Chapter 6

Medical and Vision Benefits

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Chapter 6
Medical & Vision Benefits

This chapter provides important information regarding your medical and vision options and coverage details.

6.1 Medical & Vision Benefits Overview

Your healthcare benefits are an important part of your total compensation and benefits. Intel's healthcare program is designed to be sustainable, competitive and to provide you with access to comprehensive and quality medical and vision care when you need it.

You and Intel share the cost of covering yourself and your family. Specific employee contribution amounts for you and your family are located on the *My Health Benefits* website.

6.2 Medical Options

Intel realizes that every employee has unique medical coverage needs. To meet these needs, Intel sponsors the Intel Corporation Health and Welfare Plan (the "Plan"), which provides you a choice when selecting a medical coverage option. Each medical coverage option under the Plan offers a comparable range of coverage and quality services. For a description of each medical coverage option, refer to the specific sections below that discuss each medical coverage option.

Not all medical options will be available to you. When you enroll, the *My Health Benefits* website details the options for which you are eligible based on your location and eligibility. The website also provides information on the Plan features and premium costs (i.e., employee contributions for you and your family) associated with each option. The medical options available under the Plan include the following:

Connected Care – available only to employees located in Arizona, Northern California, New Mexico and Oregon:

Arizona

- **Connected Care ACN High Deductible Health Plan** (HDHP)*
- **Connected Care ACN Primary Care Plus***

Northern California

- **Connected Care California High Deductible Health Plan** (HDHP)*

New Mexico

- **Connected Care Presbyterian High Deductible Health Plan** (HDHP)*
- **Connected Care Presbyterian Copay Plan***

Oregon

- **Connected Care Providence High Deductible Health Plan** (HDHP)*
- **Connected Care Providence Primary Care Plus***
- **Connected Care Kaiser High Deductible Health Plan** (HDHP)* **Connected Care Kaiser Copay***

Other Options – Availability will vary by location and eligibility:

- **Anthem Blue Cross High Deductible Health Plan** (HDHP)*

- **Health Maintenance Organizations** (HMO):
  - Arizona - Aetna *
  - California - Kaiser Permanente*
  - New Mexico - Presbyterian Health Plan*
- **HMSA -** Hawaii PPO medical plan is the only medical plan available to employees who work and reside in Hawaii.
- **Anthem J1-Visa***

- **Aetna International** - the only medical and dental option for U.S. Expats (U.S. employees on a 2-way international assignment). For additional information, including the summary plan descriptions, from Circuit > My Benefits & Career > Career > Relocation > 2 Way International > Healthcare on Assignment.

* Self-funded

6.3 General Provisions - Connected Care and Anthem

Topics

6.3.1 In-Network Benefits
6.3.2 Out-of-Network Benefits
6.3.3 Maximum Allowed Amount
6.3.4 Specialty Networks
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6.3.19 Virtual Visits

Connected Care and Anthem provide comprehensive benefit coverage that includes preventive care and wellness programs to help keep you and your family healthy. This section provides an overview of general provisions. For specific information for each health plan option, refer to the specific sections below.

6.3.1 In-Network Benefits

Each medical option has a network of contracted providers that provide discounts on covered medical services to members. You receive the highest level of coverage on covered medical services at the lowest cost by receiving care from any of the providers or facilities in the network.

In order to receive in-network benefits, you are responsible for confirming that all providers (specialist, hospitals, labs, etc.) are in-network.

Finding an In-Network Provider

Providers included in the network are listed in the medical coverage option's provider directory or by calling the medical coverage option directly. Refer to the Claims Administrator table in section 6.16 for contact information.

You can also use the Find a Doctor tool on the My Health Benefits website or on the respective Connected Care sites. These online tools allow you to narrow your search (by specifying gender, specialty, etc.), view maps, and get driving directions.

Role of the Primary Care Physician

Although it is not required, members are encouraged to select a patient centered medical home (PCMH), where applicable, or a primary care physician (PCP). A PCMH or PCP gives you and your dependents a valuable resource and a personal health advocate. PCMH/PCPs maintain the physician-patient relationship with members who select them, and they aid members in coordinating medical and hospital services and the overall healthcare needs of members. When you enroll in, you may select a PCMH/PCP for yourself and for each of your covered dependents from the Plan Provider Directory. Each member of your family can select a different PCMH/PCP, or you can all choose the same PCMH/PCP.

If you choose a PCMH/PCP, it is important to establish a relationship as soon as possible. Your PCMH/PCP will:

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

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

In addition, your PCMH/PCP can refer you for services such as the following:

- Any test or procedure estimated to cost more than $500
- Visits to a specialist
- Any visit to an out-of-network provider
- Ongoing outpatient treatment (e.g., chemotherapy, allergy injections, radiation therapy, and total obstetrical care)
- Physical, speech or occupational therapy

Obtaining In-Network Benefits Away From Home

When you or your covered family members are outside your home service area, you can still take advantage of the lower in-network fees just as you would at home.

Participating network providers are available nationwide. Customer service can help you locate participating doctors and facilities wherever you are. This is especially helpful if you have covered children attending school away from home.

6.3.2 Out-of-Network Benefits

You will still receive benefits if you choose to seek services outside of your medical coverage network, but services will cost you more because out of network providers are not contracted to provide discounted services to members, and services are covered at the lower out-of-network benefit level. You may see any qualified practitioner.

6.3.3.3 Maximum Allowed Amount

The Maximum Allowed Amount (MAA) is the maximum amount the plan will pay for covered healthcare services and supplies. The MAA is sometimes referred to as "eligible expense," "payment allowance," or "negotiated rate" and may vary depending upon whether the provider is in-network or out-of-network.

In-network
For covered services performed by an in-network provider, MAA is the rate the provider has agreed to accept as reimbursement for the covered services. Because in-network providers have agreed to accept MAA as payment in full for those covered services, they should not send you a bill to collect for amounts above the MAA. However, you may receive a bill or be asked to pay all or a portion of the MAA to the extent you have not met your deductible or have a copayment or coinsurance obligation.

Out-of-network
An out-of-network provider can charge a patient the provider's full amount for a service, but the amount covered by the plan is only the MAA for a given covered service. The MAA is often less than the amount charged to you by the out-of-network provider. You are responsible for any amounts charged by an out-of-network provider above MAA even if you've already met your deductible and out of pocket maximum. This means you may have to pay the out-of-network provider the difference between the MAA paid by you and/or the plan and the amount charged to you by the out-of-network provider.

Example #1: You have met your deductible and out-of-pocket maximum for the year. You receive plan covered services from an out-of-network provider.

Out-of-network provider charges:	$1,000
The MAA:	$600

The plan will pay $600, and the provider may bill you for the remaining $400.

Example #2: You have not met your deductible or out-of-pocket maximum for the year. You receive plan covered services from an out-of-network provider.

Out-of-network provider charges:	$1,000
The MAA:	$600

You pay $600 toward your deductible, and the provider may bill you for the remaining $400.

For covered services you receive from an out-of-network provider, MAA for the plan will be one of the following as determined by the claims administrator (e.g. Anthem, Providence, etc.):

- An amount based on the out-of-network provider fee schedule/rate, which the claims administrator has established in its discretion, and which the claims administrator reserves the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar providers contracted with the claims administrator, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data
- An amount based on reimbursement or cost information from the Centers for Medicare and Medicaid Services ("CMS"). When basing MAA upon the level or method of reimbursement used by CMS, the claims administrator will update such information, which is unadjusted for geographic locality, no less than annually
- An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable providers' fees and costs to deliver care
- An amount negotiated by the claims administrator or a third-party vendor which has been agreed to by the provider. This may include rates for services coordinated through case management
- An amount based on or derived from the total charges billed by the out-of-network provider

6.3.4 Specialty Networks

Certain specialized benefits may be administered by specialty network administrator. These specialty networks contract with certain providers. To receive in-network benefits on covered medical services, you must seek care from a contracted network provider. If you elect to use out-of-network providers for your care, you receive a reduced benefit or benefits may be denied.

Specialized benefits, both in-network and out-of-network, may be administered and reimbursed by the specialty network.

6.3.5 Deductible

A deductible is the dollar amount an individual or family must first pay before reimbursements from the medical coverage begin. Only eligible expenses count toward the deductible. An eligible expense is the contracted amount for network providers and the MAA for out-of-network providers.

6.3.6 Copayment

A copayment is a fixed dollar amount you pay each time you access medical care through an in-network provider.

6.3.7 Coinsurance

A coinsurance payment is the specific percentage of an eligible expense that is paid by the member once the deductible has been satisfied. An eligible expense is the contracted amount for network providers and the MAA for out-of-network providers.

The difference between the eligible expense and the medical coverage payment is the coinsurance payment, which the member is responsible for paying. In addition to the coinsurance amount, the participant is responsible for paying the difference between the actual billed amount for out-of-network services and the MAA.

Table: In- and Out-of-Network Cost Comparison (HDHP example)

In-Network Provider Example		Out-of-Network Provider Example	
Cost of covered medical service	$150	Cost of covered medical service	$150
Eligible expense based on contract amount	$100	Eligible expense based on MAA	$100
Difference: provider discount	$50	Difference: patient responsibility	$50
Coinsurance*	$10	Coinsurance*	$40
Total patient responsibility	$10	Total patient responsibility	$90

*In this example, the deductible has been met and the in-network member cost share is 10% and out-of-network member cost share is 40%. The copayment/coinsurance payment will vary depending on the medical coverage option you are enrolled in and whether or not you are using in-network or out-of-network benefits.

6.3.8 Out-of-Pocket Maximums

Once you pay a certain amount of covered medical expenses in any given year, your medical coverage will pay the majority of eligible expenses at 100%. The amount you pay to reach this level of coverage is called the out-of-pocket maximum.

For exclusions to the out-of-pocket maximum calculations, see the specific medical coverage option sections below.

6.3.9 HDHP options: Changing Enrollment Mid-Year - Transferring Deductibles and Out-of-Pocket Maximums

If you change from one HDHP option to another HDHP option mid-year due to a qualified change in status event, your accumulated deductible and out-of-pocket maximum amounts will transfer. However, only the accumulated deductibles and out-of-pocket maximums transfers for

claims submitted and processed prior to and no later than 60 days from effective date of the change. If you change to or from a non-HDHP option, your deductible and out-of-pocket maximum amounts will not transfer.

For example:

- You change mid-year from Connected Care HDHP to Connected Care Copay due to a qualified change in status event. Your deductible and out-of-pocket maximums will not transfer to the Connected Care Copay.
- You change mid-year from Connected Care HDHP to Anthem HDHP due to a qualified change in status event. Your deductible and out-of-pocket maximum from the Connected Care HDHP will transfer to the Anthem HDHP (it does not start over) as described above.

6.3.10 Lifetime Maximum

In general, there is no lifetime limit on the dollar value of benefits. However, specific covered benefits other than essential health benefits may be subject to lifetime maximums regardless of which medical coverage option you are enrolled in each year. For example, if you change from a Connected Care option to an Anthem option, the amounts under each option accumulate for purposes of determining whether you have reached the lifetime maximum for a particular benefit. Once a lifetime maximum for a specific covered benefit has been reached it is no longer considered a covered medical service.

6.3.11 Transition of Care

Transition of Care benefits are provided in certain situations when a disruption of current medical treatment occurs as a result of changing to another medical coverage option. In these situations, you may receive benefits at the in-network coverage level until your treatment plan is completed. Transition of care services must be approved by the new medical coverage option. Contact your old and new medical coverage for information on the transition of care process.

Note: Reimbursement will be based on billed charges unless an otherwise negotiated rate is established between you and your provider.

Transition of Care benefits are offered when you are enrolled in the Intel Group Health Plan, you are receiving a course of treatment under your prior medical coverage, and one of the following situations apply:

- The medical coverage you were enrolled in is terminated by Intel.
- You are an employee with a participating Intel acquired company but can no longer visit your healthcare provider on an in-network basis under the new medical coverage option.
- You or your covered dependent are hospitalized on the effective date of a change from one medical coverage option to a new medical coverage option. In this situation, your coverage in effect prior to any change will remain in place through discharge from the hospital.

