Section 3
Eligibility, premium payments, and changes

About this section

This section describes HP benefit eligibility rules, how to enroll yourself and your eligible dependents, paying for your HP health benefits, and how to make changes.

Eligibility for HP medical benefits
- Eligible retirees
- If you decline HP medical coverage
- Eligible dependents

Domestic partner medical benefits
- Tax consequences for domestic partner health coverage

When HP medical coverage begins

When HP medical coverage ends
- Coverage for eligible HP retirees
- Coverage for eligible dependents
- When your dependents are no longer eligible for dependent status

Paying your monthly health benefit premiums
- Cost of coverage

Opportunities to make changes
- Available health benefit changes
- Qualified status changes
- If you move and your current medical option is no longer available

Annual enrollment period

How to make changes

If you have a change of address

Also see related sections

For more information about specific plans and covered benefits, you should refer to the sections describing each benefit. Also refer to Section 7, **How certain life events affect your benefits**, for details on some specific situations that might cause you to make changes as well as the types of changes that are available for those situations.

For information regarding the HP 401(k) Plan, HP Retirement Plan, HP Deferred Profit Sharing Plan, HP Cash Account Pension Plan, EDS Retirement Plan, or Retirement Medical Savings Account, see the separate summary plan descriptions that apply to these programs (contact the resources described in Section 2, **Benefits resources and phone numbers**).

Eligibility for HP medical benefits

This section provides details about eligibility for HP health benefits under the HP Retiree Medical Program, plus information about eligible dependents.

Eligible retirees

To be eligible for HP medical benefits under the HP Retiree Medical Program, you must satisfy one of the following eligibility criteria:

- You were hired or rehired by HP on or after January 1, 2003—this includes most HP Enterprise Services employees;
- You were age 45 or older and being paid on the former Compaq payroll as of December 31, 2002; or
- As of the date you left HP, you were not eligible to qualify for the Pre-2003 HP Retiree Medical Program either currently or in the future (for example, due to having age-plus-service "points" fewer than 62 as of December 31, 2005, or being more than five years from satisfying the Pre-2003 HP Retiree Medical Program's eligibility criteria as of June 30, 2007).

In order to qualify, you also must have retired from HP in an eligible status on or after January 1, 2003, and after satisfying at least one of the following age-service combinations:

- At age 55 or later with at least 10 years of qualifying service; or
- If you left HP on or after January 1, 2011, with at least 80 age-plus-service "points."

For this purpose, "qualifying service" is defined the same way as years of service under the HP Retirement Medical Savings Account (for details, see "Years of service" in the separate summary plan description that applies for this program). Service for former EDS employees also includes prior EDS service if you were employed by EDS on the August 26, 2008 acquisition date.

You may also qualify as a retiree if any of the following applies:

- You qualified as a retiree under the former EDS retiree health program, which was merged into the HP Retiree Medical Program and continues to provide access to HP medical coverage (along with access to retiree-paid life insurance benefits, where applicable);
- You left HP under a workforce reduction program with a termination date that fell within one year of the date you would have otherwise satisfied the eligibility criteria described above; or

- You left HP under an Enhanced Early Retirement (EER) Program that provided access to the HP Retiree Medical Program.

Important exception: Employees described above do not qualify for the HP Retiree Medical Program if they qualify for participation in the Pre-2003 HP Retiree Medical Program, the former Compaq Retiree Health Program, or the former Digital Retiree Health Program. This may include rehired retirees who return to work in 2003 or later, employees who met eligibility criteria under the former Digital Retiree Health Program as of February 28, 1999, and other employees who qualify for any of these separate retiree medical programs.

For additional information on circumstances that can cause eligibility for you or your dependents to end, see "When HP medical coverage ends" later in this section. Also note that eligibility for specific medical options requires that your principal residence fall within the ZIP code area where HP offers that option. For specific options available in your ZIP code, see your annual enrollment materials or go to Your Benefits Resources™ website (accessible from MyHPBenefits at www.myhpbenefits.com).

If you left under an EER Program within the last 24 months

If you left HP under an Enhanced Early Retirement (EER) Program that provided access to the HP Retiree Medical Program, you may qualify for HP medical coverage for up to 24 months following retirement, paying the same costs paid by active HP employees. During this 24-month period, some special considerations apply to your medical benefits:

- Your medical coverage options will be the same as those offered to active HP employees. This means you may be eligible for the Build Your Own Preferred Provider Organization (PPO) and Consumer Driven Health Plan (CDHP) options offered to active employees instead of the standard retiree PPO and CDHP options. In addition, you will not be eligible for the Comprehensive Medical Plan $5,000, HP Medicare Supplement options, or HMO Senior Plan options, since these options are only offered to retirees.

- If you or a covered dependent is eligible for Medicare, HP coverage will continue to be your primary coverage (pays benefits first) until the 24-month period has ended. At that time, Medicare will become your primary coverage, and you will need to participate in HP medical options that coordinate coverage with Medicare. For more information about Medicare and your retiree benefits, see Section 4, **Medical benefits**.

