In-network coverage for durable medical equipment.
- **Hospice Care**: In-network coverage must be provided by in-network facility.
- **Inpatient Hospital confinement**: In network confinement requires precertification or authorization by Cigna (except for maternity deliveries within the Federal mandate of 48/96 hours).
- **Orthotics**
- **Prosthetic (External) Appliances**: including repair or replacement.
- **Prosthetic (Internal) Appliances**: must be the original or a replacement.

- **Rehabilitative Therapy**
- **Skilled Nursing Facility**
- **Travel and living expenses**
- **Weight Reduction Services**
- **Wigs and Hairpieces**; coverage will be reviewed on a case-by-case basis and will require a doctor's recommendation including an overall history of the medical problem.
- **Other services requiring prior authorizations**: transplants, potential experimental/investigational/unlisted procedures, advanced radiology – CT/MRI/MRA/MRS/PET, hysterectomy, sinal procedures, injectables, IMRT, and home infusion therapy.

Medical Case Management

If you or your eligible spouse or domestic partner 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.

Health Advisor

Health Advisor is a clinical integration model aimed at improving the consumer's health care experience and optimizing the value of Cigna's underlying medical management programs. It is a "high-touch" consumer-focused health facilitation model delivered by dedicated Nurse Health Advisors. Health Advisor is a proactive, early intervention model that expands on our traditional case-management services, and reaches the members who aren't completely engaged and better manages those who are. The Health Advisor acts as a health educator and coach, and refers the case to complex or specialty case management based on need. Health Advisors are generalists who complement, but do not replace, Complex/Specialty Case Managers.

24-Hour Information Line

Helpful, reliable health information is available from any phone, anywhere in the U.S. 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.

Second and Third Surgical Opinions

Based on medical information, Cigna may require a second surgical opinion. If it is not required, you may still request a second opinion which will be covered at 100 percent at the in-network, out-of-network, or Medicare-eligible benefit levels, as applicable. A third opinion is available and covered, as is the second opinion, if the first and second opinions differ. The second and third opinion must be obtained from one of three physicians or surgeons recommended by Cigna.

If Cigna requires a second (and possibly third) opinion and you do not obtain the opinion(s), you will not be considered pre-certified for the surgical procedure and will be subject to either denied benefits or reduced benefits. If you do not obtain the requested second (and possibly third) opinion, your submitted claim will be reviewed to determine if the medical procedures, hospital admission, and length of stay were medically necessary. If so, you will be responsible for the first $500 of covered medical services, in addition to the required deductibles for failure to complete the pre-certification requirements requested by Cigna. If the medical services, hospital admission, and length of stay are determined not to be medically necessary, those services will not be covered.

Travel

Travel and Living Expenses: Your plan will cover up to $10,000 lifetime maximum for expenses incurred in conjunction with authorized medical services and/or a transplant. Prior authorization is required; contact Cigna at (800) 468-3510 for more details and coordination of reimbursement.

World Wide 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 Cigna to receive reimbursement. Also check with Cigna on emergency care notification requirements.

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 ("primary" plan), and the other plan ("secondary" plan) may pay additional benefits depending on its coordination of benefits provision. If the 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.

There are several criteria for determining which plan is the primary plan:

- If the other plan does not have a provision coordinating its benefits with the IRMP, then the other plan is always the primary plan

- The IRMP is the primary plan for the retiree and the secondary plan for an eligible dependent who has coverage under another plan. If the retiree is also covered under a spouse's or domestic partner's plan, then that medical plan is considered primary for the spouse or domestic partner and secondary for the retiree
- If the person is covered under a plan as a laid-off, retired or disabled employee or as a dependent of a laid-off, retired or disabled employee, the plan covering the person as an active employee or as a dependent of an active employee will be primary
- If a person's coverage is provided under a right of continuation (e.g., COBRA) pursuant to federal or state law, the plan covering the person as an active employee or as a dependent of an active employee will be primary
- If none of the other rules of this section apply, the plan under which the person has been covered for a longer period of time will be primary

Examples of Coordinated Benefits

Your spouse is enrolled in the medical plan at his or her employer. You and your spouse are also enrolled in the IRMP. Your spouse incurs surgical expenses of $1,000. Your spouse's plan is the primary plan for his or her coverage, and he or she has already met the deductible.

Your spouse's plan, the primary plan for his or her coverage, pays 70 percent of the surgery bill or $700. The IRMP in-network surgery is payable at 80 percent. The IRMP subtracts the amount paid by the primary plan from the in-network benefit normally payable:

- IRMP benefit: $800
- Less the benefit paid by the primary plan: $700
- IRMP coordinated benefit: $100

Continue with the same example, but assume that your spouse incurs $1,000 in surgical expenses out-of-network and you have already met your deductible. The IRMP out-of-network reimburses surgery at 60 percent of reasonable and customary costs. The IRMP subtracts the amount paid by the primary plan from the out-of-network benefit normally payable:

- IRMP benefit: $600
- Less the benefit paid by the primary plan: $700
- IRMP coordinated benefit: $0

In this example, the amount paid by the primary plan exceeds the IRMP benefit, so there is no additional benefit payable under the IRMP.

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.

Section 3 – IRMP Medical Non-Medicare Plan (typically under age 65)

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 or not other coverage is available for your covered eligible dependent(s).

Section 4 - IRMP Medical Medicare-eligible (typically over age 65)

If you retire from Intel and meet the IRMP eligibility requirements and you or your eligible dependent(s) are eligible for Medicare, you may enroll in one of two IRMP medical plan options:

1) **IRMP Cigna Indemnity plan, or;**
2) **IRMP Cigna Indemnity without Rx1 (medical-only) plan**

NOTE: An Intel **Catastrophic Rx Health Reimbursement Account (HRA)** is also available to Medicare eligible retirees enrolled in a Medicare Part D Plan to provide more financial protection and extra peace of mind regarding prescription expenses. No enrollment or election is necessary for this benefit, but you must be enrolled in a Medicare Part D Plan.

Regardless of which plan you enroll in, your IRMP benefits will be coordinated with Medicare. If you or your spouse or domestic partner, or eligible children are eligible for Medicare because of age (65 or older) or a disability, you or your eligible dependent must apply for and enroll in Medicare Part A and Part B to maximize IRMP benefits.

Once enrolled in Medicare Parts A and B, you and/or your eligible dependent(s) will be covered by both Medicare and the IRMP and benefits will be coordinated between Medicare and the IRMP Cigna Indemnity plan or the IRMP Cigna Indemnity plan without Rx*. If a plan member in the IRMP is eligible but has not enrolled in Medicare Parts A and B, the IRMP will pay benefits as if the plan member is enrolled in Medicare Parts A and B, and will not pay benefits that are normally paid by Medicare.

If your Medicare eligibility is due to End Stage Renal Disease (ESRD) the IRMP will be primary for the first 30 months after it is determined there is Medicare entitlement due to ESRD.

For more information about Medicare entitlement due to ESRD, you can link to http://www.ssa.gov/mediinfo.htm or call (800) MEDICARE.

If you are enrolled in IRMP Cigna Indemnity with Rx, enrollment in a Medicare Part D plan is not required to receive maximum benefits because the coverage you get from IRMP is at least as good as Medicare Part D (creditable prescription drug coverage). Please see the Medicare Part D and Notice of Creditable Coverage for more information.

If you are enrolled in the IRMP Cigna Indemnity without Rx (medical-only) plan, you should consider obtaining Medicare Part D coverage outside of Intel. If you fail to enroll in Part D or other creditable prescription drug coverage, you may be charged a higher premium for late enrollment in a Part D plan. Please visit www.medicare.gov for more information on Medicare Part D coverage.

Refer to the Coordination of Benefits section for a description of how benefits are coordinated between Medicare and the IRMP medical plans.

[1] Rx = prescription drug

To receive maximum benefits, you and your eligible dependent(s) are strongly encouraged to use providers that accept Medicare assignment, except as described above for plan members with End Stage Renal Disease (ESRD).

How IRMP Cigna Indemnity Plan Works

There are two plans available to eligible participants:

- IRMP Cigna Indemnity plan – Coverage includes medical, mental health, substance abuse, and prescription drug benefits. It does not include vision or dental coverage.
- IRMP Cigna Indemnity Plan without RX - Coverage includes medical, mental health, and substance abuse benefits. It does not include prescription drug, vision or dental coverage.

If you are a Medicare-eligible plan member, you will receive Medicare-eligible benefits for both preventive and medically necessary treatment. Medicare-eligible benefits are coordinated with Medicare and coverage and payment by IRMP Cigna are based on coverage and payment level by Medicare and/or Cigna. Refer to the Benefits Chart and Covered Medical Services provided within this section for more detailed benefit information.

Deductibles

A deductible is the dollar amount an individual must pay before any charges are reimbursed by the medical plan. When accessing medical care, you must first satisfy an annual deductible equal to the first $500 of eligible medical expenses you incur in a calendar year. Prescription drug copayments do not count toward the medical plan deductible.

Coinsurance Payments

The coinsurance amount is a percentage of the allowable charge of covered services. You will be required to first pay the annual deductible before the plan will begin to pay claims. Once you have met your deductible, you will then pay the applicable coinsurance amount for covered services.

Out-of-Pocket Maximum

Once you have paid a certain amount of covered medical expenses in any given year, the plan will pay most eligible expenses at 100 percent of allowable. The amount you pay to reach this level of coverage is called the out-of-pocket maximum. The out-of-pocket maximum for the plan is $2,000 for an individual; $4,000 for a family (includes deductible).

Your prescription copayments may be applied to your out of pocket maximum. It is your responsibility to provide proof of payment (e.g., Explanation of Benefits, prescription receipts) to Cigna for application towards the medical out-of-pocket maximum. Please contact Cigna at

(800) 468-3510 for details regarding how to submit. For exclusions to the out-of-pocket maximum calculations, see table below.