- You or your covered dependent are receiving active, acute treatment but you can no longer visit your healthcare provider on an in-network basis under the new medical coverage option.

6.3.12 Elective Surgery

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

- In-network: If your network physician feels you need elective surgery, the physician will contact your medical coverage to obtain required approvals.
- Out-of-network: You are responsible for ensuring that approval from your medical coverage is obtained before any elective surgery is performed. Failure to do so will result in either denied benefits or penalties and reduced benefits.

6.3.13 Second and Third Surgical Opinions

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

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

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

6.3.14 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, seek care immediately.

Emergency In-Network Care

Whenever possible, emergency services must be obtained through your in-network physician. Emergency services obtained outside the network will be considered for in-network coverage if, on review, your medical coverage determines that treatment without prior approval was medically necessary to prevent serious medical complications, permanent disability, or death.

Emergency Out-of-Network Care

If you use out-of-network emergency services, 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 in-network coinsurance amount. If not a medical emergency, the service will be paid at the out-of-network benefit level--subject to the MAA and the deductible.

Emergency Hospital Admission

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

If you do not contact your medical coverage 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 denied or reduced benefits.

Your submitted claim will be reviewed to determine if the services, hospital admission, and length of stay were medically necessary. If the services, hospital admission, and length of stay are determined not to be medically necessary, those services will not be covered.

6.3.15 Hospital Preadmission Certification Continued Stay Review

Preadmission Certification and Continued Stay Review refers to the process used to certify the medical necessity and length of any hospital confinement (emergency and nonemergency). Preadmission Certification and Continued Stay Review are performed through a hospital utilization review program by the claims administrator for the medical coverage option you are enrolled for medical hospital admissions and for mental health or chemical dependency hospitalizations or Alternate Care. "Alternate Care" means less intensive level of services than inpatient that may include partial hospitalization, day hospital treatment, residential treatment centers and outpatient programs.

At a minimum, you must receive authorization for inpatient and Alternate Care within 48 hours of admission. If you do not receive authorization within 48 hours of the admission, your benefits, if determined to be medically necessary, will be paid at the out-of-network level. If the services, hospital/facility admission, and length of stay are determined not to be medically necessary, those services will not be covered.

In-network: If you need hospitalization, your network provider will obtain authorization for network inpatient care.

Out-of-network: You are responsible for fulfilling the Preadmission Certification and Continued Stay Review requirements. Failure to do so may result in a reduction of benefits and a $500 penalty.

Note: Under federal law, benefits for any hospital stay in connection with childbirth for the mother or the newborn cannot be restricted to less than:

- 48 hours following a normal vaginal delivery
- 96 hours following a cesarean section

Although you are encouraged to call, neither you nor your physician needs to pre-notify your medical coverage for any length of stay less than these periods for childbirth. However, the physician, after consulting with the mother, may discharge the mother or newborn before the 48- or 96-hour timeframe noted above.

6.3.16 Prescription Drug Benefit

Formulary Drug List

The Formulary Drug List is a list of brand-name and generic medications that are referred by your medical coverage based on efficacy, safety and cost. An independent group of physicians and pharmacists reviews the list to ensure that it includes medications for most medical conditions that are treated on an outpatient basis.

Medications can be added to or removed from the formulary. When a drug is removed from the formulary list, it becomes a non-preferred drug or excluded from coverage. Patients may be notified when certain drugs are removed from the formulary; however, it is not required.

To get the most up-to-date formulary information, including possible preferred alternatives for a drug that is non-preferred or excluded, contact your medical plan.

Quantity Limits

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

If your physician feels it is necessary for you to have a quantity greater than that allowed under the Plan's quantity limit guidelines, have your physician contact the pharmacy benefit administrator to request a prior authorization review.

Prescription Drug Prior Authorization Review Program
Certain prescriptions or drug therapies are only covered for specific conditions or diagnoses, or under specific circumstances. Such prescriptions or drug therapies must be authorized by the pharmacy benefit manager to ensure that they meet these specific criteria before they are approved for payment.

These prior authorization criteria are 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 to pharmacy or through mail

order and the prescription requires authorization, the pharmacist will receive a message to have your physician contact the pharmacy benefit manager 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 business days. Once your prescription is authorized, the authorization is valid for up to 12 months for most drugs.

The drugs currently requiring prior authorization include, but are not limited to, medications for erectile dysfunction, weight loss, growth hormone deficiencies, narcolepsy, cancer, and acne for members over certain ages.

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.

Coverage of Specialty Medications
Most specialty medications (typically requiring injection or special handling) will only be covered when ordered through a specialty care pharmacy. If you use a pharmacy other than the specialty pharmacy provider for your medical coverage, you will be responsible for the full cost of the medication. Contact your specific medical coverage for information on specialty care pharmacy.

6.3.17 Support Services

Medical Case Management
If you or your dependents experience a serious medical condition, catastrophic injuries or conditions requiring long-term hospitalizations, you may be offered a service called "case management."

Case management 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 appropriate 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
All the medical coverage options provide access to helpful, reliable health information from any phone anywhere in the U.S. Your medical coverage's 24-hour Information line provides you access to a registered nurse any hour of the day or night.

6.3.18 Temporary Coverage for COVID-19 Testing, Treatment and Preventive Services

The Intel Group Health Plan is temporarily covering COVID-19 testing, treatment and preventive services when medically appropriate and, as determined by a health care provider, as

described below. This temporary coverage continues only during the COVID-19 Public Health Emergency Period (the "Emergency Period").*

- **Testing/diagnostics****: Medical care services described below, whether provided by an in or out-of-network provider, for COVID-19 testing/diagnostics are temporarily covered during the Emergency Period with applicable deductibles and copays/coinsurance waived under the Intel Group Health Plan, The testing services are:
    - Emergency Room services with the purpose of testing
    - Urgent Care services with the purpose of testing
    - Office visit services (including in-person, telehealth visits and drive-through screening and testing) for the purpose of evaluation and management with the purpose of testing

- **Treatment**: Medical care services for COVID-19 treatment are temporarily covered during the Emergency Period with applicable deductibles and copays/coinsurance waived under the Intel Group Health Plan.
  Out-of-network provider or facility: you may be responsible for additional costs if the provider/facility bills you for any cost over the Maximum Allowed Amount (MAA). See Section 6.3.3.3 for additional information on MAA.

  Prior authorization requirements are temporarily suspended.

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

* The Emergency Period is the period declared an emergency or disaster by the President of the U.S. and a public health emergency declared by the Secretary of Health and Human Services pursuant to applicable laws.
** Tests that are approved, cleared, or authorized by the US Food and Drug Administration (FDA), including tests that are in development under the auspices of the FDA, states, and the US Department of Health and Human Services (HHS).
± A qualifying coronavirus preventive service means an item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is, with respect to the individual involved—(1) an evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); or (2) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices (regardless of whether the immunization is recommended for routine use).

6.3.19 Virtual Visits

Virtual visits with in-network providers are covered without cost share (e.g. deductible). This includes telephone, video, and online medical visits.

6.4 Connected Care

Topics

6.4.1 Connected Care Provider Network
6.4.2 Connected Care High Deductible Health Plan (HDHP) – How the Plan Works
6.4.3 Connected Care Primary Care Plus – How the Plan Works
6.4.4 Connected Care Copayment – How the Plan Works

This section describes how Connected Care works. For a comparison of each of the medical coverage option's specific features (i.e., copayments, coinsurance, deductibles and coverage limits) refer to the Comparison Charts sections in this chapter.

Connected Care is a healthcare model designed by Intel and regional healthcare provider partners. The goal of the Connected Care model is an improved healthcare experience for you and your family.

Connected Care is based on a medical home. A medical home is a place, a team, and an approach that focuses on prevention and managing existing conditions proactively. Your care is managed by a care team that is led by your primary care provider (PCP). Your PCP may be a doctor or a nurse practitioner. Depending on your needs, your team may also include:

- Pharmacist clinician
- Behavioral health clinician
- Diabetes educator
- Promotora
- Case manager
- Nurse care manager
- Nurses and medical assistants
- Clinic support staff
- Nurse practitioners and physician assistants who work with your provider

6.4.1. Connected Care Provider Network

Connected Care utilizes provider networks. There are four types of provider groups and they can all be categorized as either "in-network" or "out-of-network."

- In-Network:
    - Your medical home – This includes your primary care provider and medical care team forming your patient centered medical home.
    - Your medical neighborhood – The medical neighborhood is an extension of your medical home and includes a wide variety of providers; for example, specialists, hospitals, and lab facilities.
    - Providers outside the local Connected Care area may be treated as in-network if care is coordinated by your primary care doctor.
    - Your "out-of-area wrap" – These national in-network providers are available across the U.S. All out-of-area wrap providers are in-network; however, you should call the Connected Care option you are enrolled before using one of

these providers to confirm coverage.

- Out-of-Network:
    - Normally, accessing out-of-network providers is the exception, though some members choose to pay more and use out-of-network providers. Services from out-of-network providers are covered at the out-of-network benefit level.

- The Intel Health for Life Centers are considered an extension of your medical home. They will coordinate with your Connected Care providers to avoid duplication of services and help close any gaps in care. For employees and family members that have a primary care physician at the Intel Health for Life Centers, that relationship can continue in Connected Care. When more complex care is needed, the Health for Life Centers will work closely with the Connected Care option you are enrolled to assist you with your care. All medical services provided at the Health for Life Centers are in-network.

Connected Care options are currently available to employees located in Arizona, California, New Mexico and Oregon.

6.4.2 Connected Care High Deductible Health Plan (HDHP) – How the Plan Works

6.4.2.1 Options

This section applies to the Connected Care HDHP with Optional Health Savings Account.

Intel offers the following Connected Care HDHP options:

- Connected Care Arizona Care Network HDHP (available only in AZ)
- Connected Care California HDHP (available only in Northern CA)
- Connected Care Presbyterian HDHP (available only in NM)
- Connected Care Providence HDHP (available only in OR)
- Connected Care Kaiser HDHP (available only in OR)

Contact and Website Information		
Connected Care Partner	**Telephone**	**Website^**
Arizona Care Network (ACN) (AZ)	(800) 974-4517	www.connectedcarehealth.com/az
Connected Care California (Dignity Health and Stanford Health Care) (CA)	(800) 971-4153	www.connectedcarehealth.com/ca
Presbyterian (NM)	(505) 923-8000; or (855)-780-7737	http://presintel.org/
Providence (OR)	(855) 210-1590	www.providenceoregon.org/intel
Kaiser Permanente (OR)	(844) 533-2885	http://my.kp.org/connectedcare
^ Available to members. Websites provide many self-service features, including the ability to view your claim history, review the list of providers in your area, select a primary care physician, order new ID cards and obtain other health related information.		

6.4.2.2 Connected Care Health Savings (an "HSA") Account Administrator

For Connected Care HDHP, Intel has partnered with Fidelity, an HSA± administrator, to establish HSAs for participants in the Connected Care HDHP.

Table: Connected Care HSA administrator

Connected Care HSA Administrator
Fidelity 888-401-7377 or www.netbenefits.com/intel

For an overview of services provided by an HSA administrator, see the Health Savings Account section in this Chapter.

±The HSA is not an Intel-sponsored benefit or an ERISA welfare benefit plan.

6.4.2.3 Features of the Connected Care HDHP

The HDHP is designed to help you and your family take control of your healthcare dollars and decisions. It provides you flexibility and control in choosing the healthcare services you and your family members receive, and in choosing how the cost of these services is paid.