If you're rehired by HP

If, after qualifying as a retiree, you later return to active employment with HP, your retiree coverage will be suspended, and you will participate in active employee benefits. At the time you once again leave HP, your retiree status will be restored and you will once again be eligible for the HP Retiree Medical Program.

If you decline HP medical coverage
If at any time you are eligible but decline HP retiree medical coverage (for reasons other than enrolling in the Aon Hewitt Navigators service for Medicare-eligible retirees), or if your HP medical coverage is dropped due to nonpayment of premiums (as described under "Paying your monthly health benefit premiums" later in this section), your future ability to enroll will be limited. You will only be eligible to enroll in the future if you do so within 31 days of losing coverage under another employer group medical program (as defined below). This could include the loss of your own coverage through another employer, or the loss of coverage under your spouse's employer's plan (even if your spouse works for HP or is an HP retiree). This 31-day enrollment opportunity may be used more than once if you lose coverage under another employer group medical program at different times. **However, you will not be permitted to enroll during the annual benefits enrollment period or under any other circumstances**.

For purposes of your future ability to enroll in HP coverage, an "employer group medical program" is defined as group medical coverage provided to you or your spouse by an employer or a similar organization (whether as an employee, retiree, or COBRA participant), including coverage through an employer, a union, a school system, the federal, a state, or local government (in their capacity as employers), or the U.S. military. Coverage provided through a government-sponsored health program outside the U.S. also qualifies, even if the coverage is not provided in the government's capacity as an employer.

Coverage purchased on an individual basis directly from an insurance company, or through a group like AARP, is not considered to be "employer coverage." Medicare and Medicaid are also not considered to be "employer coverage," even though they are provided through the federal government.

To enroll in HP medical coverage following the loss of coverage under another employer group medical program, you must contact the HP Benefits Center within 31 days of losing your other coverage (for contact information, see Section 2, **Benefits resources and phone numbers**). In order to enroll, you also must continue to meet all other eligibility requirements under the HP Retiree Medical Program.

Important note: If you die after declining HP medical coverage under the HP Retiree Medical Program, your surviving dependents will not be eligible to participate in HP benefits following your death. Only dependents who are covered on the date of death can continue HP benefits as a survivor or through COBRA coverage continuation. For more information, see "If you die" in Section 7, **How certain life events affect your benefits**.

Eligible dependents
If you are enrolled or eligible to enroll in HP medical coverage under the HP Retiree Medical Program, you can also elect coverage for your eligible dependents. Eligible dependents are defined as follows:

- Your legal spouse, unless legally separated from you pursuant to a court order (former spouses are not eligible, even if you are required to provide coverage as part of a divorce decree). In states that recognize same-sex marriages, your same-sex spouse is treated as a domestic partner for purposes of benefits eligibility.

- Your common-law spouse, if common-law marriages are recognized in your state as valid under its state laws, and you register your marriage with the appropriate public official.

- Your qualifying domestic partner of the same sex, as long as you and your domestic partner register your domestic partnership with a state or local government that accepts such registrations, or you satisfy program criteria described in "Domestic partner benefits" later in this section. Coverage for a domestic partner is subject to taxable imputed income if you are continuing HP coverage at active employee rates as part of an Enhanced Early Retirement program, but HP provides a year-end "gross up" payment to help offset estimated income taxes that apply to you based on coverage for your domestic partner and your domestic partner's children.

- Your biological or adopted children (including children placed with you for adoption, even if the adoption has not yet been finalized), your or your qualifying domestic partner's stepchildren who primarily live with you, your qualifying domestic partner's biological or adopted children who primarily live with you (including children placed with your domestic partner for adoption, even if the adoption has not yet been finalized), your or your qualifying domestic partner's foster children who live with you exclusively, and other children who qualify as your dependents for federal tax purposes.

- Children who live with you exclusively and for whom you or your domestic partner has been appointed legal guardian by court order.

- Your biological or adopted children (including children placed with you for adoption, even if the adoption has not yet been finalized) for whom a Qualified Medical Child Support Order (QMCSO) has been issued by a U.S. court or state agency. (Orders should be submitted to the HP Benefits Center for review and qualification.)

Other relatives are not eligible for coverage unless they qualify under the provisions above. Parents are also ineligible.

Please note that dependent eligibility provisions under certain HMO or Senior HMO medical options may vary. For details about any exceptions that may apply, see the medical option coverage summaries provided with your annual enrollment materials or available through Your Benefits Resources website (accessible at MyHPBenefits at www.myhpbenefits.com), or contact the HMO directly.

Additional eligibility criteria for children
For medical coverage, eligible children described above must be under age 26 and do not need to satisfy full-time student or other requirements. Extended eligibility beyond age 26 may be available for incapacitated children as described below, in "Health benefit eligibility extension for incapacitated children".

Health benefit eligibility extension for incapacitated children
Children who meet the child eligibility criteria described above but have reached age 26 can continue to qualify if they are incapable of self-sustaining employment by reason of physical or mental disability. In order to qualify for extended eligibility, the incapacitated child must meet all of the following qualifications:

- Must have become incapacitated before age 26;
- Must be enrolled in HP coverage prior to age 26 (or **within 31 days** of the child's initial plan eligibility, if later); and
- Must remain continuously enrolled in HP coverage thereafter.