Exclusions to Out-of-Pocket Maximum Calculation

	IRMP Medicare Eligible Benefits
Prescription drug retail surcharges and costs beyond the Express Scripts copayments	X
Surgeon's fees paid at 50 percent because a required second opinion was not obtained	X
The $500 penalty incurred when inpatient hospitalizations are not certified	X
Charges made in excess of the usual, reasonable and customary 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.	X
Charges above Medicare allowable or charges that are otherwise excluded under the plan	X

Medical Lifetime Benefit Maximum

There is no lifetime maximum benefit for covered medical services.

How the Plan Works?

An Indemnity Plan is a type of health plan under which the covered person pays 100% of all covered charges up to an annual deductible. Once the annual deductible is reached, the plan will begin to pay claims at a percentage of the fee (coinsurance amount) for covered services.

The annual deductible for IRMP Cigna Indemnity plans is $500 per individual. After you reach your deductible, the plan then pays a percentage of covered charges (based on Medicare allowable charge), your coinsurance amount is 20% or a copayment based on the service received (see Medicare Eligible Benefit Section for more information). If you receive services from a provider who does not accept Medicare, the claim(s) will be paid based on Medicare allowable.

Note: You may also be responsible for costs beyond Medicare allowable also called excess charges or balance billing. You can maximize your coverage by ensuring you receive care from providers who participate with Medicare.

IRMP Cigna Indemnity plan benefits are determined as if the member is enrolled in Medicare Parts A & B, and will not pay benefits that are normally paid by Medicare. What this means to you is that Medicare pays first, and the IRMP Cigna Indemnity plans will pay secondary. In addition, any charges for services, treatment or supplies furnished by a Provider who has opted

out of Medicare that would otherwise have been covered by Medicare will be reduced by the amount normally paid by Medicare.

About the Cigna Network

Primary Care Physician (PCP)

Although the IRMP Cigna Indemnity plans do not require a Primary Care Physician (PCP) we encourage you to establish one. The PCP or Personal Doctor gives you or your eligible dependent(s) 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 health care needs of members.

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.

To receive maximum benefits, you and your dependents are strongly encouraged to use providers that accept Medicare assignment, except as described above for plan members with End Stage Renal Disease (ESRD).

Additional Networks

Other organizations administer certain specialized benefits provided by the Cigna Indemnity plans. Each of these specialty administrators contracts with certain providers. In order to receive in-network benefits, you must seek care from one of these network providers. If you elect to use out-of-network providers for your care, you receive a reduced benefit or benefits may be denied. Both in-network and out- of-network specialized benefits are administered by the specialty networks. The networks are identified in the Networks table shown next.

Mental Health and Chemical Dependency	Cigna Behavioral Health
Prescription Services	Express Scripts*
*Prescription services are not available in the IRMP Cigna Indemnity without Rx plan. Prescription services provided by Express Scripts only applies to the IRMP Cigna Indemnity plan.	

Benefits Chart

The following charts summarize plan benefit information and provide an abbreviated comparison between the Medicare benefits, Cigna Indemnity plan and the Cigna Indemnity without RX plan.

Plan Provisions	Medicare	IRMP Cigna Indemnity & IRMP Cigna Indemnity w/o Rx
Deductible Wherever coinsurance percentages are payable by you, you must first meet the deductible.	Part B (Outpatient services): In 2016 the monthly Part B deductible amount is $ 166. Part A (Hospitalization): In 2016 the amounts for each benefit period are: Days 1 - 60: $1,288 deductible Days 61 - 90: $322 per day Days 91 - 150: $ $644 per lifetime reserve day Call (800) MEDICARE (633-4227) for information about lifetime reserve days.	$500 Individual $1,000 Family
Out-of-Pocket (OOP) Maximum	Not applicable	$2,000 individual/ $4,000 retiree & spouse or domestic partner Coinsurance and deductible are applied towards OOP maximum
Pre-existing Condition Limitation	Not applicable	Not applicable
Medical Services Lifetime Maximum Per Member	Not applicable	Unlimited
In-Hospital Preadmission Certification (PAC), Continued Stay Review (CSR), and Surgical Precertification	Not applicable	Covered member must obtain authorization from Cigna
Primary Care Physician Office Visit Services (including medical eye care) • Adult Medical Care • Injections	20% of Medicare Approved	20% coinsurance based on Medicare Allowable (after deductible)
• Preventive Care Services • Preventative Care Routine	20% of Medicare Approved – please consult “Your Medicare Benefits” booklet at www.medicare.gov	20% coinsurance based on Medicare Allowable after deductible

Plan Provisions	Medicare	IRMP Cigna Indemnity & IRMP Cigna Indemnity w/o Rx
Immunizations and Injections		
Specialist Physician Services, Referral Physician Services, Allergy Testing and Treatment	20% of Medicare Allowable	20% coinsurance based on Medicare Allowable after deductible
Acupuncture and Naturopathic Services by a licensed practitioner	Not covered	20% coinsurance based on Cigna allowable after deductible; Acupuncture is limited to 30 visits per calendar year
Chiropractic Services	Not covered	20% coinsurance based on Cigna Allowable after deductible. Limited to 30 visits per calendar year.
Second Surgical Opinion	20% of Medicare Allowable	No charge (deductible does not apply)
Outpatient Laboratory and X-ray Services (including preadmission testing) in Physician's Office or in Dedicated Lab/X-ray Facility	20% of Medicare allowable	20% coinsurance based on Medicare Allowable after deductible
Inpatient Hospital Services Semiprivate Room and Board ***NOTE:*** *Preadmission Certification may be required.*	Coverage per Medicare Part A (Hospitalization)	20% coinsurance based on Medicare Allowable after deductible
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 Chemo- therapy, Rehab Services, Physician/ Surgeon Charges ***NOTE:*** *Preadmission Certification (PAC) may be required.*	20% of Medicare Allowable	20% coinsurance based on Medicare Allowable after deductible

Plan Provisions	Medicare	IRMP Cigna Indemnity & IRMP Cigna Indemnity w/o Rx
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.*	20% of Medicare allowable	20% coinsurance based on Medicare Allowable after deductible
Hospital Emergency Room	20% of Medicare Approved	20% coinsurance based on Medicare Allowable after deductible
Urgent Care Facility	20% of Medicare allowable	20% coinsurance based on Medicare Allowable after deductible
Ambulance	20% of Medicare Approved	20% coinsurance based on Medicare Allowable after deductible
Outpatient Physical, Occupational, and Speech Therapy (Short Term Rehabilitative Therapy)	20% of Medicare allowable	20% coinsurance based on Medicare Allowable after deductible
Pulmonary Therapy	20% of Medicare allowable	20% coinsurance based on Medicare Allowable after deductible
Dialysis Treatment	20% of Medicare allowable	20% coinsurance based on Medicare Allowable after deductible
Cardiac Rehabilitation Outpatient Therapy	20% of Medicare allowable	20% coinsurance based on Medicare Allowable after deductible
Family Planning Services • Office Visit • Vasectomy • Tubal Ligation • Depo-Provera	Please consult www.medicare.gov to determine Medicare coverage	20% coinsurance based on Cigna allowable after deductible
Services for Infertility • Office visit and diagnosis • Corrective Surgical	Please consult www.medicare.gov to determine Medicare coverage	20% coinsurance based on Cigna allowable with PAC for inpatient procedures after deductible
Hearing Services • Routine Hearing Examination	Not covered	20% coinsurance based on Cigna allowable after deductible

Plan Provisions	Medicare	IRMP Cigna Indemnity & IRMP Cigna Indemnity w/o Rx
• Routine Hearing Aid		
Vision Training/ Therapy	Not covered	20% coinsurance based on Cigna allowable after deductible.
Nutritional Counseling	20% of Medicare Approved – medically necessary when ordered by a doctor or for people with kidney disease or have a kidney transplant or people with diabetes	20% coinsurance based on Medicare allowable after deductible
TMJ Services	Not covered	20% coinsurance based on Cigna allowable after deductible.
Transplant Services	20% of Medicare Approved for doctor services; the amount varies for facility charges – please consult "Your Medicare Benefits" booklet at www.medicare.gov	20% coinsurance based on Medicare/Cigna allowable after deductible.
Travel and Living Expenses	Not covered	$10,000 lifetime maximum for expenses incurred in conjunction with authorized medical services and/or a transplant; prior authorization required
Weight Reduction Services (See Covered Medical Services and General Exclusions and Limitations)	Not covered	20% coinsurance based on Cigna allowable after deductible
Tobacco Cessation Services	Not covered	20% coinsurance based on R&C after deductible
Orthotics	20% of Medicare Approved – medically necessary	20% coinsurance based, as approved by Cigna, after deductible
Durable Medical Equipment	Amount varies – please consult "Your Medicare Benefits" booklet at www.medicare.gov	20% coinsurance, as approved by Cigna, after deductible
External Prosthetic Appliances	20% of Medicare Approved	20% coinsurance, as approved by Cigna, after deductible
Other Health care Facilities (e.g., skilled nursing facilities, inpatient physical rehabilitation facility)	Amount varies – please consult CMS' "Your Medicare Benefits" booklet at www.medicare.gov	20% coinsurance based on Medicare/Cigna Allowable after deductible with Preadmission Certification (PAC) to a maximum benefit of 100 days per benefit period.
Home Health Care	You pay $0 for all covered home health visits.	20% coinsurance based on Medicare Allowable after deductible

Plan Provisions	Medicare	IRMP Cigna Indemnity & IRMP Cigna Indemnity w/o Rx
Hospice	You pay $0 for hospice care – please consult "Your Medicare Benefits" booklet at www.medicare.gov	You pay $0 for hospice care.