Table: Connected Care HDHP at a glance

Features	In-Network	Out-of Network*
Health Savings Account±: Maximum Annual Employee Contribution□	$3,600 individual/$7,200 family	
Preventive Care	Covered 100%	40% coinsurance after deductible
Deductible (includes covered medical, pharmacy and behavioral health services)	$1,400 individual $2,800 individual plus one or more children $3,500 individual plus spouse or individual plus spouse and one or more children	
Traditional Health Care Coverage (i.e., coinsurance rate when accessing care): • Primary Care Physician/Specialist • Urgent care • Inpatient hospitalization • Out-patient services • Prescription Drugs	5% coinsurance after deductible	40% coinsurance after deductible
Out-of-Pocket maximum (includes covered medical, pharmacy and behavioral health services)	$2,100 individual $4,200 individual plus one or more children $5,000 individual plus spouse or individual plus spouse and one or more children	
□ HSA: A voluntary program that allows you to set aside pretax contributions into an account, which may be used to pay for certain medical expenses on a pretax basis. ±The HSA is not an Intel-sponsored benefit or an ERISA welfare benefit plan. Please see the section on Health Savings Accounts. * Out of network coverage limited to Maximum Allowable Amount (MAA). See the subsection on MAA above for complete details of MAA.		

Services covered under this medical coverage option are outlined in the Covered Medical Services section. While some services may be deemed covered, the service must also be considered medically necessary, and not be otherwise excluded from coverage to qualify for reimbursement. See the General Exclusions and Limitation section for a complete listing of exclusions.

Examples of Using the Connected Care HDHP

Example 1: Mary Jones

Mary is a healthy 25-year-old who works out four days a week. Here is a list of the services used by Mary:

Year 1		**Year 2**	
Mary's pretax HSA contribution	$3,300	HSA rollover from year 1	$2,900
Total HSA funds available for year 1	$3,300	Mary's pretax contribution Total HSA funds available for year 2	$3,300 $6,200
Expenses: Preventive care service Office visits Prescription drugs	 $350 $300 $100	Expenses: Preventive care services Office visits Prescription drugs	 $250 $400 $200
Total expenses	$750	Total expenses	$850
Amount paid by preventive care benefit (medical coverage pays 100%, no deduction from HSA)	$350	Amount paid by preventive care benefit (medical coverage pays 100%, no deduction from HSA)	$250
Deductible amount paid from HSA	$400	Deductible amount paid from HSA	$600
HSA rollover to year 2	$2,900	HSA rollover to year 3	$5,600

Example 2: The Smith Family

The Smith Family is a family of four. Below outlines all of the healthcare used by the Smiths during the year including back surgery for George Smith (father):

As you can see in the example below, the Smith's HSA savings from year 1 were sufficient to cover the entire deductible for his back surgery in year 2.

Year 1		**Year 2**	
The Smith's pretax HSA contribution	$6,450	HSA rollover from year 1	$5,000
Total HSA funds available for year 1	$6,450	The Smith's pretax contribution Total HSA funds available for year 2	$6,450 $11,450
Expenses: Preventive care service Physical therapy Office visits Prescription drugs	 $500 $700 $450 $300	Expenses: Preventive care services Hospital and surgery fees Office visits Prescription drugs	 $500 $14,300 $300 $300
Total expenses	$1,950	Total expenses	$15,400
Amount paid by preventive care benefit (medical coverage pays 100%, no deduction from HSA)	$500	Amount paid by preventive care benefit (medical coverage pays 100%, no deduction from HSA)	$500
Deductible amount paid from HSA	$1,450	Deductible amount paid from HSA	$3,180
HSA rollover to year 2	$5,000	Coinsurance paid by Traditional Health Care Coverage (medical coverage pays 90% of $11,720)	$11.134
		Coinsurance paid from the HSA	$586
		Coinsurance paid by the employee out-of-pocket	$0
		HSA rollover to year 3	$7,684

6.4.2.4 Connected Care HDHP Preventive Care Benefit

You will receive 100% coverage, without any out-of-pocket costs, for nationally recommended preventive care services received from an in-network provider. Out-of-network preventive care is subject to cost share and MAA limitations. See *Covered Services* for a list of covered preventive services and *Maximum Allowed Amount* for an explanation of MAA.

6.4.2.5 Connected Care HDHP Prior Authorization Requirements

Some service may require Prior Authorization; check with your health plan.

Prior authorization and continuation of care review allows you to know in advance whether a procedure, treatment or service will be covered. It helps ensure that you receive the appropriate level of care in the appropriate setting and it enables your HDHP to identify situations that may allow you to receive additional attention (e.g. referrals to disease or case management programs) based on the type or services requested.

6.4.2.6 Connected Care HDHP Out-of-Pocket Maximums

Once you pay a certain amount of covered medical expenses required for out-of-pocket expenses in a given year, the HDHP pays all further covered medical expenses at 100%, with some exceptions. The out-of-pocket maximum combines in-network and out-of-network covered expenditures with some exceptions.

Table: Connected Care HDHP Out-of-Pocket Maximum Calculation Exclusions

Covered Services Exclusions to Out-of-Pocket Maximum Calculation	In-Network Coverage	Out-of-Network Coverage
Surgeon's fees paid at 50% because a required second opinion was not obtained		X
The reduction in benefits incurred when inpatient hospitalizations are not certified		X
Charges above MAA and charges that are otherwise excluded under the HDHP		X

6.4.2.7 Connected Care HDHP Prescription Benefits

Your prescription drug benefit is provided through your Connected Care HDHP and is available to all Connected Care HDHP members.

Prescription drugs count toward your deductible and out-of-pocket maximum.

Table: Connected Care HDHP prescription benefit coverage

Connected Care HDHP Prescription Drug Benefit			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Network Retail Pharmacy Up to 30-day supply*	5% Coinsurance	5% Coinsurance	5% Coinsurance
Mail Order Up to 90-day supply	5% Coinsurance	5% Coinsurance	5% Coinsurance
Certain medications are covered at 100%. These drugs are used to treat conditions such as high blood pressure, high cholesterol, and diabetes. For a list of medications covered at 100%, contact your Connected Care Customer Services representative. **Dispensing Limitation:** If you request a brand-name 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 drug and the generic medication. * You may purchase up to a 90-day supply at select retail pharmacies; for details contact your Connected Care Customer Services representative.			

Connected Care HDHP Mail Order Pharmacy
Mail order is an alternative and convenient way 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. Contact your HDHP for mail order options.

6.4.2.8 Changing Plan Options Mid-Year Due to a Qualified Change In Status Event

See Section 6.3.9 above regarding transferring accumulated deductibles and out-of-pocket maximum amounts mid-year between HDHP options.

6.4.3 Connected Care Primary Care Plus – How the Plan Works

The provisions in this section apply to the Connected Care Primary Care Plus ("PCP").

Contact and Website Information		
Connected Care PCP Partner	**Telephone**	**Website^**
Providence	(855) 210-1590	www.providenceoregon.org/intel
Arizona Care Network (ACN)	(800) 974-4517	www.connectedcarehealth.com/az
^ Available to members. Website provides many self-service features, including the ability to view your claim history, review the list of providers in your area, select a primary care physician, order new ID cards, and obtain other health related information.		

With the Connected Care PCP, you will pay a copayment for your primary care* office visits and prescription drugs. For all other services, you must first meet a deductible before you begin paying a coinsurance amount. The table below highlights your responsibilities when accessing care. Review the Comparison Charts for additional detail.

*Primary care is provided by a primary care provider—usually a family or general practitioner, internist, OB/GYN, or pediatrician.

Table: Connected Care PCP at a glance

Features	In-Network	Out-of-Network*
Preventive Care	Covered 100%	40% coinsurance after deductible
Primary Care Office Visit	$10 Copayment	40% coinsurance after deductible
Deductible (in- and out-of-network deductibles are separate)	$250 individual/$500 family	$250 individual/$500 family
Coinsurance rate when accessing care: • Specialist Office Visit • Urgent care • Inpatient hospitalization • Out-patient services	5% coinsurance after deductible	40% coinsurance after deductible
Prescription Drugs	$10 Copay Generic $20 Copay Formulary $35 Copay Non-formulary	40% coinsurance
Out-of-Pocket maximum (includes covered medical, pharmacy and behavioral health services)	$1,500 individual/$3000 family	
*Out-of-network coverage limited to Maximum Allowable Amount (MAA).		

Medical services covered under this option are outlined in the section, "Covered Medical Services." While some services may be deemed covered medical services, the service must also be considered medically necessary, and not be otherwise excluded from coverage to qualify for reimbursement. See the General Exclusions and Limitation section for a complete listing of exclusions.

6.4.3.1 Connected Care PCP Preventive Care Benefit

You will receive 100% coverage, without any out-of-pocket costs, for nationally recommended preventive care services received from an in-network provider. Out-of-network coverage is subject to cost share and MAA limitations. See *Covered Service* for a list of covered preventive services and *Maximum Allowed Amount* for information on MAA.

6.4.3.2 Connected Care PCP Deductible

In the Connected Care PCP, the deductibles for in- and out-of-network accumulate separately. Once an individual has met the deductible traditional coverage will begin. For example, if you are enrolled in family coverage, once an individual family member meets the deductible, traditional coverage for

the individual will begin. The individual deductible and other family member expense will continue to accumulate toward the family deductible. Primary care copayments and prescription drug copayments do not count toward the plan deductible.

6.4.3.3 Connected Care PCP Out-of-Pocket Maximums

Once you pay a certain amount of covered medical expenses beyond the required deductible in any given year, the Connected Care PCP will pay all further covered expenses at 100%. The out-of-pocket maximum combines in-network and out-of-network covered expenditures, with some exceptions.

In the Connected Care PCP, an individual will not pay more than the individual out-of-pocket maximum for covered medical expenses. For example, if you are enrolled in family coverage, once an individual family member meets the individual out-of-pocket maximum, the Connected Care PCP will pay all further covered expense for this individual at 100%. Other family member expense will continue to accumulate toward the family out of pocket maximum. For exclusions to the out-of-pocket maximum calculations, see the following table.

Table: Connected Care PCP Out-of-Pocket Maximum Calculation Exclusions

Covered Services Exclusions to Out-of-Pocket Maximum Calculation	In-Network Coverage	Out-of-Network Coverage
Surgeon's fees paid at 50% because a required second opinion was not obtained		X
The reduction in benefits incurred when inpatient hospitalizations are not certified		X
Charges above MAA and charges that are otherwise excluded		X

6.4.3.4 Connected Care PCP Prior Authorization Requirements

Care outside the Connected Care Medical Neighborhood may require Prior Authorization. Prior authorization and continuation of care review allows you to know in advance whether a procedure, treatment or service will be covered. It helps ensure that you receive the appropriate level of care in the appropriate setting and it enables Connected Care PCP to identify situations that may allow you to receive additional attention (e.g. referrals to disease or case management programs) based on the type or services requested.

6.4.3.5 Connected Care PCP Prescription Benefits

Your prescription drug benefits are provided through your Connected Care and are available to all Connected Care PCP members. Prescription drugs do not count toward the in- or out-of-network deductible; however, your prescription drug expenses will count toward the Connected Care PCP's out-of-pocket maximum.

Connected Care PCP Prescription Benefit Coverage

Table: Details the Connected Care PCP prescription benefit coverage

Connected Care PCP Prescription Drug Benefit			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Network Retail Pharmacy* Up to 30-day supply	$10 Copayment	$20 Copayment	$35 Copayment
Mail Order Pharmacy Up to 90-day supply	$25 Copayment	$50 Copayment	$90 Copayment
Certain medications are covered at 100%. These drugs are used to treat conditions such as high blood pressure, high cholesterol, and diabetes. For a list of medications covered at 100%, contact your Connected Care Customer Services representative. **Dispensing Limitation:** If you request a brand-name 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 drug and the generic medication. *You may purchase up to a 90-day supply at select retail pharmacies. Connected Care PCP may have an arrangement with a preferred retail pharmacy providing 90-day supply at reduced copay. Contact Connected Care PCP for more information.			

The following examples highlight how the Connected Care PCP prescription benefit works:

Network Retail Pharmacy

For medications purchased at a retail pharmacy:

- For retail generic prescription drugs, you will pay a $10 copayment for up to a 34-day supply.
- For preferred brand prescription drugs, you will pay a $20 copayment for up to a 34-day supply
- Once you have reached your out-of-pocket maximum, Connected Care PCP will pay 100%

Mail Order Pharmacy

Mail-order pharmacy service is an alternative and convenient way 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. Contact Connected Care PCP for mail order options.