Eligibility for this continued coverage is subject to periodic certification and approval by your medical option or claims administrator. If you change medical options following a qualified status change or during the annual enrollment period, you may be required to recertify your previously eligible incapacitated child with your new medical option in order to continue HP medical benefits.

If you discontinue the child's enrollment in HP benefits for any reason, **the child may not be re-enrolled at any future date**. No child age 26 or older may be added to coverage, except an incapacitated child can be added to HP medical coverage **within 31 days** of his or her initial plan eligibility (for example, within 31 days of your initial eligibility, or marriage).

Important note: It is your responsibility to ensure that the dependents you cover meet program eligibility requirements. If you continue to cover a dependent who is no longer eligible, that dependent's coverage will be dropped retroactively to his or her date of ineligibility, but you will not receive retroactive premium refunds. **Dependent eligibility is also subject to periodic audits that could result in termination of benefits if you fail to provide the required information by the due date, or you are covering an ineligible dependent.** If benefits are terminated due to failure to comply with a dependent eligibility audit, you may not be able to reinstate your eligible dependent's coverage until a subsequent annual enrollment period or **within 31 days** of a qualified status change that would otherwise allow you to add the dependent who was dropped from coverage.

Domestic partner medical benefits

Qualifying domestic partners generally must be of the same sex. Opposite-sex domestic partners only qualify if they meet HP's definition of a common-law spouse.

In order to comply with federal tax law, same-sex individuals will be treated as domestic partners if they satisfy domestic partner requirements, even if they may be spouses under certain state laws. To be eligible for HP medical coverage, you and your domestic partner must register your domestic partnership with a state or local government that accepts such registrations. If registration is not an option in your area or you simply prefer not to register your domestic partnership, you can also qualify if you and your domestic partner have satisfied *all* of the following requirements *for at least six full months:*

- You must be each other's sole domestic partner and intend to remain so indefinitely;
- You must reside together in the same principal residence and intend to remain so indefinitely;
- You must be emotionally committed to one another, share joint responsibilities for your common welfare, and be financially interdependent;
- You must each be at least 18 years of age and mentally competent to consent to a contract;
- You must not be related by blood closer than would bar marriage under applicable law in effect where you reside; and
- You must not be legally married to anyone else or involved in any other domestic partnership.

Because of the six-month requirement for unregistered domestic partnerships, you cannot enroll a new domestic partner until at least six months after termination of any previous domestic partnership or until at least six months after a divorce.

A small number of HMO and Senior HMO options may not accept domestic partners or may impose more restrictive criteria than HP criteria. Please refer to the current edition of the *Benefits for domestic partners* enrollment guide (available from the HP Benefits Center) for additional information and forms related to domestic partner benefits.

Tax consequences for domestic partner health coverage

If you enroll your domestic partner or any of your domestic partner's eligible children in medical coverage, you may be subject to taxable income on the value of your domestic partner's coverage. **Taxable income only applies if you are continuing HP coverage at active employee rates for up to 24 months under an HP Enhanced Early Retirement program.** Other participants in the HP Retiree Medical Program are not subject to taxable income for

domestic partner coverage, because they pay the full cost of domestic partner coverage on an after-tax basis.

If you are continuing HP coverage at active employee rates under an Enhanced Early Retirement program:

- Internal Revenue Code restrictions generally require that the value of your qualifying domestic partner coverage will be taxable to you as income (unlike coverage for a spouse or other eligible children), so you will owe additional federal and (in most states) state income taxes, as well as Social Security and Medicare (FICA) taxes. This taxable income will be reported on a Form W-2 each year it applies.

- Taxes can be avoided only if your qualifying domestic partner and *all* of your qualifying domestic partner's covered children are your legal tax dependents. In this case, you must submit a completed Certification of Legal Tax Dependents form to avoid tax reporting and withholding (this form is included in the *Benefits for domestic partners* enrollment guide available from the HP Benefits Center).

- In some cases, you may be able to avoid paying additional state income taxes on the value of your domestic partner coverage, even if federal income taxes apply (for example, if you are a California resident who has registered your domestic partnership with the state, a Massachusetts resident who has married your same-sex domestic partner, or a Connecticut resident who has entered into a civil union with your same-sex domestic partner).

If you are subject to additional federal and/or state income taxes, HP provides a year-end "gross up" payment to help offset estimated income taxes that may apply to you based on coverage for your domestic partner and your domestic partner's children. The payment is an estimate and is not based on your individual tax rates, but is designed to help offset additional income taxes that may apply based on current federal and state tax laws.

For details about domestic partner coverage and taxation, please refer to the current edition of the *Benefits for domestic partners* enrollment guide, available from the HP Benefits Center. You should consult with your tax advisor if you have any tax-related questions.

When HP medical coverage begins

To participate in HP retiree medical coverage, you must enroll on Your Benefits Resources website (accessible from MyHPBenefits at www.myhpbenefits.com) or by calling the HP Benefits Center (through Your HP Directory at 1-800-890-3100) no later than 60 days from your retirement date (or from the date you are notified of COBRA rights by the HP Benefits Center, if later). Your coverage will be effective retroactive to your first day of eligibility.