Mental Health Chart

Plan Provisions	Medicare (without IRMP)	IRMP Cigna Indemnity & IRMP Cigna Indemnity w/o Rx
Mental Health Deductible	Same deductible and copayments as inpatient hospital care.	Combined with Medical Deductible
Mental Health • Inpatient or alternative care**	Same deductible and copayments as inpatient hospital care.	20% coinsurance based on Medicare Allowable after deductible
Mental Health • Outpatient	50% of Medicare allowable + a separate copayment amount of the facility service. Please consult CMS' "Your Medicare Benefits" booklet at www.medicare.gov	20% coinsurance based on Medicare Allowable after deductible
**** 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	Medicare (without IRMP)	IRMP Cigna Indemnity & IRMP Cigna Indemnity w/o Rx
Chemical Dependency • Inpatient or alternate care**	Same deductible and copayments as inpatient hospital care.	20% coinsurance based on Medicare Allowable after deductible,
Chemical Dependency • Outpatient	50% of Medicare Approved + a separate copayment amount of the facility service. Please consult CMS' "Your Medicare Benefits" booklet at www.medicare.gov	20% coinsurance based on Medicare Allowable after deductible
**** 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.**		

Prescription Drugs Chart – Express Scripts Network

Plan Provisions	Medicare (without IRMP)	IRMP Cigna Indemnity*
• Retail Prescription Drugs - Express Scripts Select Network	Available via a Medicare Part D Plan. Go to www.medicare.gov for more information	See Chart Below
Mail Prescription Drugs – • Express Scripts Pharmacy	Available via a Medicare Part D Plan. Go to www.medicare.gov for more information	See Chart Below
***Prescription drug coverage is not included in the Cigna Indemnity without Rx plan. You must purchase a separate Medicare Part D plan for prescription drug coverage. Retirees enrolled in Medicare Part D are eligible for the Catastrophic Rx HRA.**		

IRMP Cigna Indemnity with RX All prescription except for maintenance medications (See chart below for maintenance medication prescription drug benefit)			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Retail Pharmacy	$10 up to 34-day supply	$20 up to 34-day supply	$30 up to 34-day supply
Express Scripts Pharmacy (Mail Order) / Walgreens / Costco	$20 up to 90-day supply	$40 up to 90-day supply	$60 up to 90-day supply

IRMP Cigna Indemnity with RX All prescription except for maintenance medications (Prescriptions you take for three months or more, such as high blood pressure or Cholesterol medication.)				
Where	**When**	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Retail Pharmacy	First two times you purchase each prescription (Retail Refill Allowance)	$10 up to 34-day supply	$20 up to 34-day supply	$30 up to 34- day supply
Express Scripts Pharmacy (Mail Order) / Walgreens / Costco	Beginning with the third refill	*$20 up to 34-day supply	*$40 up to 34-day supply	*$60 up to 34- day supply
Express Scripts Pharmacy	All prescription purchases	$20 up to 90-day supply	$40 up to 90-day supply	$60 up to 90- day supply

IRMP Cigna Indemnity with RX All prescription except for maintenance medications (Prescriptions you take for three months or more, such as high blood pressure or Cholesterol medication.)				
Where	**When**	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
(Mail Order) / Walgreens / Costco				
** Out-of-pocket costs for maintenance medications beyond the standard mail benefit will not apply toward deductible/out of pocket maximums*.				

Specialty Services: Medicare-Eligible

Medically necessary eye care is available through Cigna. Contact Cigna for more information.

Prescription Drug Benefits

Under an agreement with Express Scripts prescription benefits are available to IRMP Cigna Indemnity (with Rx) plan members.

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 utilizes an independent group of individuals, including pharmacists, called the Pharmacy and Therapeutics Committee (P&T) to review 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 being deleted, or 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
- Explain that your copayment is lower when you use a preferred drug on the Formulary Drug 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 an eligible dependent(s) is added to your coverage. Additional cards can be ordered by calling Express Scripts.

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 copayment. 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.

How the IRMP Indemnity with RX Prescription Drug Benefit Works

IRMP Cigna Indemnity with RX All prescription except for maintenance medications (See chart below for maintenance medication prescription drug benefit)			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Retail Pharmacy	$10 up to 34-day supply	$20 up to 34-day supply	$30 up to 34-day supply
Express Scripts Pharmacy (Mail Order) / Walgreens / Costco	$20 up to 90-day supply	$40 up to 90-day supply	$60 up to 90-day supply

IRMP Cigna Indemnity with RX Maintenance Medications (Prescriptions you take for three months or more, such as high blood pressure or cholesterol medication.)			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Retail Pharmacy	First two times you purchase each prescription (Retail Refill Allowance)	$10 up to 34-day supply	$20 up to 34-day supply
Retail Pharmacy	Beginning with the third refill	*$20 up to 34-day supply	*$40 up to 34-day supply
Express Scripts Pharmacy (Mail Order) / Walgreens / Costco	All prescription purchases	$20 up to 90-day supply	$40 up to 90-day supply
** Out-of-pocket costs for maintenance medications beyond the standard mail benefit will not apply toward deductible/out of pocket maximums.*			

Retail Refill Allowance

For maintenance drugs, such as blood pressure and cholesterol medications, you will pay more for your prescriptions after the second fill unless you move your prescriptions to Express Scripts Pharmacy (mail order), Walgreens or Costco (preferred retail pharmacies). You will pay $10 for Generic drugs, $20 for Preferred Brand or $30 for Non-Preferred brand.

Through Retail Refill Allowance, you may fill a prescription twice at retail –a trial period to ensure the medication is effective with no adverse side effects. After your Retail Refill Allowance period ends you will pay a higher rate if you continue to fill your prescription at non-preferred retail pharmacy. You will pay $20 for Generic drugs, $40 for Preferred Brand or $60 for Non-Preferred brand. (You should continue to purchase short-term drugs, such as antibiotics, at your retail pharmacy.)

Mail order and preferred retail pharmacies offers you an opportunity to avoid the higher rates and receive a larger quantity. When you use mail order or a preferred retail pharmacy you may order up to a 90-day supply and pay a $20 copay for generic drugs, $40 for Preferred Brand or $60 for Non-Preferred Brand.

Your prescription drug cost may count toward your out-of-pocket maximum; however, the retail maintenance surcharge and out-of-pocket costs beyond the standard mail benefit will not apply toward deductible/out of pocket maximums.

Maintenance Medication

Maintenance medications are used to treat ongoing conditions such as cholesterol, asthma, acid reflux, and high blood pressure. You will pay a higher coinsurance (i.e., a surcharge) for maintenance medication purchased at retail. The additional retail refill surcharge will not count toward your out-of-pocket maximum and you will continue to pay this amount after meeting your out-of-pocket maximum. To avoid this surcharge you can purchase your maintenance medication through Express Scripts Pharmacy (mail order), Walgreens or Costco. By using the Express Scripts Pharmacy or a preferred pharmacy you avoid the higher retail cost and receive up to a 90-day supply of your maintenance medication prescriptions.

Express Scripts Pharmacy

Express Scripts Pharmacy is a mail-order pharmacy service and it is one of the preferred ways for you to fill your maintenance (long-term) medications. 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. Express Scripts specialist pharmacists have expertise in the medications used to treat:

- Diabetes
- High cholesterol
- High blood pressure
- Asthma
- Depression
- Cancer
- Women's Health conditions

Follow these steps to get started using Express Scripts Pharmacy.

OPTION 1 – **Mail in** your prescription:

Step 1:

Ask your doctor for a new prescription for up to a 90-day supply, plus refills for up to 1 year (as appropriate). Make sure you have a 2-week supply on hand. If not, ask your doctor for a 14-day prescription that you can fill at a participating retail pharmacy while you wait for your mail-order prescription to arrive.

Step 2:

Mail the new prescription using the enclosed order form and envelope. You can use e-check to have payments automatically deducted from your checking account. Or you can use AutoCharge to have payments automatically charged to the credit card of your choice. You can also pay for individual orders by money order, personal check, or credit card. For more information, visit www.express-scripts.com or call Member Services.

Your medication will usually be delivered within 8 days after we receive your order.

OPTION 2 – **Have your doctor fax** your prescription:

Step 1:

Follow Step 1 in the Mail-in section above.

Step 2:

Provide your doctor with your ID number (located on your ID card and ask him or her to call **1 888 327-9791** for instructions on how to use our fax service. You will be billed later.

Your medication will usually be delivered within 8 days after your doctor faxes the order.

Prescriptions and your Out of Pocket Maximum

Your prescription copayments may be applied to your out of pocket maximum. It is your responsibility to provide proof of payment (e.g., Explanation of Benefits, prescription receipts) to Cigna for application towards the medical out-of-pocket maximum. Please contact Cigna at (800) 468-3510 for details regarding how to submit.

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 a 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, which 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 a Express Scripts drug authorization request, call (800) 899-2713; select the Express Scripts option to speak directly with a 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 Pharmacy 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 *nonpreferred* drugs, unless special circumstances exist. Express Scripts Pharmacy & Therapeutics Committee has reviewed and approved the clinical basis for the Preferred Drug Step Therapy Program.

Coverage of Specialty Medications

Most specialty medications (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, 7 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 8:00 a.m. and 8:00 p.m., Eastern Time, Monday through Friday.

Elective Surgery

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

You are responsible for ensuring that Cigna 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.

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 if certain steps are followed, as described below. If you have a medical emergency, you should seek care immediately:

- For emergency hospital admissions, you must contact Cigna at (800) 468-3510 within 48 hours to receive the maximum level of benefits and coverage.

  If you do not contact Cigna, 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 co-insurance amount. If the emergency hospital visit is determined not to be medically necessary, that service will not be covered.

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).