6.4.4 Connected Care Copayment – How the Plan Works

The provisions in this section apply to the Connected Care Copayment ("Copay") options. Intel offers two Connected Care Copay Plans:

- Connected Care Presbyterian Copay (available only in NM)
- Connected Care Kaiser Copay (available only in OR)

Contact and Website Information		
Connected Care Copay Partner	**Telephone**	**Website^**
Presbyterian	(505) 923-8000 or 1 (855) 780-7737	http://presintel.org/
Kaiser Permanente	(844) 533-2885	http://my.kp.org/connectedcare
^ Available to members. Website provides many self-service features, including the ability to view your claim history, review the list of providers in your area, select a primary care physician, order new ID cards, and obtain other health related information.		

The Connected Care Copay options use a traditional model where you pay a copayment for in-network services at the time you access medical care. The tables below summarize out-of-pocket expenses for the copayment medical option, for a complete listing of out-of-pocket expenses, refer to the Comparison Charts.

Table: Connected Care Copay at a glance

Features	**In-Network**	**Out-of-Network***
Preventive Care	Covered 100%	40% coinsurance after deductible
Deductible	None	$250 individual/ $750 family
Copayment/Coinsurance rate when accessing care using a primary care physician** (PCP): • Office Visits • Preventive care	$10 Copayment	40% coinsurance after deductible
Copayment/Coinsurance rate when accessing care using a Specialist	$25 Copayment	40% coinsurance after deductible
Copayment/Coinsurance rate when accessing care: • Urgent care • Outpatient surgery • Inpatient hospitalization	• $50 Copayment • $100 Copayment • $100 Copayment • $250 Copayment	40% coinsurance after deductible
Out-of-Pocket maximum (includes covered medical, pharmacy and behavioral health services)	$1,500 individual/$3,000 family	
*Out of network coverage limited to Maximum Allowable Amount (MAA).		

Features	In-Network	Out-of-Network*
**Primary care physician includes family or general practitioner, internist, OB/GYN or pediatrician Physician from the network's physicians.		

Medical services covered under the Connected Care PCP are outlined in the Covered Medical Services section. While some services may be deemed covered medical services, the service must also be considered medically necessary, and not be otherwise excluded from coverage to qualify for reimbursement under the medical plan. See the General Exclusions and Limitations for a complete listing of exclusions.

6.4.4.1 Connected Care Copay Preventive Care Benefit

You will receive 100% coverage, without any out-of-pocket cost, for nationally recommended preventive care services received from an in-network provider. Out-of-network coverage is subject to cost share and MAA limitations.

6.4.4.2 Connected Care Copay Out-of-Pocket Maximums

Once you pay a certain amount of covered medical expenses beyond the required deductible in any given year, Connected Care copay will pay all further covered expenses at 100%. The out-of-pocket maximum combines in-network and out-of-network covered expenditures, with some exceptions.

Table: Connected Care Copay Out-of-Pocket Maximum Calculation Exclusions

Covered Services Exclusions to Out-of-Pocket Maximum Calculation	In-Network Coverage	Out-of-Network Coverage
Surgeon's fees paid at 50% because a required second opinion was not obtained		X
The $500 reduction in benefits incurred when inpatient hospitalizations are not certified		X
Charges above MAA and charges that are otherwise excluded under the plan		X

6.4.4.3 Connected Care Copay Prior Authorization Requirements

Care outside the Connected Care Medical Neighborhood may require prior authorization. Prior authorization and continuation of care review allows you to know in advance whether a procedure, treatment or service will be covered. It helps ensure that you receive the appropriate level of care in the appropriate setting and it enables your medical coverage to identify situations that may allow you to receive additional attention (e.g. referrals to disease or case management programs) based on the type or services requested.

6.4.4.4 Connected Care Copay Prescription Benefits

Your prescription drug benefits are available to all Connected Care Copay members. Prescription drugs do not count toward the out-of-network deductible; however, your prescription drug expenses will count toward the out-of-pocket maximum.

Table: Connected Care Copay Prescription Benefits

Connected Care Copay Prescription Benefits			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Network Retail Pharmacy* Up to 30-day supply	$10 Copayment	$20 Copayment	$35 Copayment
Mail Order Up to 90-day supply	$20 Copayment	$50 Copayment	$90 Copayment
Certain medications are covered at 100%. These drugs are used to treat conditions such as high blood pressure, high cholesterol, and diabetes. For a list of medications covered at 100%, contact your medical plan. **Dispensing Limitation:** If you request a brand-name 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 drug and the generic medication. *You may purchase up to a 90-day supply at select retail pharmacies. Connected Care Copay may have an arrangement with a preferred retail pharmacy providing 90-day supply at reduced copay. Contact your Connected Care Copay plan for more information.			

Mail Order Pharmacy

Mail-order pharmacy service is an alternative and convenient way 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. Contact your medical coverage for mail order options.

6.5 Anthem Blue Cross - High Deductible Health Plans ("HDHP") – How the Plan Works

Topics

6.5.1 Features of Anthem HDHP
6.5.2 Anthem HDHP Preventive Care Benefit
6.5.3 Anthem HDHP Out-of-Pocket Maximum
6.5.4 Changing Plan Options Mid-Year Due to a Qualified Change In Status Event
6.5.5 Anthem HDHP Prior Authorization Requirements
6.5.5 Anthem HDHP Prescription

Contact and Website Information		
Medical Plan	**Telephone**	**Website^**
Anthem Blue Cross	(800) 811-2711	www.anthem.com/ca
^ Available to members. Website provides many self-service features, including the ability to view your claim history, review the list of providers in your area, select a primary care physician, order new ID cards, and obtain other health related information.		

6.5.1 Features of Anthem Blue Cross HDHP

The HDHP is designed to help you and your family take control of your healthcare dollars and decisions. It provides you flexibility and control in choosing the healthcare services you and your family members receive, and in choosing how the cost of these services is paid.

Table: Anthem Blue Cross HDHPs at a glance

Features	In-Network	Out-of-Network*
Health Savings Account (HSA): Maximum Annual Employee Contribution□	$3,600 individual/$7,200 family	
Preventive Care	Covered 100%	40% coinsurance after deductible
Deductible (includes covered medical pharmacy and behavioral health services)	$1,570 individual $3,150 individual plus one or more children $3,940 individual plus spouse or individual plus spouse and one or more children	
Traditional Health Care Coverage (i.e., coinsurance rate when accessing care): • Primary Care Physician/Specialist • Urgent care • Inpatient hospitalization	10% coinsurance after deductible	40% coinsurance after deductible

Features	In-Network	Out-of-Network*
• Outpatient services		
Out-of-Pocket maximum (includes covered medical pharmacy and behavioral health services)	$2,355 individual $4,710 individual plus one or more children $5,830 individual plus spouse or individual plus spouse and one or more children	
□ HSA is a voluntary program that allows you to set aside pretax contributions into an account, which may be used to pay for certain medical expenses on a pretax basis. The HSA is not an Intel-sponsored benefit or an ERISA welfare benefit plan. Please see the section below on Health Savings Accounts. * Out of network coverage limited to maximum allowable amount (MAA)		

Covered medical services are outlined in the "Covered Medical Services" section. While some services may be deemed covered medical services, the service must also meet any prior authorization requirements, be considered medically necessary, and not be otherwise excluded from coverage to qualify for reimbursement. See the sections on Prior Authorization and General Exclusions and Limitations.

Table: HSA administrator

Anthem Blue Cross HDHP
Fidelity (888) 401-7377

The HSA is not an Intel-sponsored benefit or an ERISA welfare benefit plan but is available for eligible participants in the Anthem Blue Cross HDHPs. Please see the *Health Savings Account* section in this Chapter.

Examples of Using the HDHP

Example 1: Mary Jones

- Mary is a healthy 25-year-old who works out four days a week.

Year 1		**Year 2**	
Mary's pretax HSA contribution	$3,300	HSA rollover from year 1	$2,900
Total HSA funds available for year 1	$3,300	Mary's pretax contribution Total HSA funds available for year 2	$3,300 $6,200
Expenses: Preventive care service Office visits Prescription drugs	 $350 $300 $100	Expenses: Preventive care services Office visits Prescription drugs	 $250 $400 $200
Total expenses	$750	Total expenses	$850
Amount paid by preventive care benefit (medical plan pays 100%, no deduction from HSA)	$350	Amount paid by preventive care benefit (medical plan pays 100%, no deduction from HSA)	$250
Deductible amount paid from HSA	$400	Deductible amount paid from HSA	$600
HSA rollover to year 2	$2,900	HSA rollover to year 3	$5,600

Example 2: The Smith Family

The Smith Family is a family of four. Below outlines all of the healthcare used by the Smiths during the year including back surgery for George Smith (father).

As you can see in the example below, the Smith's HSA savings from year 1 were sufficient to cover the entire deductible for his back surgery in year 2.

Year 1		**Year 2**	
The Smith's pretax HSA contribution	$6,450	HSA rollover from year 1	$5,000
Total HSA funds available for year 1	$6,450	The Smith's pretax contribution Total HSA funds available for year 2	$6,450 $11,450
Expenses: Preventive care service Physical therapy Office visits Prescription drugs	 $500 $700 $450 $300	Expenses: Preventive care services Hospital and surgery fees Office visits Prescription drugs	 $500 $14,300 $300 $300
Total expenses	$1,950	Total expenses	$15,400
Amount paid by preventive care benefit (medical plan pays 100%, no deduction from HSA)	$500	Amount paid by preventive care benefit (medical plan pays 100%, no deduction from HSA)	$500
Deductible amount paid from HSA	$1,450	Deductible amount paid from HSA	$3,180
HSA rollover to year 2	$5,000	Coinsurance paid by Traditional Health Care Coverage (90% of $11,720)	$10,548
		Coinsurance paid from the HSA	$1,172
		Coinsurance paid by the employee out-of-pocket	$0
		HSA rollover to year 3	$7,098

6.5.2 Anthem Blue Cross HDHP Preventive Care Benefit

You will receive 100% coverage, without any deductions from your HSA or any out-of-pocket costs, for nationally recommended preventive care services received from an in-network provider. Out-of-network coverage is subject to cost share and MAA limitations. See *Covered Services* for a list of covered preventive services.

6.5.3 Anthem Blue Cross HDHP Out-of-Pocket Maximums

Once you pay a certain amount of covered medical expenses required for out-of-pocket expenses in a given year, the HDHP pays all further covered medical expenses at 100%, with some exceptions. The out-of-pocket maximum combines in-network and out-of-network covered expenditure with some exceptions.

Table: Anthem Blue Cross HDHP Out-of-Pocket Maximum Calculation Exclusions

Covered Services Exclusions to Out-of-Pocket Maximum Calculation	In-Network Coverage	Out-of-Network Coverage
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 reduction in benefits incurred when inpatient hospitalizations are not certified		X
Charges above MAA and charges that are otherwise excluded		X

6.5.4 Changing Plan Options Mid-Year Due to a Qualified Change In Status Event

See Section 6.3.9 above regarding transferring accumulated deductibles and out-of-pocket maximum amounts mid-year between HDHP options.

6.5.5 Anthem Blue Cross HDHP Prior Authorization Requirements

Prior authorization and continuation of care review allows you to know in advance whether a procedure, treatment or service will be covered. It helps ensure that you receive the appropriate level of care in the appropriate setting and it enables your medical plan to identify situations that may allow you to receive additional attention (e.g. referrals to disease or case management programs) based on the type or services requested.

The follow services may require prior authorization. Check with your medical plan prior to receiving any of these services:

- Certain outpatient procedures such as durable medical equipment (DME), home health care/hospice, MRI/MRA, CT scans and PET scans, etc. This list is not inclusive; contact your medical plan prior to an outpatient procedure to verify if prior authorization is required.
- All inpatient admissions and non-obstetric observation stays
- Potentially experimental and investigational procedures

- Potentially cosmetic procedures
- Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (Cesarean section)
- Hysterectomies
- Back surgery
- Autism Benefit
- Gender confirmation surgery

6.5.6 Anthem Blue Cross HDHP Prescription Benefits

If you are enrolled in the Anthem Blue Cross HDHP, your prescription drug benefits are provided by Express Scripts and are available to all Anthem Blue Cross HDHP members.