For the first 18 months following your retirement, coverage is generally provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), with coverage under the HP Retiree Medical Program beginning after you complete the maximum period of coverage available through COBRA. Benefits automatically continue thereafter under the HP Retiree Medical Program, unless you elect to discontinue coverage.

Coverage under the HP Retiree Medical Program can begin earlier if you decline COBRA coverage or discontinue COBRA coverage prior to the end of your maximum COBRA eligibility period. However, it is generally a good idea to elect COBRA coverage as long as you remain eligible, since coverage costs under COBRA are the same or less than costs that apply under the HP Retiree Medical Program.

If at any time you decline HP retiree medical coverage (for reasons other than enrolling in the Aon Hewitt Navigators service for Medicare-eligible retirees), or if your HP medical coverage is discontinued, you will only be eligible to enroll in the future if you do so within 31 days of losing coverage under another employer group medical program (for details, see "If you decline HP medical coverage" earlier in this section). If you continue to be eligible and elect to enroll following a loss of other employer coverage, your HP medical coverage will begin as of the date you are no longer covered by other employer coverage. However, you must enroll **within 31 days** following the loss of other employer coverage.

Coverage for your eligible dependents under HP medical benefits begins at the same time your coverage begins, provided they are enrolled. If you enroll dependents at a later date, your dependents' coverage will begin as follows:

- If you enroll your dependents **within 31 days** of a qualified status change, coverage generally begins on the date you make your change by calling the HP Benefits Center. If you enroll dependents following your marriage, divorce, the birth or adoption of your child, or the loss of other coverage, however, coverage can begin as of the date of your status change instead.

- If you enroll your dependents during the annual enrollment period, coverage begins on the following January 1 as long as you and your dependents are still in an eligible status on that date.

Keep in mind that there may be limitations on your ability to enroll dependents, as described under "Available health benefit changes" later in this section.

When HP medical coverage ends

This section describes when your HP medical coverage ends, and when coverage ends for eligible dependents.

Coverage for eligible HP retirees
Once you enroll in the HP Retiree Medical Program as an eligible HP retiree (as defined under "Eligible retirees" earlier in this section), your HP medical coverage generally continues until the first of the following to occur:

- The date your coverage is terminated for nonpayment of premiums;
- The date you drop coverage; or
- The date you die (in this case, your covered dependents may be eligible to continue current coverage for up to 48 months, as described in Section 7, **How certain life events affect your benefits**).

If your HP retiree medical coverage is dropped for any reason (including nonpayment of premiums but not including enrollment through the Aon Hewitt Navigators service), or if you elect to drop coverage during the annual benefits enrollment period or within 31 days of a qualified status change, you **will only be able to enroll in the future if you do so within 31 days of losing coverage under another employer group medical program**. For additional information, see "If you decline HP medical coverage" earlier in this section.

If you fail to make timely payments for coverage, your coverage will be cancelled as of the end of the last month for which payment was made in full. If your coverage is cancelled, you will have a one-time 90-day grace period from the date of your termination notice to request that coverage be reinstated retroactively to the date it was dropped for nonpayment. **If you do not request reinstatement before the end of this 90-day grace period, you will never be able to request reinstatement of coverage in the future.** You will only be eligible to enroll in the future if you do so within 31 days of losing coverage under another employer group medical program. For additional details, see "Paying your monthly health benefit premiums" later in this section.

Coverage for eligible dependents
Coverage for eligible dependents, including your children and your spouse or domestic partner, ends upon the earliest of the following to occur:

- The date your coverage ends;
- The date you discontinue coverage for your dependents (once dropped, coverage for your dependents can only be reinstated as described under "Available health benefit changes" later in this section); or
- The date the dependent no longer meets the definition of eligible dependents (as described earlier in this section). In this case, your dependents may be eligible to continue coverage for up to 36 months under COBRA (see Section 8, **Administrative information**).

Coverage for you or your dependents may end earlier than the time frames described above if the HP Retiree Medical Program is terminated, or the program is changed or amended in a manner that ends eligibility for you or a dependent.

If you or your dependents are California residents enrolled in a California HMO option (other than a self-insured HMO option), you may be able to continue coverage for additional periods (beyond those provided under COBRA), as provided under the California Continuation Benefits Replacement Act (Cal-COBRA). Contact your HMO directly for details. It's a good idea to examine your options carefully before declining this coverage, since other types of health insurance may require a review of your medical history that could result in a higher premium or denial of coverage depending on your circumstances.

When your dependents are no longer eligible for dependent status

When any of your covered dependents cease to meet the HP Retiree Medical Program's eligibility requirements (for example, you divorce, or a covered child reaches the maximum age limits), they are no longer eligible for coverage effective as of the date they cease to meet eligibility requirements. *In this case, you must notify the HP Benefits Center immediately*. If you wish to make available changes to your coverage, this must be done by calling the HP Benefits Center **within 31 days** (be sure to call as soon as possible, since retroactive premium refunds are not available).