Hospital Preadmission Certification and Continued Stay Review

In-Network: If you need hospitalization, your network provider will obtain authorization from Cigna 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 and/or your responsibility for the first $500 of covered medical services, 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 Cigna for medical hospital admissions and mental health or substance abuse treatment hospitalizations.

Note: Cigna does not have the authority to pre-certify inpatient hospitalization for mental health or substance abuse problems nor handle appeals related to mental health or substance abuse treatment claims.

- Cigna can be reached during normal business hours at (800) 468-3510.

Prior Authorization Requirements

Cigna must pre-authorize the following:

- **Ambulance**: Non-emergency ambulance requires approval.
- **Durable Medical Equipment**: In-network coverage for durable medical equipment.
- **Inpatient Hospital confinement**: In network confinement requires precertification or authorization by Cigna (except for maternity deliveries within the Federal mandate of 48/96 hours).
- **Orthotics**
- **Outpatient Procedures**: Must be authorized by Cigna (e.g., potential cosmetic, dental and jaw/face/TMJ, vein treatment, oral pharynx, erectile dysfunction, infertility, ear devices and cochlear surgical procedures).
- **Prosthetic (External) Appliances**: including repair or replacement.
- **Prosthetic (Internal) Appliances**: must be the original or a replacement.
- **Rehabilitative Therapy**
- **Skilled Nursing Facility**
- **Travel and living expenses**
- **Weight Reduction Services**
- **Wigs and Hairpieces**; coverage will be reviewed on a case-by-case basis and will require a doctor's recommendation including an overall history of the medical problem.
- **Other services requiring prior authorizations**: transplants, potential experimental/investigational/unlisted procedures, advanced radiology –

CT/MRI/MRA/MRS/PET, hysterectomy, sinal procedures, injectables, IMRT, and home infusion therapy.

Medical Case Management

If you or your eligible spouse or domestic partner 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.

24-Hour Information Line

Helpful, reliable health information is available from any phone, anywhere in the U.S. 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.

Second and Third Surgical Opinions

Based on medical information, Cigna may require a second surgical opinion. If it is not required, you may still request a second opinion which will be covered at 100 percent at the in-network, out-of-network, or Medicare-eligible benefit levels, as applicable. A third opinion is available and covered, as is the second opinion, if the first and second opinions differ. The second and third opinion must be obtained from one of three physicians or surgeons recommended by Cigna.

If Cigna requires a second (and possibly third) opinion and you do not obtain the opinion(s), you will not be considered pre-certified for the surgical procedure and will be subject to either denied benefits or reduced benefits. If you do not obtain the requested second (and possibly third) opinion, your submitted claim will be reviewed to determine if the medical procedures, hospital admission, and length of stay were medically necessary. If so, you will be responsible for the first $500 of covered medical services, in addition to the required deductibles for failure to complete the pre-certification requirements requested by Cigna. If the medical services, hospital admission, and length of stay are determined not to be medically necessary, those services will not be covered.

Travel

Travel and Living Expenses: Your plan will cover up to $10,000 lifetime maximum for expenses incurred in conjunction with authorized medical services and/or a transplant. Prior

authorization required; contact Cigna at (800) 468-3510 for more details and coordination of reimbursement.

World Wide Coverage for Emergent 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 Cigna to receive reimbursement. Also check with Cigna on emergency care notification requirements.

Coordination of Benefits: Medicare Eligible

As a Medicare eligible retiree, your benefits or the benefits for your Medicare eligible dependent(s) are coordinated with Medicare. For most of your health care services, Medicare will pay benefits first.

Reduction of Benefits for Medicare

Generally, the Cigna plan will reduce the amount of benefits it will pay for Medicare- eligible retirees; even if you are not enrolled in Medicare Parts A and B (see below for special rules applicable to End Stage Renal Disease). In other words, because you or your eligible dependent(s) are eligible for Medicare, Medicare will be treated as the primary payer and the IRMP will be treated as the secondary payer.

Two examples are provided.

- **A** - illustrates your out-of-pocket costs when you receive services from a provider who accepts Medicare;
- **B** - illustrates your out of pocket costs when you receive services from a provider who does not accept Medicare:

Example A – Provider accepts Medicare

After you reach your deductible, the plan then pays a percentage of covered charges (based on Medicare allowable charge), your coinsurance amount is 20 percent or a copayment based on the service received (see plan compare for details).

For example, you are billed $100 for a doctor's visit and your provider accepts Medicare. Medicare considers $65 of the charge allowable Medicare.

➢ Doctor's submits bill	$100
➢ Medicare allowable on this bill	$65
➢ Medicare Pays 80% of allowed amount	$52 (65 x.80)
➢ Your coinsurance amount (20% of allowed amount)	$13 (65 x.20)
➢ Cigna Pays	$0
➢ Your Total Out of Pocket	$13

According to the benefits chart, Cigna also reimburses 80 percent of $65. The Cigna Indemnity amount is reduced by the amount paid by Medicare. In this case, Cigna's Benefit of $52 (80

percent of $65) is reduced by $52 (amount paid by Medicare), therefore, the amount paid by the IRMP Cigna Indemnity plan is $0.

Example B – Provider does not accept Medicare

If you receive services from a provider who does not accept Medicare, nor is a participating provider with Cigna, the claim(s) will be paid based on Medicare allowable. In addition, you may also be responsible for costs beyond Medicare allowable also called excess charges or balance billing. You can maximize your coverage by ensuring you receive care from providers who participate with Medicare.

For example, you are billed $100 for a doctor's visit. Medicare considers $65 of the charge allowable Medicare/Cigna reimburse 80 percent of $65. Therefore, assuming you have met your deductible, you pay 20 percent of the allowed charge, $65, Medicare pays 80 percent and Cigna pays $0. The provider could bill you the excess charge of $35, therefore you pay $48 (the 20 percent coinsurance and the excess charge of $35).

➢ Doctor's submits bill	$100
➢ Medicare allowable on this bill	$65
➢ Medicare Pays 80% of allowed amount	$52 (65 x.80)
➢ Your coinsurance amount (20% of allowed amount)*	$13 (65 x .20)
➢ Excess Charge (difference between Medicare Allowable and billed charges)*	$35
➢ Cigna Pays	$0
➢ Your Total Out of Pocket	$48 ($13* + $35*)

This demonstrates the importance of utilizing a provider who accepts Medicare as well as ensure you are enrolled in both Medicare Parts A & B. To receive the maximum plan benefits when coordinating with Medicare, you and your spouse or domestic partner are strongly encouraged to use providers that accept Medicare assignment, except as described below for plan members with ESRD. If a plan member is eligible but has not enrolled in Medicare Parts A & B, the plan will pay benefits as if the plan member is enrolled in Medicare Parts A & B, and will not pay benefits that are normally paid by Medicare.

Coverage Through Another Medical Plan Other than Medicare

If you or your eligible dependent(s) are enrolled in a Cigna Indemnity plan (with or without Rx) and you also have coverage through another medical plan, your benefits will be coordinated based on the rules in this section. Examples of coverage through another medical plan other than Medicare include:

- Your spouse and you are enrolled in the medical plan at his or her employer. You and your spouse are also enrolled in the Cigna Indemnity plan.
- You are enrolled in a medical plan as an active employee and you are also enrolled in the Cigna Indemnity plan.

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.

If the Cigna Indemnity plan is the primary plan, benefits will be paid without regard to the other plan coverage. When the Cigna Indemnity plan is the secondary plan, benefits will be limited to the amount normally payable under the Cigna Indemnity plan as the primary plan, minus the benefits paid under the other coverage.

Determining the Primary Plan

There are several criteria for determining which plan is the primary plan:

When Medicare provides covered benefits, Medicare will be considered primary.

- If the other plan does not have a provision coordinating its benefits with the IRMP, then the other plan is always the primary plan.
- Other than Medicare, the Cigna Indemnity plan is the primary plan for the retiree and the secondary plan for a spouse or domestic partner who has coverage under another plan. If the retiree is also covered under a spouse's or domestic partner's plan, then that medical plan is considered primary for the spouse or domestic partner and secondary for the retiree.
- Any plan covering the person as an active employee or as a dependent of an active employee will be primary.
- If none of the other rules of this Section apply, the plan under which the person has been covered for a longer period of time will be primary.

Examples of Coordinated Benefits

Your spouse is enrolled in the medical plan at his or her employer. You and your spouse are also enrolled in the Cigna Indemnity plan. Your spouse incurs surgical expenses of $1,000. Your spouse's plan is the primary plan for his or her coverage, and he or she has already met the deductible.

Your spouse's plan, the primary plan for his or her coverage, pays 70 percent of the surgery bill or $700. The Cigna Indemnity plan subtracts the amount paid by the primary plan from the in-network benefit normally payable:

- Cigna Indemnity plan benefit: $800
- Less the benefit paid by the primary plan: $700
- Cigna Indemnity plan coordinated benefit: $100

Continue with the same example, but assume that your spouse incurs $1,000 in surgical expenses out-of-network and you have already met your deductible. The Cigna Indemnity plan out-of-network reimburses surgery at 80 percent. The Cigna Indemnity plan subtracts the amount paid by the primary plan from the out-of- network benefit normally payable:

- Cigna Indemnity plan benefit: $800
- Less the benefit paid by the primary plan: $900
- Cigna Indemnity plan coordinated benefit: $0

In this example, the amount paid by the primary plan exceeds the Cigna Indemnity plan benefit, so there is no additional benefit payable under the Cigna Indemnity plan.

Special Rules Regarding End Stage Renal Disease (ESRD)

The plan will not reduce the benefits it will pay as a result of you or your spouse's or domestic partner's eligibility for Medicare due to ESRD during the 30-month period beginning with the first month you or your spouse or domestic partner are entitled to benefits due to ESRD (or, if earlier, the first month in which you or your spouse or domestic partner would have been entitled to benefits had an application for benefits been filed). However, after this 30 month period expires, the plan will reduce the benefits it will pay in the same manner that it would reduce the benefits it would pay if you or your spouse or domestic partner were eligible for Medicare for any other reason (see the explanation of the reduction of benefits above).