Your coinsurance (excluding maintenance medication retail surcharge) for prescription medication will be included in the calculation of your HDHP deductible and out-of-pocket maximums.

Anthem Blue Cross HDHP Maintenance Medication Coinsurance
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. 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 one of these options you avoid the higher retail cost and receive up to a 90-day supply of your maintenance medication prescriptions.

Anthem Blue Cross HDHP Retail Refill Allowance
The Retail Refill Allowance allows you to fill a maintenance medication prescription twice at retail pharmacies. This allowance is a trial period to ensure the medication is effective with no adverse side effects. Upon your third retail fill (i.e., your Retail Refill Allowance has been exhausted), you will pay a surcharge if you continue to fill your prescription at retail.

Non-maintenance medications (e.g., medications taken for short-term care such as antibiotics for an infection) are not subject to the retail coinsurance surcharge.

Anthem Blue Cross HDHP Mail Order Pharmacy
Mail order is the preferred way 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.

Anthem Blue Cross HDHP mail order is provided through Express Scripts Pharmacy.

Table: Details of the Anthem Blue Cross HDHP prescription benefit

Anthem Blue Cross HDHP Prescription Benefit All prescriptions except for maintenance medications (See chart below for maintenance medication prescription drug benefit)			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**

Network Retail Pharmacy Up to 34-day supply	10% Coinsurance	10% Coinsurance	10% Coinsurance
Mail Order Pharmacy Up to 90-day supply	10% Coinsurance	10% Coinsurance	10% Coinsurance

Anthem Blue Cross HDHP Prescription 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**
Network Retail Pharmacy Up to 34-day supply	First two times you purchase each prescription (Retail Refill Allowance)	10% Coinsurance	10% Coinsurance	10% Coinsurance
Network Retail Pharmacy Up to 34-day supply	Beginning with the third refill	40% Coinsurance	40% Coinsurance	40% Coinsurance
Mail Order Pharmacy / Walgreens / Costco Up to 90-day supply	All maintenance prescription purchases	10% Coinsurance	10% Coinsurance	10% Coinsurance
Out-of-pocket costs for maintenance medications beyond the standard mail benefit will not apply toward deductible/out-of-pocket maximums. **Dispensing Limitation:** If you request a brand-name 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 drug and the generic medication. **Retail Refill Allowance** limits do not apply to prescriptions purchased at **Costco and Walgreens**. Contact Express Scripts for more information.				

For non-maintenance medications purchased at a retail pharmacy and maintenance medications purchased during the Retail Refill Allowance:

- You may purchase up to a 34-day supply

    - **While in your deductible:** you will pay 100% of the cost of the drug; this amount will apply toward your deductible and out-of-pocket maximum.
    - **After you met your deductible:** you will pay 10% of the cost of the drug; this amount will apply toward your out-of-pocket maximum.
    - **Once you have reached your out-of-pocket maximum:** the medical plan will pay 100% of the cost.

For maintenance medication purchased at a retail pharmacy:

- You may purchase up to a 34-day supply
    - **While in your deductible:** You will pay 100% of the cost of the drug; 30% of the cost will not apply to your deductible or out-of-pocket maximum.
    - **After you met your deductible:** you will pay 40% of the cost of the drug; 10% will apply to your out-of-pocket maximum and 30% will not apply.
    - **Once you have reached your out-of-pocket maximum:** you will continue to pay 30% of the cost of the drug.

For maintenance medication purchased at Express Scripts Pharmacy (mail order), Walgreens or Costco:

- You may purchase up to a 90-day supply
    - **While in your deductible:** you will pay 100% of the cost of the drug; this amount will apply toward your deductible and out-of-pocket maximum.
    - **After you met your deductible:** you will pay 10% of the cost of the drug; this amount will apply toward your out-of-pocket maximum.
    - **Once you have reached your out-of-pocket maximum:** the medical coverage will pay 100% of the cost.

6.6 Anthem J1-Visa – How the Plan Works

Topics

6.6.1 Anthem J1-Visa Preventive Care Benefit
6.6.2 Anthem J1-Visa Deductible
6.6.3 Anthem J1-Visa Out-of-Pocket Maximums
6.6.4 Anthem J1-Visa Prior Authorization Requirements
6.6.5 Anthem J1-Visa Prescription Benefit

Contact and Website Information		
Claim Administrator	**Telephone**	**Website^**
Anthem	(800) 811-2711	www.anthem.com/ca
^ Website provides many self-service features, including the ability to view your claim history, review the list of providers in your area, select a primary care physician, order new ID cards, and obtain other health related information.		

The J1-Visa is primarily a "pay for what you use" model, where you are responsible for paying a certain percentage of the covered medical expenses when you access care. You will pay a copayment for your primary care* office visits and prescription drugs.

For all other services, you must first meet a deductible before you begin paying a coinsurance amount. The table below highlights your responsibilities when accessing care. Review the Comparison Charts for additional detail.

*Primary care is provided by a primary care provider including a family or general practitioner, internist, OB/GYN, or pediatrician.

Table: Anthem J1-Visa at a glance

Features	In-Network	Out-of-Network*
Preventive Care	Covered 100%	40% coinsurance after deductible
Primary Care Office Visit	$15 Copayment	40% coinsurance after deductible
Deductible (in- and out-of-network deductibles are separate)	$500 individual/$1000 family	$500 individual/$1000 family
Coinsurance rate when accessing care: • Specialist Office Visit • Urgent care • Inpatient hospitalization • Outpatient services	10% coinsurance after deductible	40% coinsurance after deductible

Features	In-Network	Out-of-Network*
Prescription Drugs	$10 Copay Generic $20 Copay Formulary $35 Copay Non-formulary	Member pays the amount above allowable cost plus: $10 Copay Generic $20 Copay Formulary $35 Copay Non-formulary
Out-of-Pocket maximum (includes covered medical, pharmacy and behavior health services)	$1,500 individual/$3,000 family	
* Out of network coverage limited to maximum allowable amount (MAA)		

Medical services covered under the plan are outlined in the Covered Medical Services section. While some services may be deemed covered medical services, the service must also be considered medically necessary, and not be otherwise excluded from coverage to qualify for reimbursement under the medical coverage. See the sections on Prior Authorization and General Exclusions and Limitations.

6.6.1 Anthem J1-Visa Preventive Care Benefit

You will receive 100% coverage, without any out-of-pocket costs, for nationally recommended preventive care services received from an in-network provider. Out-of-network coverage is subject to cost share and MAA limitations. See the Covered Medical Services section for a list of covered preventive services.

6.6.2 Anthem J1-Visa Deductible

Once the deductible has been met, traditional coverage will begin. For example, if you are enrolled in family coverage, once an individual family member meets the deductible, traditional coverage for the individual will begin. The individual deductible and other family member expense will continue to accumulate toward the family deductible. Primary care copayments and prescription drug copayments do not count toward the deductible.

6.6.3 Anthem J1-Visa Out-of-Pocket Maximums

Once you pay a certain amount of covered medical expenses beyond the required deductible in any given year, any further covered expenses are covered at 100%. The out-of-pocket maximum combines in-network and out-of-network covered expenditures, with some exceptions.

An individual will not pay more than the individual out-of-pocket maximum. For example, if you are enrolled in family coverage, once an individual family member meets the individual out-of-pocket maximum, further covered expense for this individual are covered at 100%. Other family member expense will continue to accumulate toward the family out-of-pocket maximum. For exclusions to the out-of-pocket maximum calculations, see the table below.

Table: Anthem J1-Visa Out-of-Pocket Maximum Calculation Exclusions

Covered Services Exclusions to Out-of-Pocket Maximum Calculation	In-Network Coverage	Out-of-Network Coverage
Prescription drug retail surcharge and costs beyond the copayment	X	X
Surgeon's fees paid at 50% because a required second opinion was not obtained		X
The reduction in benefits incurred when inpatient hospitalizations are not certified		X
Charges above MAA and charges that are otherwise excluded		X

6.6.4 Anthem J1-Visa Prior Authorization Requirements

Prior authorization and continuation of care review allows you to know in advance whether a procedure, treatment or service will be covered. It helps ensure that you receive the appropriate level of care in the appropriate setting and it enables your medical plan to identify situations that may allow you to receive additional attention (e.g. referrals to disease or case management programs) based on the type or services requested.

Anthem J1-Visa Services Requiring Prior Authorization – This is not a comprehensive list and prior authorization requirements may differ by medical plan option**.** To understand if prior authorization is required for specific services, contact your medical plan prior to receiving services.

- Certain outpatient procedures such as durable medical equipment (DME), home health care/hospice, MRI/MRA, CT scans and PET scans, etc. This list is not inclusive; contact your medical plan prior to an outpatient procedure to verify if prior authorization is required.
- All inpatient admissions and non-obstetric observation stays
- Potentially experimental and investigational procedures
- Potentially cosmetic procedures
- Maternity stays longer than 48 hours (vaginal delivery) or 96 hours (Cesarean section)
- Hysterectomies
- Back surgery
- Autism Benefit
- Gender confirmation surgery

6.6.5 Anthem J1-Visa Prescription Benefit

Prescription drugs are administered by Express Scripts. Prescription benefits are available to all members.

For pharmacy benefit questions, contact, Express Scripts Member Services at (800) 899-2713 or visit the Express Scripts website at www.express-scripts.com and complete the one-time registration to access the information on the site.

Prescription drug copayments do not count toward the in or out-of-network deductible; however, your prescription drug expenses will count toward the out-of-pocket maximum.

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 mail order. By using the mail order you avoid the higher retail cost and receive up to a 90-day supply of your maintenance medication prescriptions.

Retail Refill Allowance
The Retail Refill Allowance allows you to fill a maintenance medication prescription twice at retail pharmacies. This allowance is a trial period to ensure the medication is effective with no adverse side effects. Upon your third retail fill (i.e., your Retail Refill Allowance has been exhausted), you will pay a surcharge if you continue to fill your prescription at retail.

Non-maintenance medications (e.g., medications taken for short-term care such as antibiotics for an infection) are not subject to the retail coinsurance surcharge.

Mail Order Pharmacy
Mail-order pharmacy service is the preferred way 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.

Mail order is provided through Express Scripts Pharmacy.

Table: Details the Anthem J1-Visa prescription benefit

Cigna J1-Visa Prescription Benefit All prescription except for maintenance medications (See chart below for maintenance medication prescription drug benefit)			
Where	**Generic**	**Preferred Brand**	**Non-Preferred Brand**
Network Retail Pharmacy Up to 34-day supply	$10 Copayment	$20 Copayment	$35 Copayment
Mail Order Pharmacy Up to 90-day supply	$25 Copayment	$50 Copayment	$90 Copayment
Cigna J1-Visa Prescription 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
Network Retail Pharmacy Up to 34-day supply	First two times you purchase each prescription (Retail Refill Allowance)	$10 Copayment	$20 Copayment	$35 Copayment
Network Retail Pharmacy Up to 34-day supply	Beginning with the third refill	$25 Copayment	$50 Copayment	$90 Copayment
Mail Order Pharmacy / Walgreens / Costco Up to 90-day supply	All maintenance prescription purchases	$25 Copayment	$50 Copayment	$90 Copayment
Out-of-pocket costs for maintenance medications beyond the standard mail benefit will not apply toward deductible/out of pocket maximums. **Dispensing Limitation:** If you request a brand-name 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 drug and the generic medication. Retail Refill Allowance limits do not apply to prescriptions purchased at **Costco and Walgreens**. Contact Express Scripts for more information.				