If you do not notify the HP Benefits Center that your covered dependents are no longer eligible **within 60 days** of the date your dependents cease to qualify for medical coverage, your eligible dependents will not be able to continue coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA).

Paying your monthly health benefit premiums

You must pay your share of premiums for HP medical benefits in full and on a timely basis in order to avoid your coverage being cancelled. You have two options for paying for your benefits:

- **Direct debit.** For convenience, you have the option of having your benefit premiums automatically deducted from your checking or savings account on the payment due date. The direct debit option means you don't have to write a check or mail your payments, and helps reduce any concerns about coverage being dropped for failure to pay premiums by the due date (as described below). There are two ways to sign up for this convenient service:

  — **Through Your Benefits Resources website.** When you access the site (link from MyHPBenefits at www.myhpbenefits.com), choose the "Health and Insurance" tab and then click on "Billing and Payments." On the next screen, you'll see the option to choose how to pay for your benefits.

— **By calling the HP Benefits Center.** Call Your HP Directory at 1-800-890-3100 and choose the option for "Benefits Center" to reach an HP Benefits Center representative. Tell the representative you'd like to enroll in the "direct debit" form of payment. You'll need the name of your financial institution, your financial institution's routing (or ABA) number, and your account number.

When you sign up for the direct debit option, your premium payments will be taken directly from the bank account you choose, and you will not receive a billing statement each month. Depending on when you sign up, your direct debit may take effect the first of the following month, or the first of the second following month.

If there is any change in your direct debit amount (for example, if you change your medical option and your premium therefore changes), you will receive a notice in the mail indicating your new debit amount.

You can discontinue the direct debit option at any time by changing your payment election through Your Benefits Resources website or by calling the HP Benefits Center.

- **Billing.** If you don't elect the direct debit option, you'll receive a monthly bill for your benefit cost. To keep your coverage active, you'll need to pay this bill on time.

  To pay your required premiums by mail, make a check payable to Hewlett-Packard Company and write the account number listed on your billing statement on the check. Send the check along with your payment coupon to the address shown on the coupon. Be sure to mail your payment and coupon in plenty of time to allow your payment to be processed by the due date. Because services such as Federal Express or UPS are not able to deliver overnight mail to a P.O. Box, overnight delivery service will only be accepted if sent through the U.S. Postal Service.

Important reminder regarding premium payments
Payment for benefits must be made in full before the due date reflected on your monthly invoice. **Failure to make payment by the due date will cause your coverage to be dropped for nonpayment.** If coverage is dropped for nonpayment, you will receive a termination notice in the form of a Health Insurance Portability and Accountability Act (HIPAA) certificate of group health coverage. You will then have a one-time 90-day grace period from the date of your termination notice to request that coverage be reinstated retroactively to the date it was dropped for nonpayment. To request reinstatement, you must call the HP Benefits Center and pay any outstanding premium payments (payment is due immediately upon making the reinstatement request).

The reinstatement option is only available one time. If you do not request reinstatement before the end of this 90-day grace period, or you previously used your one-time reinstatement, you will never be able to request reinstatement of coverage in the future. You

will only be eligible to enroll in the future if you do so within 31 days of losing coverage under another employer group medical program (for more information, see "If you decline HP medical coverage" earlier in this section).

If at any time you have overpaid your premiums, this amount will be used to offset future premium amounts due for your coverage. If a refund is due to you, you must request it from the HP Benefits Center. Please allow four to six weeks for processing of refunds. You will receive any refund via a check in the mail, regardless of your billing arrangement.

Cost of coverage

Participants in the HP Retiree Medical Program pay the full cost of coverage, based on costs specific to a retiree population. Although retirees pay the full cost of coverage, you can benefit from group rates and added benefit features beyond those that might be available to purchase on your own. You also have the option to use your Retirement Medical Savings Account (RMSA) balance (including HP or other special company credits to your account, if applicable) to cover part or all of your premium costs. For more information about the RMSA program, see the separate summary plan description that applies to this program.
Your costs for medical coverage vary based on the plan option you select and the eligible dependents you enroll.

Coverage costs are subject to change at any time and are typically updated each January 1. For information on current coverage options and costs, see your annual enrollment materials or go to Your Benefits Resources website (accessible from MyHPBenefits at www.myhpbenefits.com). You can also contact the HP Benefits Center with questions.

If you left under an EER Program within the last 24 months

If you left HP under an Enhanced Early Retirement (EER) Program that provided access to the HP Retiree Medical Program, you may qualify for HP medical coverage for up to 24 months following retirement, paying the same costs paid by active HP employees. After your 24-month period of paying active employee rates, you will pay the full cost of coverage, consistent with other retirees under the HP Retiree Medical Program.

Opportunities to make changes

As a participant in the HP Retiree Medical Program, you can change your HP medical benefits over time as your needs change. You can also make changes under certain other HP benefit programs. Here's a summary of your change opportunities under HP medical benefits and other programs that allow changes. Information on **how** to make changes is provided later in this section. For additional information, also see Section 7, **How certain life events affect your benefits**. For contact information, see Section 2, **Benefits resources and phone numbers**.