For more information about Medicare entitlement due to ESRD, visit: www.ssa.gov/mediinfo.htm, www.medicare.gov, or call (800) MEDICARE (633-4227).

How to File Claims if you are enrolled in Multiple Coverage

As a Medicare eligible retiree, your benefits or the benefits for your Medicare eligible dependent(s) is coordinated with Medicare. For most of your health care services, Medicare will pay benefits first.

If you and your eligible dependent(s) are covered by two plans (other than Medicare), you should submit claim forms 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 Cigna if you have other coverage. Failure to notify Cigna will result in the denial of claims for your enrolled eligible dependent(s) until you notify the Cigna of whether or not other coverage is available.

Important Information Regarding Medicare Part D

Medicare prescription drug coverage (Part D) is available to everyone with Medicare. Make sure you check the *Enrolling in Medicare* booklet (available online at www.medicare.gov) for your Enrollment options.

Cigna Indemnity Plan with Rx Members:

The Cigna Indemnity plan includes more comprehensive prescription drug coverage than Medicare Part D; therefore you do not need to purchase a Medicare Part D plan if you enroll in the Cigna Indemnity Plan. For more details, please read the Notice of Creditable Coverage (NOCC) below. The Cigna Indemnity plan will not coordinate prescription drug benefits with

Medicare Part D. Any charges considered for coverage under Medicare Part D will not be eligible for IRMP reimbursement.

Note: IRMP Indemnity with RX is not considered a Medicare Part D plan. It is creditable to Medicare Part D.

Cigna Indemnity Plan without Rx members:

The Cigna Indemnity without Rx plan does not include prescription drug coverage; therefore, you will need to purchase a Medicare Part D plan if enroll in the Cigna Indemnity Plan. You will need a Notice of Creditable Coverage (NOCC) to enroll in Medicare Part D plan. See Notice of Credible coverage for more information.

Catastrophic Rx HRA – Capping Your Out-of-Pocket Costs Under Medicare Part D

Effective January 1, 2016, enrollees in a Medicare Part D Plan for prescription coverage will not spend more than the Medicare Donut Hole (Coverage Gap) total annual out-of-pocket maximum ($4,850 in 2016). Medicare Part D plans cover a broad range of medications at a cost share that changes as your prescription drug costs increase during the year. With Medicare Part D coverage alone, you continue to pay 5% coinsurance for drugs, even after you reach the annual Donut Hole maximum. Intel's new Catastrophic Rx HRA will reimburse all Intel Retirees for that 5% coinsurance. See Section 9, Catastrophic Rx HRA – below for more information on the Catastrophic Rx HRA.

If you have questions about Medicare Part D, please visit the Medicare Web site at www.medicare.gov/.

Coverage History Notice

The Coverage History Notice may be needed if you are Medicare-eligible and you elect to enroll in Medicare Part D plan. Intel provides you the notice upon retirement or termination of employment. 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, 7 a.m. to 5 p.m. (Pacific).

Section 5 - IRMP Medical - Covered Medical Services

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 in order for benefits to be payable. If you are disabled, certain denied medical services may be accommodated through the Americans with Disabilities Act (ADA).

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).

Breast Reconstruction, Breast Prostheses, and Complications of Masectomy

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
- Protheses 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.

Dental Services

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

- In connection with accidental injury of sound natural teeth or
- 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 immunosuppresives
- 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 sound, natural tooth. The physician or dentist must certify that the injured tooth was a virgin or unrestored tooth, or a tooth that has no decay, no filling on more than two surfaces, no gum disease associated with bone loss, no root canal therapy, is not a dental implant and functions normally in chewing and speech. Dental services for final treatment to repair the damage must be both of the following: started within three months of the accident and completed within 12 months of the accident.

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 presurgical 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 under the Plan 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.

Coverage is provided for medical, surgical, hospital and related health care 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

Emergency Services

Coverage is provided for medical, surgical, hospital and related health care 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 shall 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

Hearing Care

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

Home Birth

Professional services for home birth are covered when provided by a licensed nurse mid-wife or physician.

Home Health Care

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

- They are delivered or supervised by licensed technical or professional medical personnel in order 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 in order to be delivered safely and effectively
- They are not Custodial Care

Home health care 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 health care facility, such as a skilled nursing facility

Home health care services include:

- Part-time or intermittent visits by professional nurses and other health care 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
- Health care services at home, including nursing care, use of medical equipment, rental of wheel chairs 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 spouses, eligible covered female 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. CBH 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 health care 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

New born 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.

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 it 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 are 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 utilized 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 & 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-Injectables
- 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 or 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. 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 Web site, http://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 health care 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 purposes 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., by-pass 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 on a daily basis.

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 health care professionals, including office visits
- Periodic health assessments
- Hospital care
- Consultation
- Surgical procedures

Transsexual Surgery

Coverage includes medical procedures, psychological counseling, and hormonal therapy in preparation for, or subsequent to, any such surgery. This benefit only applies to the IRMP Cigna Coinsurance Plan. Benefit may be subject to tax.

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

Reasonable travel and living expenses are also covered for the patient and a 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 is 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 a family member are covered for organ transplants. Reasonable travel and living expenses may be covered for other in-network services if the services are deemed appropriate and when services are not available within a reasonable distance from a patient's home. Travel and living expenses will not be covered for

out of network care unless the care is directed by the plan administrator. All travel and living expenses require prior authorization.

Travel Immunizations

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

Vision Therapy

Vision therapy is available on IRMP Cigna Coinsurance Plan (Non-Medicare) as long as the following conditions apply:

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

Weight Reduction Services
(This benefit only applies to the IRMP Cigna Coinsurance Plan)

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– Vision Plan

Routine Vision Care Benefits

Routine Vision benefits are provided under an agreement with 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 (800) 468-3510 or (866) 798-9193. 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 elect to charge his or her R&C charges.

Out-of-Network: Eye exam and prescription eyewear benefits are covered if you do not utilize 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 (call VSP at 855-663-2836 to request a form)

Send a copy of the itemized bill(s) and claim form:

VSP
P.O. Box 997105
Sacramento, CA 95899-7105

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

In-Network Benefit Only

Make an appointment for Primary Eyecare Program services with an VSP Vision network provider, and identify yourself as an VSP patient. If you need assistance in locating an 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 • Sty

The Primary Eye care 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 Cigna Coinsurance provider for treatment.

***Note**: The Primary Eye care Program offers you an alternative choice of seeing your VSP network provider for the conditions and symptoms mentioned above. If you prefer, you may seek treatment directly from your Cigna IRMP primary care provider. There is no out-of-network benefit for the Primary Eye care Program under VSP.*

VSP Basic Vision

Vision Coverage	VSP Basic Vision Plan (In-Network)	VSP Basic Vision Plan (Out-of-Network)
Exam	Exam every 12 months	
Comprehensive Exam	$0	Reimbursed to $40
Standard Contact Lens Fit	Up to $55	NA
Premium Contact Lens Fit	Up to $55	NA
Retinal Screening	Covered 100% if diabetic, Otherwise $25	NA
Eyewear	Frame every 24 months and lenses every 12 months	
Eyeglass frames	$130 allowance/$70 if Costco affiliate	Reimbursed to $70
Standard Single vision	$25 copay	Reimbursed to $30
Standard Bifocal	$25 copay	Reimbursed to $50
Standard Trifocal	$25 copay	Reimbursed to $70
Standard Lenticular	$25 copay	Reimbursed to $85
Standard Progressive	$55 copay	Reimbursed to $50

Vision Coverage	VSP Basic Vision Plan (In-Network)	VSP Basic Vision Plan (Out-of-Network)
Exam	Exam every 12 months	
Premium Progressive	$95-$105	Reimbursed to $50
Custom Progressive	20% off Usual & Customary	NA
UV Coating	$16	NA
Tint	$15	NA
Standard Scratch Resistant	20% off Usual & Customary	NA
Polycarbonate Single Vision	$31	NA
Polycarbonate Multi-Focal	$45	NA
Standard Anti-Reflective Coating	$41	NA
Other Add-ons & Services	NA	NA
Contact lenses	Contact lenses every 12 months	
Contact lenses (elective)	$130 allowance	$130
Contact lenses (medically necessary)	$25 copay	$210
Other – Primary Eye care	$15 copay	
Laser Vision Correction	Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	

VSP PLUS Vision Plan

Vision Coverage	VSP PLUS Vision Plan (In-Network)	VSP PLUS Vision Plan (Out-of-Network)
Exam	Exam every 12 months	
Comprehensive Exam	$0	Reimbursed to $40
Standard Contact Lens Fit	Up to $55	N/A
Premium Contact Lens Fit	Up to $55	N/A
Retinal Screening	Covered 100% if diabetic, Otherwise $25	N/A
Eyewear	Frame and lenses every 12 months	
Eyeglass frames	$200 allowance/$110 if Costco affiliate	Reimbursed to $110
Standard Single vision	$10 copay	Reimbursed to $30
Standard Bifocal	$10 copay	Reimbursed to $50
Standard Trifocal	$10 copay	Reimbursed to $70
Standard Lenticular	$10 copay	Reimbursed to $85

Section 6 – IRMP - Vision Plans

Vision Coverage	VSP PLUS Vision Plan (In-Network)	VSP PLUS Vision Plan (Out-of-Network)
Exam	Exam every 12 months	
Standard Progressive	$55 copay	Reimbursed to $50
Premium Progressive	$95-$105	Reimbursed to $50
Custom Progressive	20% off Usual & Customary	NA
UV Coating	$16	NA
Tint	$15	NA
Standard Scratch Resistant	20% off Usual & Customary	NA
Polycarbonate Single Vision	$31	NA
Polycarbonate Multi-Focal	$45	NA
Standard Anti-Reflective Coating	$41	NA
Other Add-ons & Services	NA	NA
Contact lenses	Contact lenses every 12 months	
Contact lenses (elective)	$200 allowance	$200
Contact lenses (medically necessary)	$10 copay	$210
Other – Primary Eye care	$15 copay	
Laser Eye Correction	Anyone who enrolls in the VSP Vision Plus Plan receives the added benefit of laser vision correction (Lasik) coverage. The benefit is a $2,000 allowance per lifetime per covered member.	