The following examples highlight how the Anthem J1-Visa prescription plan works:

For non-maintenance medications purchased at a retail pharmacy and maintenance medications purchased during the Retail Refill Allowance:

- For retail generic prescription drugs, you will pay a $10 copayment for up to a 34-day supply.
- For preferred brand prescription drugs, you will pay a $20 copayment for up to a 34-day supply
- Once you have reached your out-of-pocket maximum, the plan will pay 100%

For maintenance medication purchased at a retail pharmacy

- An additional retail refill cost will start with your third fill. The additional cost will not apply toward your out of pocket plan maximums. You will continue to pay this amount after meeting your out-of-pocket maximum.
- For example, for a third refill of a generic medication at retail, you will pay a $25 copayment. For a 34-day supply, only $10 may be applied to your out-of-pocket maximum,

For maintenance medication purchased at Express Scripts Pharmacy (mail order), Costco or Walgreens

- When you use Express Scripts Pharmacy for medication you take on a regular basis, you can order up to a 90-day supply and will pay a copayment for each prescription.
- For example, you will pay $25 for a 90-day of a generic medication.
- Once you have reached your out-of-pocket maximum, the plan will pay 100%.

6.7 Covered Medical Services - Connected Care and Anthem Blue Cross

The following is a list of covered medical services for the Connected Care and Anthem Blue Cross options. Only those services, supplies, and treatments that are identified as covered medical services are covered. Covered services and supplies shall be rendered in the least intensive professional setting that is appropriate for the delivery of the services and supplies.

There are some differences among the plans. In addition, each claims administrator utilizes its own internal guidelines and protocols for determining whether a service is covered. Refer to the Comparison Charts for additional details. Covered medical services must otherwise meet all other applicable terms and conditions for coverage under the plan in order for benefits to be payable.

Select desired service below:		
Acupuncture	Home Health Care	Prescription Drug Benefits
Allergy Services	Hospice Care	Preventive Care
Ambulance	Hospital and Partial Hospital Services	Private Duty Nursing
Autism Benefit	Hospital Ancillary Services	Reconstructive Surgery
Breast Reconstruction, Breast Prostheses, and Complications of Mastectomy	Internal Prosthetic/Medical Appliances	Short –Term Rehabilitative Therapy
Chiropractic Services	Maternity Care	Therapies for Developmental Delay
Conception Services	Mental or Nervous Disorders or Substance Abuse	Skilled Nursing Facility
Covid-19	Naturopath Services	Tobacco Cessation Services
Dental Services	Newborn Care	Temporomandibular Joint Syndrome (TMJ)
Diagnostic and Therapeutic Radiology Services	Non-Durable Medical Supplies	Transsexual Surgery (Gender confirmation)
Diabetes Education	Nutritional Counseling	Transplant Services
Durable Medical Equipment	Oral Surgery	Virtual Visits
Emergency Services		

Select desired service below:		
External Prosthetic Appliances	Orthotics	Travel and Living Expenses
Family Planning Services	Outpatient Services	Travel Immunizations
Hearing Care	Physician Services	Weight Reduction Services
Home Birth	Podiatry	

If you are disabled, certain denied medical services may be accommodated through the Americans with Disabilities Act (ADA). For more information regarding ADA, contact an Employee Services representative via *Get Help*. If you do not have access to Intel's intranet, you can call an Employee Service representative at (800) 238-0486.

Note: The Health Plan Comparison tool is also available online to help you decide on a plan based on key features (e.g., copayments, deductibles, and co-insurance) and cost (i.e., paycheck deductions). By entering your home or work ZIP code, the tool conveniently shows you a customized, side-by-side comparison (by plan and coverage level) of only those medical plans in which you are eligible to enroll. The tool is available on the *My Health Benefits* website at www.intel.com/go/myben

Acupuncture

Acupuncture services can help with pain associated with a medical condition or nausea (e.g., nausea from chemotherapy, post-operative nausea, or nausea of early pregnancy). Acupuncture coverage is subject to limitations and is covered without regard to medical diagnosis.

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

Ambulance transportation consists of either a local professional ground 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 authorized by the health plan medical director (or designee).

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

Autism Benefit

Autism Spectrum Disorders are neurological disorders (including Rett's Syndrome), usually appearing in the first three years of life that affect normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive and stereotyped behaviors.

The autism benefit provides medical coverage for Applied Behavior Analysis (ABA) treatment only. It does not cover other non-traditional treatments, unproven treatments, tuition for school-based programs, wilderness camps, etc. Prior authorization may be required; check with your medical coverage prior to receiving services.

The medical coverage option will approve providers that are certified in ABA therapy. For this Autism benefit, all providers approved to provide treatment will be treated as in-network. Eligible providers include:

- Providers that have met established qualifications such as "certified in ABA"
- Providers who perform services in consultation with "certified" providers
- Clinically licensed professionals, such as select Doctorate and Master's prepared providers, trained to treat Autism and Autism Spectrum Disorders

Breast Reconstruction, Breast Prostheses, and Complications of Mastectomy

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

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

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 your medical 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. Chiropractic coverage is subject to limitations and shall be covered without regard to medical diagnosis.

Conception Services

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 are covered benefits and are not subject to a lifetime maximum.

Expanded Conception services include assisted reproductive technology (e.g., in vitro fertilization, artificial insemination, intrafallopian transfer), prescriptions, donor ovum and semen and related costs, including collection and preparation fees and, monthly fees for maintenance and storage of frozen egg, embryos, sperm, and embryo transport and are subject to a lifetime maximum.

Intel also provides reimbursement for long-term storage of cord blood and surrogacy related expenses through the Adoption Assistance benefits; for more information see Adoption Assistance.

COVID-19

See section 6.3.17 above for details on temporary coverage for COVID-19 related services.

Dental Services

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

- In connection with accidental injury of sound natural teeth
- For surgery or treatment of disease or injury of the jaw
- For covered medical services for the treatment of temporomandibular joint (TMJ) syndrome
- For dental X-rays, supplies and appliances and all associated expenses, including hospitalizations and anesthesia, covered for the following:
    - Transplant preparation
    - Initiation of immunosuppressive
- For general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center for members who have an underlying medical condition, health is compromised, and general anesthesia is medically necessary.
- For 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 un-restored 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--that is not a dental implant--and that functions normally in chewing and speech. Dental services for final treatment to repair the damage must have been started within three months of the accident and completed within 12 months of the accident.

Diagnostic and Therapeutic Radiology Services

Benefits under this section include only the facility charge and the charge for required services, supplies, and equipment. Coverage for diagnostic laboratory and diagnostic and therapeutic radiology services includes the following:

- Diagnostic X-ray, consisting of radiology, ultrasound, nuclear medicine, PET scans and magnetic resonance imaging
- Diagnostic laboratory and pathology tests
- Diagnostic medical procedures consisting of EKG, EEG, EMG, and other electronic diagnostic medical procedures
- Pre-admission pre-surgical tests that are made prior to a covered person's inpatient or outpatient surgery
- Other diagnostic tests and therapeutic treatments, including cancer chemotherapy or intravenous infusion therapy

Diabetes Education

Diabetes self-management education is covered as medically necessary when ALL of the following criteria are met:

- The patient has a diagnosis of diabetes mellitus, including gestational.
- The services have been prescribed by a physician.
- The services are provided by a licensed healthcare professional (e.g., registered dietician, registered nurse or other health professional) who is a certified diabetes educator (CDE).

Durable Medical Equipment

Durable medical equipment (DME) includes the short-term rental or purchase--at the claim administrator's sole discretion--of durable equipment that is used solely for medical purposes. You must rent or purchase the DME from a vendor identified by the medical plan.

Such items must be able to withstand repeated use by more than one person, must customarily serve a medical purpose, must generally not be useful in the absence of illness or injury, and must not be disposable (unless directly required to operate 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.

Wigs and hairpieces will be covered for hair loss resulting from disease or treatment of certain medical conditions. Covered conditions include, but are not limited to, chemotherapy and radiation

treatments for cancer, alopecia areata, and endocrine and metabolic diseases. Documentation will be reviewed on a case-by-case basis and will require a doctor's recommendation, including an overall history of the medical problem.

Emergency Services

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

Emergency services are required in life-threatening emergencies 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

External Prosthetic Appliances

Coverage is provided for the purchase and fitting of external prosthetic appliances that 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 the following:

- 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 covered family planning services include the following:

- 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. Hearing aid batteries may be covered, check with your medical plan.

Home Birth

Professional services for home birth are covered when provided by a licensed midwife or physician.

Home Health Care

Benefits are available only when the Home Health 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 participant requires skilled care and you or an eligible participant:

- Are homebound 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 the following:

- 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 for more information.

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. Hospice care includes the following:

- Inpatient care for terminally ill patients (generally patients 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 wheelchairs and hospital-type beds, and homemaker services
- Emotional support services
- Physical and chemical therapies
- Bereavement counseling sessions for family members
- Respite care

Hospital and Partial Hospital Services
Covered expenses for hospital 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 semiprivate care is at the convenience of the patient, payment will be made only for semiprivate 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 an operating room and related facilities
- Blood and blood products
- The collection and storage of autologous (self-donated) blood up to six weeks prior to surgery
- X-rays, laboratory, and other diagnostic services
- Anesthesia and oxygen services
- Inhalation therapy
- Radiation therapy
- Such other services customarily provided in acute care hospitals

- Radiology, anesthesiology, pathology, and laboratory (RAPL) services received during an inpatient stay at an in-network hospital will be covered at the in-network benefit level regardless of the network status of the RAPL provider or facility.

Internal Prosthetic/Medical 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 employees, covered female spouses, covered female dependent children, and eligible covered female domestic partners.

Benefits for pregnancy will be paid at the same level as benefits for 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 medical plan to obtain authorization for prescribing a length of stay that 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.

Group medical 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 insurance issuer for prescribing a length of stay not in excess of 48 or 96 hours.

Mental or Nervous Disorders or Substance Abuse

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. See also the preadmission requirements under the General Provisions section of this chapter 6, “Hospital Preadmission Certification Continued Stay Review.”

Coverage is provided to help you resolve issues such as the following:

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

Treatment for substance abuse does not include smoking cessation programs, or treatment for nicotine dependency or tobacco use.

The covered services are for the medically necessary treatment of mental or nervous disorders or substance abuse, or to prevent the deterioration of chronic conditions. Covered services are:

- Inpatient hospital services and services from a residential treatment center* as stated in the "Hospital and Partial Hospital Services", for inpatient services and supplies.
- Partial hospitalization, including intensive outpatient programs and visits to a day treatment center.
- Physician visits during a covered inpatient stay.
- Physician visits for outpatient psychotherapy or psychological testing for the treatment of mental or nervous disorders or substance abuse. This includes nutritional counseling for the treatment of eating disorders such as anorexia nervosa and bulimia nervosa.

*****Residential treatment center is an inpatient treatment facility where the patient resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a mental or nervous disorder or substance abuse. The facility must be licensed to provide psychiatric treatment of mental or nervous disorders or rehabilitative treatment of substance abuse according to state and local laws.

Naturopath Services

Office visits to a licensed naturopath are covered. Herbs, supplements, and vitamins dispensed by a naturopath are not covered.

Newborn Care

Covered newborn services (including facility charges) for routine well care--including immunizations and circumcision--of a newborn child prior to discharge from the hospital nursery are covered if the mother or child is enrolled and covered in the plan on the date of the birth of the child. To enroll a newborn, you must enroll the child within 60 days of the date of birth through Intel's enrollment process and the coverage will be effective the date of birth.

Non-Durable Medical Supplies

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

Nutritional Counseling

Included are covered medical services provided by a registered dietician in an individual session for covered persons with medical conditions that require a special diet. Some examples of such medical conditions include the following:

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

Oral Surgery

Oral surgery is covered if there is a medical diagnosis (e.g., a tumor in the mouth, TMJ pain/disability that has failed medical management, etc.) or if it is due to an accident (e.g., a 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 treatment services; administered drugs, medications, biologicals, and fluids; and inhalation therapy. Services also can include certain surgical procedures, anesthesia, blood and blood products, and the collection and storage of autologous (self-donated) blood up to six weeks prior to surgery, and recovery room services.