Benefit	Change opportunities
Medical ***Note:*** *If you drop HP medical coverage (for reasons other than enrolling in the Aon Hewitt Navigators service for Medicare-eligible retirees), you will only be eligible to enroll in the future if you do so within 31 days of losing coverage under another employer group medical program. For more information, see "If you decline HP medical coverage" earlier in this section.*	• Based on HP Retiree Medical Program rules, changes can only be made: — During the annual enrollment period (with new coverages generally effective the following January 1); or — **Within 31 days** of a qualified status change (with changes generally effective the date you call the HP Benefits Center). • Participants in HMO Senior Plan medical options can also elect to disenroll from HMO coverage at any time, effective the first of the following month, and either drop HP coverage or switch to the Comprehensive Medical Plan $500 or one of the HP Medicare Supplement options. Keep in mind, you will need to complete a disenrollment form for the HMO Senior Plan before your change can take effect. • Only certain types of changes may be permitted. For details, see "Available health benefit changes" later in this section. **Note:** Except as provided for HMO Senior Plan participants above, under program rules you cannot change your medical option because one of your providers leaves your option's network during the year.
Group Legal Services	• You can change your participation decision each year during the annual enrollment period, with new coverage effective the following January 1. No changes to your Group Legal Services participation are permitted during the year.
Retirement Medical Savings Account (RMSA) (available if you retired on or after January 1, 2003 and continue to maintain a balance)	• You can change your mailing address at any time by logging on to *Your Benefits Resources* website or calling the HP Benefits Center. • You can elect at any time to have reimbursements from your RMSA paid directly to your bank account via electronic funds transfer (EFT). See the separate summary plan description that applies to this program.
Long-Term Care (closed to new entrants as of April 1, 2012)	• You can change or discontinue existing coverage at any time by notifying John Hancock or MetLife, as applicable. You can also change your level of coverage under an existing policy, according to program guidelines and/or with proof of good health.
Auto & Home insurance	• You can discontinue existing coverage at any time by contacting MetLife Auto & Home or Liberty Mutual, as applicable. As an HP retiree, you are also eligible to apply for new coverage.

Available health benefit changes

The HP medical benefit option you elect generally remains in effect through the following December 31, except under certain circumstances:

- If you participate in an HMO Senior Plan, you can disenroll from your HMO coverage at any time, effective the first of the following month, and either drop HP coverage or switch to the Comprehensive Medical Plan $500 or one of the HP Medicare Supplement options (see Section 4, **Medical benefits**, for more information). Keep in mind that you will need to complete the disenrollment process for the HMO Senior Plan before your change can take effect. Also, if you elect to drop HP retiree medical coverage (for reasons other than enrolling in the Aon Hewitt Navigators service for Medicare-eligible retirees), you will only be eligible to enroll in the future if you do so within 31 days of losing coverage under another employer group medical program (for more information, see "If you decline HP medical coverage" earlier in this section).

- You can change your medical coverage choice during the annual enrollment period, with new coverages generally effective the following January 1.

- You can also make certain benefit changes during the year following a qualified status change, such as moving, gaining a new dependent through marriage or adoption, or having a covered dependent become ineligible. To make a change during the year, you must contact the HP Benefits Center no later than 31 days from the date of your status change. If your 31-day election period ends on a weekend or holiday and you have not already made your election, you must call the HP Benefits Center no later than the end of the next business day following the end of the 31-day period. Your coverage change also must be on account of and consistent with your status change.

  If you make a change in benefits during the year following a qualified status change, your change is generally effective on the date your change is requested and approved. However, if you are enrolling following a loss of other coverage, or adding dependents following a marriage, divorce, or the birth or adoption of your child, coverage can begin as of the date of your status change instead. Keep in mind that you cannot change your medical option because one of your providers leaves your option's network during the year.

In order to enroll or re-enroll eligible dependents, you also must be covered by HP benefits, or you must be eligible to re-enroll yourself at the same time you are enrolling dependents. Any dependents you wish to cover also must satisfy program dependent eligibility criteria defined under "Eligible dependents" earlier in this section.

It is important that you review more detailed information describing the circumstances which allow you to change your benefit elections in Section 7, **How certain life events affect your benefits**.

Important note: It is your responsibility to ensure that the dependents you cover meet program eligibility requirements. If you continue to cover a dependent who is no longer eligible, that dependent's coverage will be dropped retroactively to his or her date of ineligibility, but you will not receive retroactive premium refunds. **Dependent eligibility is also subject to**

periodic audits that could result in termination of benefits if you fail to provide the required information by the due date or you are covering an ineligible dependent. If benefits are terminated due to failure to comply with a dependent eligibility audit, you may not be able to reinstate your eligible dependent's coverage until a subsequent annual enrollment period or **within 31 days** of a qualified status change that would otherwise allow you to add the dependent who was dropped from coverage.

If a covered dependent becomes ineligible due to a qualified status change or another qualifying event, continued health coverage may be available for a limited time by paying the full cost of coverage under COBRA. For more information about COBRA continuation coverage, see Section 8, **Administrative information**.