Section 7 – IRMP Medical - 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, sclerotheraphy, 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 maloccusion 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 the purpose of 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
  - Nonlegend 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, reasonable and customary 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 of 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 chord 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 chiropractically 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.

  - Orthoptics 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.

Section 7 – IRMP Medical - Exclusions and Limitations

Misc Exclusions:

- In the event that a 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 charges for services, treatment or supplies that would otherwise been covered by Medicare, specifically:
    - For a person who is eligible for that Part A, but has not applied, benefits shall be reduced by the amount the member would receive if s/he had applied.
    - For a person who is entitled to be enrolled in Part B, but is not, benefits shall be reduced by the amount the member would receive if s/he were enrolled.
    - For a person who has entered into a private contract with a provider who has opted-out of Medicare, benefits shall be reduced by the amount the member would receive in the absence of such private contract.
- Any charge for services, supplies or equipment advertised by the provider as free. Charges by a provider sanctioned under a federal program for reason 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 charge 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 8 – Sheltered Employee Retirement Medical Account (SERMA)

Overview

The Sheltered Employee Retirement Medical Account (SERMA) program is provided to help retirees and eligible spouse and dependents purchase health insurance if you have retired from Intel and meet the eligibility requirements. If you are eligible, Intel credits your SERMA account with a specific amount based on your years of completed eligible service with Intel. You must be a U.S. employee at the time you retire to be eligible for SERMA credits. You can use your SERMA for as long as you and your eligible dependent(s) have credits remaining in the account.

* SERMA reimbursements for medical, dental and vision premiums for a Domestic Partner and eligible enrolled dependent(s) of a Domestic Partner are generally treated as taxable (imputed) income. To the extent the benefits are taxable, Intel will tax-protect imputed income for same-sex domestic partner health benefits for those who are not married and live in a state that does not recognize same-sex marriage.

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

SERMA Eligibility

If you were hired before January 1, 2014, a SERMA will be established upon your retirement from Intel if you are a U.S. employee at the time you retire and meet any of Intel's retirement eligibility rules.

On or after January 1, 2014, if you separate from Intel or transfer from an Intel SERMA participating entity to a non-participating subsidiary or entity, your past years of service for the purpose of calculating SERMA will be forfeited.

For example, you are not eligible for SERMA if you were:

- Hired on or after January 1, 2014
- Rehired on or after January 1, 2014
- Transferred to Intel U.S. from a non-participating Intel subsidiary (e.g., McAfee, Wind River) or non-participating Intel entity (e.g., Intel China) on or after January 1, 2014

If you retire from Intel and subsequently return to work at Intel or any of its affiliates or subsidiaries, your SERMA account will be suspended during the time you are employed and no interest payments will be earned until you retire again. SERMA was closed to new participation on January 1, 2014. If you are retired and return to Intel as an employee on or after Jan 1, 2014 no additional service credits will be earned. Upon your subsequent retirement, you will once again be able to use your remaining SERMA.

Upon your death

Your surviving eligible dependent(s) is eligible to use your SERMA if you were eligible to participate before your death. However, if your spouse or domestic partner remarries or enters another domestic partnership following your death, your spouse or domestic partner will not be able to use SERMA for a new spouse or domestic partner or new dependent children.

Spouse/Domestic Partner who is an Intel Retiree

If both you and your eligible spouse or domestic partner are retirees of Intel, each of you will have your own SERMA and the amount for each will be based on your individual years of service.

When SERMA Ends

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

Intel reserves the right to terminate your SERMA and forfeit your SERMA balance when either of the following occur:

- The account has not been used after **20 consecutive years**
- You and your eligible dependent(s) die

Intel SERMA Contributions and Interest

If you retire from Intel and have satisfied the eligibility requirements, Intel will establish a SERMA for you or your eligible surviving eligible dependent(s). Intel credits your SERMA account with a specified amount for each year of completed eligible service with Intel. This amount is a one-time credit made to your SERMA after you retire. The only other contributions to your account will be in the form of interest earned on your account following your retirement. The interest credited is based on the average 12-month T-bill rate for the preceding calendar year. If you retire in the middle of the year, interest will be pro-rated for the partial year.

If you retire from Intel and subsequently return to work at Intel or any of its affiliates or subsidiaries, your SERMA account will be suspended during the time you are employed and no interest payments will be earned until you retire again.

Intel SERMA Credit Amounts

- As of Sept. 1, 1996, Intel initially contributed $1,000 credit for each year of completed general full-time Intel U.S. service. U.S. service is defined as being on Intel U.S. Payroll.

- Effective Jan. 1, 2001, Intel increased the credit amount to $1,500 for each year of completed general full-time Intel U.S. service. This increase is not retroactive and only

applies to employees retiring on or after Jan. 1, 2001. This amount, however, may be adjusted in the future at Intel's sole discretion.

How Service is Determined for SERMA

You must retire from Intel as a U.S. employee to be eligible for SERMA credits.

If you were hired before January 1, 2014, a SERMA will be established upon your retirement from Intel if you are a U.S. employee at the time you retire and meet any of Intel's retirement eligibility rules.

On or after January 1, 2014, if you separate from Intel or transfer from an Intel SERMA participating entity to a non-participating subsidiary or entity, your past years of service for the purpose of calculating SERMA will be forfeited. For example, you are not eligible for SERMA if you were:

- Transferred to Intel U.S. from a non-participating Intel subsidiary (e.g., McAfee, Wind River, Havok) or non-participating Intel entity (e.g., Intel China) on or after January 1, 2014

For Service Time Prior to Jan. 1, 2004

Only completed general full-time years of service as a U.S. employee (including intern) count toward eligible service. Part-time service, Intel Contract Employee (ICE) service, and personal leave time will not count in establishing the benefit amount. Also, medical leave and other leave time (except military leave) over 183 days within a seven-year period will not count toward the calculation of the SERMA amount. If you left Intel and were rehired prior to Jan. 1, 2004, your past completed general full-time U.S. years of service will count toward earning credits in your SERMA, provided you returned to Intel within five years of your termination date and returned to Intel prior to Jan. 1, 2004.

For Service Time On or After Jan. 1, 2004

Eligible Intel years of service beginning on or after Jan. 1, 2004 includes: general full-time service, intern service, part-time service, ICE service, non-US service, and all leave of absence time (including personal leave time). If you left Intel and were later rehired, your past completed eligible years of service will count toward earning credits in your SERMA, provided you return to Intel within two years of your termination date, and your return to work date was prior to Jan. 1, 2014. If you had SERMA after originally retiring from Intel and return to Intel again as an employee after Jan. 1, 2014, you will not earn any additional SERMA credits once you retire again from Intel.

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

Service with Intel subsidiaries or other Intel legally owned entities (Company Codes), which have been designated as a participating company by the Intel Benefits Administrative Committee will count toward eligibility to the extent determined by the same committee.

If you retired from Intel PRIOR to Sept. 1, 1996

If you retired from Intel prior to Sept. 1, 1996 and met the eligibility criteria to participate in the IRMP prior to leaving Intel, you or your surviving eligible dependent(s) are eligible to receive a SERMA. Effective Sept. 1, 1996; Intel established an account for you that was credited with an amount based on your completed general full-time years of service with Intel U.S., up to your date of retirement from Intel. Your account began to earn annual interest as of the effective date of the program.

SERMA Balance Inquiry

When you retire, Intel will establish a SERMA for you or your surviving eligible dependent(s) provided that you meet any of the SERMA eligibility guidelines. Within the first quarter of each year you will be sent an annual statement with your SERMA balance. 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 Your Spending Account tab or by calling the Intel Health Benefits Center at (877) GoMyBen (466-9236).

Summary of SERMA Options

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

1) IRMP Medical/Vision Premiums – 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.

2) Premiums Outside IRMP – SERMA may be used to reimburse yourself for eligible non-Intel sponsored health care premiums paid for you, your spouse or Domestic Partner, and your eligible children until you exhaust your SERMA account.

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 premiums outside IRMP within the same year.

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 you, your eligible spouse's or 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
- If you experience certain change-in-status events, the effective date of the percent change will be the event date

Enrollment Change Forms are available by calling the Intel Health Benefits Center at (877) GoMyBen (466-9236), Monday through Friday 7 a.m. to 5 p.m. (Pacific).

If You Elect Reimbursement for Health Insurance Premiums Outside of IRMP

Eligible premiums for yourself, your spouse or domestic partner, and eligible dependents may be submitted for reimbursement from your SERMA. Reimbursement is for eligible health insurance premiums for coverage beginning on or after January 1, 2016. You may submit for additional premium reimbursements even if you are enrolled in IRMP.

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

Submit 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 web site 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 Feb, 2016 cannot be submitted for reimbursement until March 1, 2016).
- You file your claim before the annual run out period ends March 31 of the following year

Claim Submission Deadline
You are allowed to submit claims for eligible premiums for the prior year (January 1 through December 31) until the run out period ends March 31 of the current year. For example a claim for premium coverage date of July 2013 can be submitted until March 31, 2014.

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

Get Your Money Faster With Direct Deposit

You can have your 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.