Benefits 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 (well woman, well baby), pre- and post-natal care, routine immunizations, allergy tests and treatments, lab work and X-rays, ultraviolet light/PUVA, injections, periodic health assessments, hospital care, consultation, and surgical procedures.

Online physician visits through an approved internet-based intermediary.

Podiatry

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 are covered. Podiatry services not covered are those procedures considered to be a part of a routine foot care, such as treatment of corns or calluses, non-surgical care of toenails, treatment of fallen arches, and other symptomatic complaints of the feet.

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

Prescription Drug 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 or coverage review criteria utilized by your plan. 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.

Prescription Drug 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. You receive a 90-day supply of medications and pay the appropriate copayment/coinsurance. Prescriptions filled through mail order will be mailed to the member's home address or an address designated by the member.

Preventive Care

Benefits for preventive services are based on national guidelines. Preventive care includes screening tests, immunizations, and counseling services designed to detect and treat medical conditions to prevent avoidable premature injury, illness and death. When delivered by in-network providers,

preventive services for the following categories are covered without cost-sharing, such as deductibles, co-pays, or coinsurance:

- Covered preventive services for adults
- Covered preventive services for women, including pregnant women
- Covered preventive services for children

The preventive services that must be covered* can be found on the department of Health and Human Services website http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html or call the Intel Health Benefits Center at 877-GoMyBen (877-466-9236) to get a hard copy of this list.

Services provided beyond the scope of preventive care during a preventive care visit could incur member cost share. Please contact the medical option you are enrolled for more information.

*Note: Compliance with changes to the recommendations or guidelines is not required until plan years beginning one year or later after the recommendation of guideline is issued.

See section 6.3.17 above for details on temporary coverage for COVID-19 related services.

The types of preventive services that are covered are listed in the following chart. **Examples of Preventive Services**	
Well baby and well child care	Baby/child preventive care office visits Baby/child screening tests: • Lead level testing • Vision screenings • Hearing screenings Baby/child immunizations: (Note: Actual dosing regimen to be determined by physician.) • Hepatitis A • Hepatitis B • Diphtheria, tetanus, pertussis (DtaP) • H. influenza type b • Polio • Measles, mumps, rubella (MMR) • Varicella (chicken pox) • Influenza - flu shot • Pneumococcal conjugate (pneumonia)
Adult Preventive Care	Adult preventive care office visits Adult screening tests: • Coronary artery disease: periodic cholesterol and lipid screening • Annual clinical breast exam and mammogram • Routine pelvic exam, Pap test, and contraceptive management • Colorectal cancer screenings: annual fecal occult blood testing or flexible sigmoidoscopy

	• Prostate cancer screenings: digital rectal examination (DRE) and prostate specific antigen (PSA) at direction of physician and patient • Diabetes (type II) screening: periodic blood glucose testing for high-risk individuals (e.g., those with hypertension or hyperlipidemia) • Osteoporosis screening: periodic bone density screening Adult immunizations: • Influenza • Pneumococcal conjugate (pneumonia) • Diphtheria, tetanus, pertussis (DatP) • Measles, mumps, rubella (MMR) • Hepatitis A: recommended for high risk groups, such as international travelers, workers in food service or health care industry • Hepatitis B and Varicella: recommended for high-risk individuals • Meningococcal: considered for college students who live in dormitories and have a slightly increased risk of getting meningococcal disease • Human Papilloma Virus (HPV)

Well Women Preventive Care	Well-woman visits include adult and female-specific screenings and preventive benefits
	
	• Breastfeeding comprehensive support, supplies and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women are covered.
	• Counseling for HIV, sexually transmitted diseases and domestic violence and abuse.
	• Domestic and interpersonal violence screening and counseling for all women.
	• Contraception: Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling, not including abortifacient drugs.
	  ○ generic birth control
	  ○ intrauterine devices (IUD)
	  ○ hormone contraceptive injections
	  ○ inserted contraceptive devices
	  ○ implanted contraceptive devices
	
	Note: Out of network coverage for contraceptive devices is covered per your plan's out of network benefit level; out of network coverage for contraceptive devices is not covered at 100%.

	• Gestational diabetes screening for women 24 to 28 weeks pregnant and those at high risk of developing gestational diabetes. • Human Immunodeficiency Virus (HIV) screening and counseling for sexually active women. • Human Papillomavirus (HPV) DNA Test: high risk HPV DNA testing every three years for women with normal cytology results who are 30 or older. • Screenings and Counseling for pregnant women including screenings for anemia, bacteriuria, Hepatitis B, and Rh incompatibility and breast-feeding counseling. • Sexually Transmitted Infections (STI) counseling for sexually active women. • Sterilization services for women only. Other services during procedure are subject to deductible and co-insurance as outlined in your Summary of Benefits. • Well –woman visits to obtain recommended preventive services for women under 65.

Private Duty Nursing

To be covered, the physician in charge of the case must certify that the patient's condition requires care that can only be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Private duty nursing applies for care given in the patient's home or a home-like setting for away from home nursing care. Coverage for Private Duty Nursing is only provided within the U.S. Private Duty Nursing is a separate benefit from Home Health Care.

Reconstructive Surgery

Charges incurred for reconstructive surgery are covered only if caused by the following:

- 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 (refer to covered medical services under Breast Reconstruction)

Short –Term Rehabilitative Therapy

Short-term rehabilitative therapy that is part of a rehabilitative program, including physical, speech, and occupational, cognitive, osteopathic manipulative and pulmonary rehabilitation therapy, when provided in the most medically appropriate setting. 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, or 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 (i.e., bypass surgery, myocardial infarction, or angioplasty). It includes nursing services, physical therapy and teaching the patient how to deal with his or 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.

Therapies for Developmental Delay

Physical, speech, and occupational therapies are covered for the treatment of Autism Spectrum Disorder and developmental delay.

Skilled Nursing Facility

Services for an inpatient stay in a licensed institution other than a hospital, (i.e., a skilled nursing facility or inpatient rehabilitation facility) are covered for covered persons 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 the following: services and supplies received during the inpatient stay and room and board in a semiprivate room (a room with two or more beds). The covered person is expected to improve to a predictable level of recovery. Benefits are available when skilled nursing, rehabilitation services, or both are needed on a daily basis.

Tobacco Cessation Services

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

Temporomandibular Joint Syndrome (TMJ)

Coverage for physician services includes the following:

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

- Consultation
- Surgical procedures

Gender Confirmation (Transgender) Surgery

Covered medical services for gender confirmation surgery (male-to-female or female to male) [and related services consistent with WPATH* recommendations], including surgical and non-surgical procedures that may be performed for feminization or masculinization and that may be considered cosmetic. *WPATH = World Profession Association for Transgender Health

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

Coverage for organ procurement costs are limited to costs directly related to the procurement of an organ, from a cadaver or a live donor. Organ procurement costs shall consist of surgery necessary for organ removal, organ transportation and the transportation, hospitalization and surgery of a live donor. Compatibility testing undertaken prior to procurement is covered if Medically Necessary. Costs related to the search for, and identification of a bone marrow or stem cell donor for an allogeneic transplant is also covered.

- When the donor is covered by a non-Intel plan any medical insurance provided for the recipient and covering the donor will be the primary payer and Anthem Blue Cross will be the secondary payer. If the recipient of the organ transplant does not have medical coverage that would cover the donor, Intel plan will be the primary payer. If these provisions do not apply, see Coordination of Benefits.

- When the recipient is covered by an Intel plan, the plan will be the primary payer for both the recipient and the donor. However, if you are covered Intel plan 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 enrolled in the same Intel plan.

Anthem Blue Cross: Reasonable travel and living expenses are also covered for the patient and a family member--if approved by the medical option medical director (or designee).

Connected Care: Reasonable travel and living expenses are also covered for the patient and a family member--if approved by the medical plan medical director (or designee).

Virtual Visits-Telephone, Video or Online Medical Visits

Provider visits and other services received over the telephone, video, or online authorized by the plan are covered. Out-of-Network provider Virtual visits are subject to cost share (e.g. coinsurance, deductibles). For 2021, in-network virtual visits are covered without cost share (e.g. coinsurance, deductible).

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 are covered for abortion when coverage is not permitted in a member's home state. Travel and living expenses will not be covered for out of network care unless the care is directed by the medical plan medical director (or designee). Travel and living expenses may require prior authorization; contact your health plan. Travel and living expenses are subject to a lifetime maximum; amounts above the lifetime maximum may be covered if deemed appropriate and approved by the appropriate medical coverage claim administrator.

Benefit payments related to health travel and living expenses that is not for medical care as defined under Internal Revenue Code § 213(d) is generally subject to income tax, income tax withholding, and employment tax, and must be reported your Form W-2 in Boxes 1, 3 and 5.

Travel Immunizations

Covered services include any immunization required for both personal and business-related travel that is appropriate based on your intended destination.

Virtual Visits-Telephone, Video or Online Medical Visits

Provider visits and other services received over the telephone, video, or online authorized by the plan are covered. Out-of Network provider Virtual visits are subject to cost share (e.g. coinsurance, deductibles). For 2021, in-network virtual visits are covered without cost share (e.g. coinsurance, deductible).

Weight Reduction Services

Weight-reduction programs are generally not a covered medical service. However, services may be covered if you are referred for weight-reduction services by your provider and authorized by the medical plan medical director (or designee). Bariatric surgery may require predetermination and pre-certification for medical necessity before scheduling the member's procedure.

6.8 General Exclusions and Limitations -Connected Care, Anthem Blue Cross, and Vision Plans

The items below--as well as charges for services associated with non-covered benefits—are excluded from coverage under Connected Care, Anthem Blue Cross and Vision plans unless specifically listed as 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.

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 the following:

- Laser surgery
- Refractive eye surgery
- Keratomileusis
- Keratophakic
- Radial keratotomy (plastic surgeries on the cornea in lieu of eyeglasses)
- All related services

Note: Corrective eye surgery coverage also available covered under the Vision Plus Plan. For more information, review the Vision Plus Plan details below.

Comfort or items of convenience: Supplies, equipment and similar incidental services and supplies for personal comfort. Examples include the following:

- Air conditioners
- Air purifiers and filters
- Batteries and battery chargers
- Dehumidifiers
- Humidifiers
- 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
- Newborn infant photographs
- Other articles that are not for the specific treatment of illness or injury

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. Cosmetic procedures include, but are not limited to the following:

- 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
- Laser hair removal
- Breast implant replacement when implant is cosmetic
- 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 and that 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 the following:

- Preventive care, diagnosis, treatment of or related to the teeth, jawbones, or gums such as the following:
    - Examinations
    - X-rays
    - Supplies
    - Appliances
    - Repairs
    - Extractions
    - Braces restoration
    - Orthodontics
    - Surgical augmentation for orthodontics
    - Periodontics
    - Casts
    - Splints
    - Miro prognathism or malocclusion
    - Replacement of teeth
- Also excluded are medical or surgical treatments of a dental condition, including:
    - Hospitalizations and anesthesia
    - Services to improve dental clinical outcomes

- Treatment of congenitally missing, malpositioned, or supernumerary teeth--even if part of a congenital anomaly

Dietary Supplements, Replacements and Products: Dietary, nutritional, and electrolyte supplements, replacements and products, except as authorized by the claim administrator for specific, severe, and chronic medical conditions. Exclusions include:

- Dietary supplements and replacements used for food allergies, lactose intolerance, weight gain or loss, and rehydration:
- Food of any kind (diabetic, low fat, cholesterol) is not covered under the plan
- Megavitamin/nutrition therapy
- Oral vitamins
- Oral minerals
- Infant formula (except when sole source of nutrition for inborn error of metabolism)
- Donor breast milk (except when sole source of nutrition for inborn error of metabolism)

Drugs and medications excluded from coverage under the prescription drug benefit:

- 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
- Anthrax vaccine/injection
- Non legend drugs other than insulin
- Charges for the administration or injection of any drug except for the administration of a vaccination
- Therapeutic devices or appliances, including support garments and other non-medicinal 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 except as required by the Affordable Care Act (ACA)
- Norplant, unless 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 the following:

- 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 maximum allowed amount (MAA) 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 investigational services, or unproven services: Procedures, or devices, that are not generally recognized as being safe and effective by the medical community, or devices that have not been approved by the FDA for the indicated use--as determined by the claims administrator. Unproven services are those that are not consistent with conclusions of prevailing medical research that demonstrate that the health service has a beneficial effect on health outcomes, and that are not based on trials that are either well-conducted randomized controlled trials or well-conducted cohort studies. 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, 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) each plan option may, in its sole discretion, determine that an experimental, investigational, or unproven service is not excluded as such under the plan option. For this to take place, the claims administrator 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 and hygienic and preventive maintenance foot care. Examples include the following:

- 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
- Orthotics for preventive maintenance foot care (e.g. orthotics for fallen arches or flat feet).