Qualified status changes

The HP Retiree Medical Program places certain restrictions on how and when you can make changes to your HP medical coverage. You can make changes to most benefits once a year during the annual enrollment period, with coverage changes generally effective the following January 1. In addition, you can make certain changes during the year if you call the HP Benefits Center **within 31 days** of one of the following qualified status changes:

- You get married (including a new common-law marriage) or begin a new qualifying domestic partnership.
- You gain an eligible dependent child through birth, adoption, placement for adoption, a court issuance of a Qualified Medical Child Support Order (QMCSO) for your own child, placement of a foster child, legal guardianship, or a child otherwise newly satisfying benefit eligibility requirements.
- You lose a dependent through death, divorce, legal separation (pursuant to a court order), termination of a domestic partnership, attainment of maximum age limits, or when a dependent otherwise ceases to meet benefit eligibility requirements.
- You or an eligible dependent gains or loses coverage under another group health plan or becomes entitled to Medicare or Medicaid.
- Your spouse or qualifying domestic partner gains or loses eligibility for benefits due to gaining or losing employment, beginning or ending a leave of absence, changing from a part-time to full-time status, or changing from a full-time to part-time status.
- You change your principal residence to an area where your current medical option is not offered by HP, or where different medical options are offered by HP.

If you have one of these qualified status changes during the year, you may be eligible to change your HP medical plan option or add or drop coverage for eligible dependents (see

"Available health benefit changes" earlier in this section for additional details). For more information, see Section 7, **How certain life events affect your benefits**. You should also keep the following important requirements in mind:

- All benefit changes must be requested by calling the HP Benefits Center **within 31 days** following the date of your qualified status change. After 31 days, ***no changes can be permitted; although ineligible dependents will still be dropped retroactive to the date of their change in eligibility status***. ***No refunds of previously paid premiums will be allowed***. If your 31-day election period ends on a weekend or holiday and you have not already made your election, you must make your election no later than the end of the next business day following the end of the 31-day period.

- Any requested benefit changes must be made on account of and consistent with your qualified status change (for example, changing from "You Only" to "You + Spouse or Domestic Partner" medical coverage when you get married or begin a new domestic partnership).

If you make a change in benefits during the year following a qualified status change, your change is generally effective on the date your change is requested and approved. However, if you are enrolling following a loss of other coverage, or adding dependents following a marriage, divorce, or the birth or adoption of your child, your coverage change is retroactive to the date of your qualified status change.

Note: Except as provided for HMO Senior Plan participants, under program rules you cannot change your medical option because one of your providers leaves your option's network during the year.

If you move and your current medical option is no longer available

If you change your principal residence and no longer reside within a ZIP code where HP offers your current medical option, you will automatically be defaulted to an alternative medical option based on your new ZIP code. If you do not want to be automatically assigned to the default medical option, you must elect a new medical option as soon as possible, but **within 31 days** after you move. You can elect a new option by calling the HP Benefits Center through Your HP Directory at 1-800-890-3100.

It's important to elect a new medical option as quickly as possible, since your current option may cancel coverage or fail to honor claims once you no longer reside in the option's service area. You have 31 days after you change your address to elect a new medical option. *If you do not elect a new option **within 31 days**, a default option will be assigned for you by the HP Benefits Center*. You will not be eligible to change this option until the next annual enrollment period or **within 31 days** of a qualified status change. The effective date of the change in your medical option is the date you change your address by calling the HP Benefits Center.

Annual enrollment period

You can make changes to your HP medical benefit option or add or drop coverage for eligible dependents each year during HP's annual enrollment period. The annual enrollment period is usually held in the fall, with new coverage elections generally effective the following January 1. **Note:** If you drop HP medical coverage during the annual enrollment period (for reasons other than enrolling in the Aon Hewitt Navigators service for Medicare-eligible retirees), you will only be eligible to enroll in the future if you do so within 31 days of losing coverage under another employer group medical program (for more information, see "If you decline HP medical coverage" earlier in this section).

If you do not make an election during the annual enrollment period, your previous coverage elections will generally remain in effect for the following year (subject to plan availability and annual changes in benefits and/or coverage costs) and cannot be changed until the next annual enrollment period (or **within 31 days** of an earlier qualified status change). If your current coverage option is no longer available to you (for example, if your principal residence no longer falls within your medical option's ZIP code service area), you will be assigned to a replacement option established as part of the enrollment process.

Additional details about the annual enrollment period are provided each year in advance of the enrollment process.

How to make changes

This section provides details on how to make changes to your HP benefits. For details on change opportunities that may be available, please refer to earlier portions of this section, along with Section 7, **How certain life events affect your benefits**.