How to Manage Your SERMA

- The My Health Benefits web site will provide you tools and resources to allow you to manage your SERMA.
- You can access the web site 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 Spending Account (YSA) 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

You may also speak with a service center representative by calling the Intel Health Benefits Center toll-free at (877) GoMyBen (1-877-466-9236) and select Your Spending Account option. Representatives are available from 7 a.m. to 5 p.m. Pacific time, Monday through Friday.

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 ineligible 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 premium tax credit, you may choose to "Opt Out" of SERMA for the remainder of the current calendar year in order to qualify. 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 carry over from year to year unless you "Opt In" again during the next Annual Enrollment following the same process.

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.

Section 8 – Sheltered Employee Retirement Medical Account (SERMA)

For those retiring during the year, you will have 31 days from the date of your retirement to notify the Intel Health Benefits Center, Your Spending Account that you want to "Opt Out" of SERMA so that you may qualify for the Federal premium tax credits. If you take no action, the default is to "Opt In" to SERMA. Remember, your "Opt Out" election will carry over from year to year unless you "Opt In" again during the next Annual Enrollment.

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) and select Your Spending Account option. You must call to "Opt Out" as it cannot be completed online.

Section 9 Catastrophic RX HRA

Catastrophic Rx HRA – Capping Your Out-of-Pocket Costs Under Medicare Part D

Effective January 1, 2016, enrollees in a Medicare Part D Plan for prescription coverage will not spend more than the Medicare Donut Hole (Coverage Gap) total annual out-of-pocket maximum ($4,850 in 2016). Medicare Part D plans cover a broad range of medications at a cost share that changes as your prescription drug costs increase during the year. With Part D alone, you continue to pay 5% coinsurance for drugs, even after you reach the annual Donut Hole maximum. Intel's new Catastrophic Rx Health Reimbursement Account (HRA) will reimburse all Intel Retirees for that 5% coinsurance.

Retirees do not need to enroll or elect the Catastrophic Rx HRA, but you must be enrolled in a Medicare Part D Plan to receive reimbursement through the Catastrophic Rx HRA.

To take advantage of the Catastrophic Rx HRA, you simply need to call the Intel Health Benefit Center at (877) GoMyBen (466-9236) and select the "Your Spending Account" option to notify the team you have exceeded the Medicare Part D Donut Hole. Your Spending Account representative will walk you through what you need to do to submit claims for reimbursement.

The Catastrophic Rx HRA Plan year runs from January 1 through December 31 of each year. You may submit a claim for reimbursement of an eligible expense incurred during these dates as long as:

- You are enrolled in Medicare Part D on the date the eligible expense was incurred
- You file your claim before the annual run out period ends March 31 of the following year

Claim Submission Deadline

You are allowed to submit claims for eligible premiums for the prior year (January 1 through December 31) until the run out period ends March 31 or each year. For example a claim for July 2016 can be submitted until March 31, 2017.

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

Get Your Money Faster With Direct Deposit

You can have your reimbursements electronically deposited 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.

Section 10 – Administrative

Enrollment Conditions

Submission of your health benefit elections via the Web site or contact center stipulates that you apply for enrollment (or changes in enrollment) in accordance with the rules for retiree health care coverage of Intel Corporation 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 the IRMP and SERMA, and that you have read the materials provided to you and are aware of the conditions of enrollment and changes.

Women's Health & Cancer Rights Act – Breast Reconstruction Medical Benefits

Group health plans, health insurers, and health maintenance organizations that provide medical and surgical benefits for a mastectomy must provide certain benefits related to breast reconstruction as required by the Women's Health and Cancer Rights Act of 1998 (WHCRA).

If you or your dependent undergoes a mastectomy and elects breast reconstruction in connection with the mastectomy, coverage will include the following:

- 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.
- Prostheses and treatments for physical complications of mastectomy, including lymph edemas.

Coverage will be provided as determined in consultation between the attending physician and the patient. This coverage is subject to deductibles and coinsurance limitations consistent with those established for other benefits under your medical plan. If you would like more information on WHCRA benefits as they apply to IRMP, please call Cigna at (800) 468-3510.

Newborns & 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). In any case, 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).

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 1900 Prairie City Road, FM3-110 Folsom, CA 95630 (916) 356-8080
Employer Identification Number	94-1672743
Plan Year Ends	Dec. 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), 7 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: Manager, Health Benefits Services
1600 Rio Rancho Boulevard, RR5-306
Rio Rancho, NM 87124 (505) 893-5655

How the IRMP and SERMA are Funded

The IRMP, medical, vision and catastrophic RX HRA options, and SERMA are self-funded. The 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 trustee for the trust is:

State Street Bank and Trust, N.A.
Specialized Services
125 Sunnynoll Court, Suite 200
Winston-Salem, NC 27106

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 (medical/vision, and Catastrophic RX HRA) Plan Number: 526	Intel Retiree Health and Welfare Benefit Trust c/o State Street Bank and Trust, N.A. Specialized Services 125 Sunnynoll Court, Suite 200 Winston-Salem, NC 27106 Additionally, Intel may pay the cost of these benefits directly through its general assets.	Medical/Vision -You and Intel may share the cost of coverage Catastrophic RX HRA – Intel pays the cost
Sheltered Employee Retirement Medical Account (SERMA) Plan Number: 526	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, SERMA, and the Catastrophic Rx HRA. 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 7 a.m. to 5 p.m. (Pacific).

Program Phone Numbers and Websites

Supplier	Customer Service Number	Group #
Cigna (IRMP)	(800) 468-3510 www.myCigna.com	2445654
Express Scripts (RX)	(800) 468-3510 www.express-scripts.com	INTELRX
VSP (Vision)	800.877.7195 www.vsp.com (Locate an VSP doctor or obtain information on how to use your VSP benefits)	
Intel Health Benefits Center -AonHewitt (SERMA & Catastrophic RX HRA)	(877) GoMyBen (466-9236), Monday through Friday 7a.m. to 5 p.m. (Pacific), www.intel.com/go/myben	

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, vision or Catastrophic RX HRA or the 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 U.S. 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 the following:

- Continued health care coverage for your spouse, or dependents if there is a loss of coverage under the plan as a result 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.

- Reduction or elimination of exclusionary periods of coverage for pre- existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance

from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you 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, U.S. Department of Labor, listed in your telephone directory or:

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

Questions about the IRMP, medical vision options, Catastrophic RX HRA**, or SERMA**

Contact your Plan Administrator at:

Intel Corporation
Plan Administrator, BAC
Attn: Manager, Health Benefits Services
1600 Rio Rancho Boulevard, RR5-306
Rio Rancho, NM 87124 (505) 893-5655

Agent for Service of Legal Process for the IRMP, medical, vision options, Catastrophic RX HRA or SERMA

General Counsel
Intel Corporation
2200 Mission College Blvd.
Santa Clara, CA 95052

Section 11– Claims

Filing an IRMP Medical, Vision or Catastrophic RX HRA Claim

For information on filing a claim for reimbursement for SERMA or Catastrophic Rx HRA, please refer to Section 8 and 9 respectively.

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 Cigna HealthCare Member Services at (800) 468-3510 for instructions or VSP Member Services at (800) 877- 7195.

***Note**: If you submit a claim, you must do so within one year of the date the service is provided.*

Out-of-Network: You must submit a claim form each time you use out-of-network or Medicare-eligible services. Except as otherwise provided by the Plan, 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.

If you disagree with how a claim has been paid, see the Appeals Process.

Intel's Cigna IRMP account number is #2445654.

Claim Forms

Supplier	How to Obtain Claim Forms	Submitting Claim Forms
• Medical Claims	You can call Member Services at (800) 468-3510	**Cigna** Use the claim address indicated on the back of your Identification Card.
• Prescription	You can call Member Services at (800) 468-3510	**Express Scripts** P.O. Box 14711 Lexington, KY 40512
• Vision	You can call Member Services at (800) 877- 7195	**VSP Vision** Submit all claims through the VSP website (www.vsp.com)
Catastrophic RX Claim	Intel Health Benefit Center at (877) GoMyBen (466-9236) and select the "Your Spending Account"	Speak with representative

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

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.

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	Pre-service Claims	Post-service
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	A decision will be made within a reasonable time, based on your medical circumstances, but no later than 15	A decision will be made within a reasonable time, based on your medical circumstances, but no later than 30 days

	Urgent Care	Pre-service Claims	Post-service
	of the claim by the Plan.	days after your claim is received.	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 more time to submit information.	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 provided. If you request, the Plan may, within its sole discretion, provide you more time to submit information.	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 provided. If you request, the Plan may, within its sole discretion, provide you more time to submit information.

Concurrent 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.

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.

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 health care 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.

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.

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

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 back to the respective Plan trust or bank account.

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) have to 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.

Refund of Overpayments

If Intel pays benefits for expenses incurred on account of a plan member, that plan member, or any other person or organization that was paid, must make a refund to Intel if either of the following apply:

- All or some of the expenses were not paid by the plan member or did not legally have to be paid by the plan member
- All or some of the payment Intel made exceeded the benefits under the plan

The refund equals the amount Intel paid in excess of the amount Intel should have paid under the plan. If the refund is due from another person or organization, the plan member agrees to help Intel get the refund when requested.

If the plan member, or any other person or organization that was paid, does not promptly refund the full amount, Intel may reduce the amount of any future benefits that are payable under the plan. The reductions will equal the amount of the required refund. Intel may have other rights in addition to the right to reduce future benefits.

Section 12 - Appeals Process

If you received notice of an adverse benefit determination on your claim for benefits under the IRMP medical or vision options, SERMA* or Catastrophic Rx HRA*, 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. If your plan supplier denies your appeal, you may submit a voluntary appeal to Medical Review Institute of America, Inc. (MRI). MRI is an external, independent organization that will decide voluntary appeals except those that involve your eligibility or enrollment in the Plan
- 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 Claims	Pre-Existing Claims	Post-service Claims
Who will review your appeal	Depending on the health services involved in your appeal, Cigna HealthCare, VSP, or Express Scripts will review and decide your appeal.	Depending on the health services involved in your appeal, Cigna HealthCare, VSP, or Express Scripts will review and decide your appeal unless the issue involves your eligibility or enrollment in the Plan. If your plan supplier denies your appeal, you may submit a voluntary appeal to MRI. Intel Health Benefits Services will decide your appeal only if it	Depending on the health services involved in your appeal, Cigna HealthCare, VSP, Aon Hewitt, or Express Scripts will review and decide your appeal unless the issue involves your eligibility or enrollment in the Plan. If your plan supplier denies your appeal, you may submit a voluntary appeal to MRI. Intel Health Benefits Services will decide

	Urgent Care Claims	Pre-Existing Claims	Post-service Claims
		involves your eligibility or enrollment in the Plan.	your appeal only if it involves your eligibility or enrollment in the Plan.
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.** 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	You or your authorized representative must file appeals in writing with the plan supplier. Your plan will review your appeal. Eligibility and enrollment appeals will be forwarded to Intel Health Benefits Services. See the Contact Information Table for address and telephone numbers.	You or your authorized representative must file appeals in writing with the plan supplier. Your plan will review your appeal. Eligibility and enrollment 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.
How to file a voluntary appeal		If your appeal is denied by your plan supplier, you have 60 days from the date of the appeal denial letter to file a voluntary appeal with	If your appeal is denied by your plan supplier, you have 60 days from the date of the appeal denial letter to file a voluntary appeal with

	Urgent Care Claims	Pre-Existing Claims	Post-service Claims
		MRI. You or your authorized representative must file the voluntary appeal in writing with your plan supplier. Your plan supplier will forward your claim denial, and all other pertinent information used to decide your appeal to MRI. You may provide additional information to MRI that you wish for MRI to consider.	MRI. You or your authorized representative must file the voluntary appeal in writing with your plan supplier. Your plan supplier will forward your claim denial, and all other pertinent information used to decide your appeal to MRI. You may provide additional information to MRI that you wish for MRI to consider.
Time period for deciding your voluntary appeal		Your voluntary 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 by MRI for your voluntary appeal.	Your voluntary 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 by MRI for your voluntary appeal.
* An appeal of a SERMA or Catastrophic Rx HRA adverse benefit determination is a Post-service claim. **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.			

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 with regard to 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 health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This health care 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

IRMP California participants: If your appeal is for a denial of in-network benefits, you will receive details of the appeals process with your denial letter.

Appointing an Authorized Representative

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

If your appeal involves urgent care, a health care 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.

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

Appealing a Denied Claim - Voluntary Appeal

If your appeal is denied, you may file a voluntary appeal with MRI. There are no fees or costs imposed on you for the voluntary appeal. The decision as to whether or not to submit a denial of your appeal to a voluntary appeal will have no effect on your rights to any other benefits under the Intel Corporation Health and Welfare Plan. You are not required to undertake a voluntary appeal before pursuing legal action.

When your appeal is denied, you will receive a letter that describes the process to follow if you wish to pursue a voluntary appeal through MRI.

If you choose to file a voluntary appeal with MRI:

- You may do so only after exhaustion of the required appeal. Accordingly, you must first submit an appeal with your plan supplier, and receive a denial of your appeal before requesting a voluntary appeal.
- After you receive a denial of your appeal, you must submit the request for a voluntary appeal with your plan supplier in writing within 60 calendar days from the date of the appeal denial letter.
- The plan supplier will forward a copy of the final appeal denial letter and all other pertinent information that was reviewed in the appeal to MRI. You may also submit additional information you wish to be considered.

- MRI is an external review organization that utilizes independent physicians with appropriate expertise to perform the review of voluntary appeals. In rendering a decision, MRI may consider any appropriate additional information submitted by you and will follow the plan documents governing your benefits.
- You will be notified of the decision of MRI within 30 days of the receipt of the request for the voluntary appeal.
- The statute of limitations or other defense based on timeliness is suspended during the time that a voluntary appeal is pending.

If you choose not to submit a voluntary appeal:

- The Plan waives any right to assert that you have failed to exhaust administrative remedies.

Request for an Intel Quality Assurance Review

If you are concerned with the processing of your claim or appeal, you may request a review by Intel Quality Assurance. Submit your request in writing to:

Intel Quality Assurance Review
C/O Karen Grending
Intel Corporation
1600 Rio Rancho Blvd. S.E., RR5-306
Rio Rancho, NM 87124-1025

What is an Intel Quality Assurance Review?

The Intel Quality Assurance Review is a process that provides an opportunity for Intel to assure that your claim or appeal was processed in accordance with applicable laws and processes, and in compliance with plan terms. The IQAR is not a decision making body, and therefore does not have authority to overturn or supersede any existing rulings, but instead offers a review of processes, procedures and communications used in and around the determination of your claim or appeal. Through this process, Intel monitors its suppliers to assure that they are providing the best quality in the handling of your case.

Contact Information Table – Where to File Your Appeal

Reviewing	Contact Information	Phone Number
Aon Hewitt (for SERMA and the Catastrophic Rx HRA)	www.intel.com/go/myben	Call the Intel Benefits Center toll- free at (877) GoMyBen (1-877-466-9236).
Cigna	Cigna Healthcare National Appeals	(800) 468-3510
Express Scripts	Express Scripts 8111 Royal Ridge Pkwy Irving, TX 75063 0000	(800) 637-6438
VSP	Vision Service Plan P.O. Box 2350 Rancho Cordova, CA 95741-	(800) 877-7195
Medical Review Institute (MRI)	MRI 2875 South Decker Lake Drive, Suite 550 Salt Lake City, UT 84119	(800) 654-2422 Fax (801) 261-3189
Intel Quality Assurance Review	Intel Quality Assurance Review Process Intel Corporation 1900 Prairie City Road, FM3-27	Mail Only
Health Benefits Services (HBS)	Intel Corporation Intel Benefits Services 4100 Sara Road, RR5-505 Rio Rancho, NM 87124	(877) GoMyBen (466-9236)

Section 13 – Medical Privacy

Medical Privacy

Intel has always taken voluntary steps to safeguard your personal information. The U.S. 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, 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.

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 – COBRA

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) or the Intel Retiree Medical Plan (IRMP) and SERMA. First, if you are enrolled in the Group Health Plan 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, if you and your eligible dependent(s) participate in the IRMP or you have a SERMA balance, your eligible dependent(s) may be eligible for COBRA under the IRMP or SERMA if he or she loses coverage due to a COBRA qualifying event. This section describes how COBRA continuation coverage is applied for retirees and eligible dependents who elect to participate in the IRMP and 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 7 a.m. to 5 p.m. (Pacific).

COBRA Qualifying Event for IRMP or SERMA Participants

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

- Divorce
- A dependent child ceases to be eligible for coverage under the terms of the plan.
- Dissolution of your domestic partnership

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.

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) begins participation in the IRMP or you retire and have a SERMA balance, only your eligible dependent(s) can become a qualified beneficiary.

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
Dependent child losing eligibility	Child	36 months
Death of employee	Dependent(s)	36 months
Dependent child losing coverage due to reaching age 26.	Child	36 months

Notice

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 7 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)).

Note: *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.*

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.

***Note**: 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 continue to utilize health care 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.

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 health care 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 7 a.m. to 5 p.m. (Pacific) to provide notice of the following events that automatically terminate COBRA coverage:
    - On 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).

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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 Jan. 1 of the following year.

Calendar Year

Begins Jan. 1 and ends Dec. 31.

Cigna

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

Cigna Open Access Plus (OAP) Network

Consists of physicians, hospitals, chiropractors, and other health care professionals who agree to provide their services under contract with the network manager responsible for administering the network. The Cigna Coinsurance IRMP use the Cigna OAP Network.

Claims Administrator

Organizations contracted by Intel (e.g., Cigna, 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.

Continued Stay Review (CSR)

For inpatient hospital admissions for medical or mental health services.

Coordination of Benefits
Rules that determine the order in which health plans must reimburse claims when coverage is provided by multiple health plans. See either Section 3 Non Medicare IRMP and/or Section 4 Medicare IMRP in this booklet for more information.

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Copay

See Copayment.

Copayment

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.

Section 15 – Glossary

CSR

Continued Stay Review.

Deductible

The amount an individual or family must first pay before reimbursements from coinsurance are available to them.

DME

Durable Medical Equipment

Domestic Partner

Two adults of the same-sex who have chosen to share their lives in an intimate and committed relationship, reside together, and share a mutual obligation of support for the basic necessities of life.

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 Cigna. 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 health care plan maintained by an employer or union that provides medical care to employees and often to their dependents.

Health Care 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 health care 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 Health Care 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 7 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.

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 health care 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 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 Jan. 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 reasonable and customary 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.

Plan Approved Charge

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

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 3 Non Medicare IRMP and/or Section 4 Medicare IMRP) section of this booklet.

PAC

Pre-Admission Certification

Participating Provider

An institution, facility, agency, or health care professional who is under contractual agreement with Cigna, 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 health care.

R&C Charges - Reasonable and Customary Charges

A charge will be considered R&C if it is the normal charge made by an individual provider for a given service, it does not exceed the normal charge made by most providers of such service in the community where the service is received, and it is adjusted due to multiple procedures performed during a single operation or through a single incision. To determine if a charge is R&C, the nature and severity of the injury, illness, or condition being treated will be considered. If the amount charged is higher than the R&C limit, you will pay the full difference between the actual amount charged and the portion paid by out-of-network coverage. Any charges you pay that exceed the R&C limit are excluded from the out-of-pocket maximum calculation.

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

Health care program for U.S. military dependents and retirees (formerly called CHAMPUS).

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.