Health benefits

Benefit	Making changes during the annual enrollment period	Making changes during the year*
Medical	Go to *Your Benefits Resources* website, accessible from MyHPBenefits at www.myhpbenefits.com, or call the HP Benefits Center through Your HP Directory at 1-800-890-3100 (choose the option for "Benefits Center"). To log on to MyHPBenefits, you'll need your Social Security number (or user ID) and your HP Benefits Center password. As part of enrolling on Your Benefits Resources website, you'll also need to select a primary care physician (PCP) if you're enrolling in a medical option that requires your PCP to coordinate in-network care (for example, an HMO). If you're newly enrolling in an HMO Senior Plan option, in addition to enrolling through *Your Benefits Resources* website and enrolling in Medicare, you may need to complete additional Medicare-related forms you'll receive from the HP Benefits Center. If you don't submit these forms on time, you will be assigned coverage under the Comprehensive Medical Plan $500 or one of the HP Medicare Supplement options until your enrollment can be completed.	If you experience a qualified status change, call the HP Benefits Center through Your HP Directory at 1-800-890-3100 (choose "Benefits Center"). Permissible changes must be made **within 31 days** of the date of your status change. You'll need your Social Security number (or user ID) and your HP Benefits Center password (the same password you use for MyHPBenefits). **Note:** Under program rules, you cannot change your medical option because one of your providers leaves your option's network during the year. However, participants in HMO Senior Plan options can disenroll from HMO coverage at any time, effective the first of the following month, and either drop HP coverage or switch to the Comprehensive Medical Plan $500 or one of the HP Medicare Supplement options. Keep in mind that you will need to complete the disenrollment process for the HMO Senior Plan before your change can take effect.

Benefit	Making changes during the annual enrollment period	Making changes during the year*
		If you're newly enrolling in an HMO Senior Plan option, in addition to enrolling through the HP Benefits Center and enrolling in Medicare, you may need to complete additional Medicare-related forms you'll receive from the HP Benefits Center. If you don't submit these forms on time, you will be assigned coverage under the Comprehensive Medical Plan $500 or one of the HP Medicare Supplement options until your enrollment can be completed.

Benefit	Making changes during the annual enrollment period	Making changes during the year*
Group Legal Services	Visit www.ARAGLegalCenter.com (access code: 15641hpr) or call 1-800-762-3217 and speak with an ARAG Customer Care specialist.	No changes to your Group Legal Services participation are permitted during the year.

* All benefit changes during the year (except for disenrolling from coverage under an HMO Senior Plan) must be made on account of and consistent with a qualified status change and must be requested **within 31 days** of the qualified status change. Changes are generally effective on the date your change is requested and approved.

Retirement benefits

Benefit	Applying for benefits or making changes
Retirement Medical Savings Account (RMSA) (available if you retired on or after January 1, 2003 and continue to maintain a balance)	• You can submit claims for eligible expenses against your existing balance at any time by submitting a completed claim through the Your Spending Account website. Eligible expenses must be submitted within 18 months of the date services are provided (or in the case of premium payments, within 18 months of the time period for which the premiums apply). For more information, see the separate summary plan description that applies to this program, or access Your Spending Account website through Your Benefits Resources, accessible from MyHPBenefits at www.myhpbenefits.com. • You can elect at any time to have reimbursements from your RMSA paid directly to your bank account via electronic funds transfer (EFT). See the separate summary plan description that applies to this program.

Other benefits

Benefit	Applying for benefits or making changes
Long-Term Care insurance (closed to new entrants as of April 1, 2012)	• You can change or discontinue existing coverage at any time by notifying John Hancock or MetLife, as applicable. • You can also change your level of coverage under an existing policy, according to program guidelines and/or with proof of good health.
Auto & Home insurance	You can cancel your coverage or request permitted changes at any time. As an HP retiree, you can also apply for new coverage. • Contact MetLife by phone at 1-800-GET-MET8 or online at www.metlife.com/mybenefits (enter company name "Hewlett-Packard" and company code: 080). • Contact Liberty Mutual at 1-800-921-4652 (or call your local Liberty Mutual office) or online at www.libertymutual.com.

If you have a change of address

It's important that you keep HP's benefit providers informed if your address changes. Otherwise, benefits may be delayed or lost under certain programs. A change of address also may affect your availability for medical plan options (see "If you relocate" in Section 7, **How certain life events affect your benefits**).

Where you need to report address changes depends on the HP benefit programs in which you participate. Here's a summary:

Program	Whom you need to notify
Medical **Retirement Medical Savings Account**	You can update your address online through *Your Benefits Resources* website or by calling the HP Benefits Center. Your health plan administrators will then be notified.
HP 401(k) Plan **HP Retirement Plan and HP Deferred Profit Sharing Plan** **HP Cash Account Pension Plan** **EDS Retirement Plan**	You can update your mailing address by calling the HP Retirement Services Center at Fidelity.
Group Legal Services	Contact ARAG.
Credit Unions	Contact your Credit Union.
Long-Term Care insurance	Contact John Hancock or MetLife, as applicable.
Auto & Home insurance	Contact MetLife or Liberty Mutual, as applicable.
Stock programs	Contact Computershare (formerly BNY Mellon Shareowner Services) or Wells Fargo Shareowner Services (depending on where your shares are held) for shares held in the HP ESPP or Share Ownership Plan. Contact Smith Barney for shares held under the former Compaq Employee Stock Purchase Plan).
Issues unrelated to benefits	Contact HR Operations through Your HP Directory.

For contact information and phone numbers, see Section 2, **Benefits resources and phone numbers**. In some cases, you may also want to update your e-mail address, if benefit providers communicate with you by e-mail.