Infertility/Conception treatments: Expenses associated with fertility services.

Institution for school, training, or nursing home: Charges incurred for education including educational therapy and training for learning disabilities or mentally challenged. This includes bed and board in an institution that is primarily a school, or other institution for training. Also excluded are charges for a rest home, nursing home, or a place for the aged.

Mental health and chemical dependency:

- Treatment of congenital and 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*.
- Treatment of mental retardation, other than the initial diagnosis.
- Private hospital rooms and private duty nursing, unless determined to be a medically necessary service and authorized by the medical 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.
- Half-way houses, Co-dependency and Wilderness treatment programs.

Non-durable medical supplies:

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, and syringes, unless specifically stated in the Covered Medical Services section, tubing, nasal cannulas, connectors and masks unless part of DME.

Non-emergency confinement: Charges for hospital room and board and other inpatient services for non-emergency confinement, unless the confinement is authorized by your provider or claim administrator.

Non-medical counseling or ancillary services: Custodial Services, education, training, vocational rehabilitation, behavioral training, neurofeedback, hypnosis, employment counseling, back to school, return-to-work services, work hardening programs, driving safety, and services training, educational therapy or other non-medical ancillary services for learning disabilities, developmental delays, Autism or mental retardation except as provided in Covered Services.

Orthopedic shoes: Orthopedic shoes, unless prescribed for a congenital anomaly.

Rehabilitative therapy: Any type of therapy, service or supply for the treatment of a condition that 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.

Services covered under another plan: Health services for which other coverage is required by federal, state, or local law to be purchased or provided through other arrangements. This includes, but is not limited to, coverage required by Workers' Compensation, no-fault auto insurance, or similar legislation.

Services not medically necessary: Services not considered medically necessary are excluded. Each plan option utilizes its own internal guidelines and protocols for determining whether a service is medically necessary. Medically necessary services must meet all of the following criteria: consistency among 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 the definition of Covered Medical Service.

Sleep disorders: Sleep therapy, medical and surgical treatment for snoring, except when provided as a part of medically necessary treatment for sleep apnea.

Speech therapy: Speech therapy except as required for treatment of a speech impediment or speech dysfunction that results from stroke, head injury, vocal cord injury, developmental delay, or because of impairment caused by a congenital defect for which corrective surgery was performed.

Spinal column manipulation:

- 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.
- For spinal column manipulation, manipulation under anesthesia, anesthesia associated with spinal column manipulation or other related services.

Tests to determine unborn baby's gender: 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 medical plan medical director (or designee).

Veteran's 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. Also, 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:

- Limited coverage on certain cosmetic materials including blended lenses, contact lenses (except as noted), oversize lenses, progressive multifocal lenses, photochromic 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, ultraviolet (UV)-protected lenses, high index

lenses, polarized lenses, polycarbonate lenses, and edge treatments. For specific coverage limits on vision appliances and materials, contact your medical plan.
- 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 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 such as, Nutri/System Program, Weight Watchers or similar programs; and hospital confinements for weight-reduction programs.

Miscellaneous exclusions:

- In the event that an out-of-network provider waives copayments/coinsurance, 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 member had no control over missing the appointment and could not notify the participating provider at least 24 hours before the scheduled appointment; completion of claim forms or record processing;
- Any charge for services, supplies or equipment advertised by the provider as free;
- Charges by a provider sanctioned under a federal program for 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.

6.9 Comparison Charts for Connected Care

Topics

6.9.1 Table: Connected Care - Overview
6.9.2 Table: Connected Care - Medical Benefits
6.9.3 Table: Connected Care - Mental Health Benefits
6.9.4 Table: Connected Care - Chemical Dependency Benefits
6.9.5 Table: Connected Care - Prescription Benefits

The Comparison Charts provide key features (e.g., copayments, coinsurance, and deductibles) for each medical coverage option's medical, mental health, chemical dependency, and prescription benefits. For details on comparison chart provisions, see Covered Medical Services and General Exclusions and Limitations.

6.9.1 Table: Connected Care Overview

Features	Connected Care HDHP with HSA		Connected Care Primary Care Plus		Connected Care Copay	
Provisions[1]	In-Network[2]	Out-of-Network[2]	In-Network[2]	Out-of-Network[2]	In-Network[2]	Out-of-Network[2]
Where Available	Arizona, California, New Mexico, Oregon		Arizona, New Mexico, Oregon		New Mexico, Oregon	
How the plan works	Must use designated Connected Care network providers to receive the maximum benefit	May use any covered licensed practitioner of your choice	Must use designated Connected Care network providers to receive the maximum benefit	May use any covered licensed practitioner of your choice	Must use designated Connected Care network providers to receive the maximum benefit	May use any covered licensed practitioner of your choice
Deductible Whenever coinsurance percentages are payable by you, you must first meet the deductible before coinsurance begins	$1,400 individual $2,800 you and your children $3,500 you and your spouse or you, your spouse and your children You may use HSA funds to pay for eligible out-of-pocket medical expenses (i.e., deductible or coinsurance).		$250 individual $500 family Deductibles do not combine for in and out-of-network. An individual is only required to satisfy his/her own individual amount.	$250 individual $500 family	No deductible	Presbyterian: $250 individual $750 family Kaiser: $250 individual $500 family
Optional Health Savings Account (HSA)	Participants in the Connected Care HDHP may be eligible to fund a Health Savings Account with pre-tax dollars to cover qualified out-of-pocket medical expenses . The account may be funded up to an annual maximum amount of $3,600 if you have single coverage or $7,200 if you have family coverage. There is no limit on rollover amounts.		N/A		N/A	

Features	Connected Care HDHP with HSA	Connected Care Primary Care Plus	Connected Care Copay
Out-of-Pocket Maximum	$2,100 individual $4,200 you and your children $5,000 you and your spouse or you, your spouse and your children Coinsurance and deductible are applied toward the out-of-pocket maximum	$1,500 individual $3,000 family Coinsurance and deductible apply toward the out-of-pocket maximum An individual is only required to satisfy his/her own individual amount.	$1,500 individual $3,000 family Copayments/coinsurance and deductible are applied toward the out-of-pocket maximum
Pre-existing conditional limitation	Does not apply	Does not apply	Does not apply
Lifetime maximum per covered member	There is no lifetime limit on the dollar value of benefits. Specific coverage provisions may be subject to a lifetime maximum.	There is no lifetime limit on the dollar value of benefits. Specific coverage provisions may be subject to a lifetime maximum.	There is no lifetime limit on the dollar value of benefits. Specific coverage provisions may be subject to a lifetime maximum.
In-hospital Preadmission Certification, Continued Stay Review (CSR), or Surgical Precertification	Some prior authorization may apply. Contact your plan for more details	Outside medical neighborhood: Member or provider must obtain authorization.	Outside medical neighborhood: Member or provider must obtain authorization

[1] In the sections indicated, coinsurance percentages that are payable by you are charged once the deductible has been met.
[2] For the out-of-network provisions under the plans, once you meet the deductible you will be responsible for paying amounts in excess of the MAA—which are not included when calculating the out-of-pocket maximum. Prior authorization may be required for services received from providers outside of the Connected Care neighborhood and out of network providers.

6.9.2 Table: Connected Care Medical Benefits

Features	Connected Care HDHP with HSA		Connected Care Primary Care Plus		Connected Care Copay	
Provisions	In-Network Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible.	Out-of-Network[1] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible.	In-Network Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible	Out-of-Network[2] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible.	In-Network	Out-of-Network[2] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible.
Primary Care - Office visit services	5% coinsurance	40% coinsurance	$10 copayment Deductible does not apply	40% coinsurance	$10 copayment	40% coinsurance
Preventive Care Services	Covered at 100%	40% coinsurance	Covered at 100%	40% coinsurance	Covered at 100%	40% coinsurance

Features	Connected Care HDHP with HSA		Connected Care Primary Care Plus		Connected Care Copay	
Specialist Physician Services	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$25 copayment	40% coinsurance
Acupuncture	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$15 copayment	40% coinsurance
	Acupuncture limited to 30 visits per year; combined in- and out-of-network		Acupuncture limited to 30 visits per year; combined in- and out-of-network		Acupuncture limited to 30 visits per year; combined in- and out-of-network	
Naturopath	5% coinsurance	40% coinsurance	$10 PCP copay; then Plan pays 100% or Specialist 5% coinsurance	40% coinsurance	$15 copayment	40% coinsurance
Chiropractic Services	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$15 copayment	40% coinsurance
	Limited to 30 visits per year; combined in- and out-of-network		Limited to 30 visits per year; combined in- and out-of-network		Limited to 30 visits per year; combined in- and out-of-network	
Second Surgical Opinions	No charge	No charge	No charge	No charge	No charge	No charge
Outpatient Laboratory and X-ray Services	5% coinsurance	40% coinsurance	$10 copay preformed in PCP office; otherwise, 5% coinsurance	40% coinsurance	No copayment	40% coinsurance
Outpatient Laboratory and X-ray Services Include preadmission testing, in physician's office, or in dedicated lab/X-ray facility.						
Outpatient Hospital Surgical Services.	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$100 copayment Presbyterian: $25 copayment for radiation therapy	40% coinsurance
Outpatient hospital / surgical services include: Physician/Surgeon charges, Operating & Recovery Room, Anesthesia & Respiratory / Inhalation Therapy, Hemodialysis, Radiation Therapy & Chemotherapy, Laboratory, and X-ray Services.						
Inpatient Hospital Services - Semiprivate Room and Board	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$250 copayment per admission	40% coinsurance
Inpatient Hospital Services	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$250 copayment per admission	40% coinsurance
Inpatient Hospital Services include: Operating and recovery room, oxygen, laboratory and X-ray services, drugs, medications, special care unit, operating/room oxygen, internal prosthetics, anesthesia and respiratory/inhalation therapy, hemodialysis, radiation therapy and chemotherapy, rehab services, physician/surgeon charges						
Hospital Emergency Room	5% coinsurance	5% coinsurance	5% coinsurance	5% coinsurance	$100 copayment	$100 copayment
Urgent care facility	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$50 copayment	40% coinsurance

Features	Connected Care HDHP with HSA		Connected Care Primary Care Plus		Connected Care Copay	
Ambulance Coinsurance based on billed charges	5% coinsurance	5% coinsurance	5% coinsurance	5% coinsurance	No copayment	No copayment
Maternity Services -Pre/Post Delivery Exams -Professional Services (physician charges)	Prenatal covered at no charge before deductible. Other maternity services: No charge after you have paid the deductible	40% coinsurance	$10 copayment for initial office visit to confirm pregnancy	40% coinsurance	Presbyterian: $25 copayment to confirm pregnancy Providence & Kaiser: $10 copayment to confirm pregnancy	40% coinsurance
Maternity Services -Facility charges	See inpatient schedule	See inpatient schedule	See inpatient schedule	See inpatient schedule	See inpatient schedule	See inpatient schedule
Newborn care	No charge after you have paid the deductible	40% coinsurance	No charge after you have paid the deductible	40% coinsurance	No copayment	40% coinsurance
Birthing centers	Same as inpatient hospital	Same as inpatient hospital	Same as inpatient hospital	Same as inpatient hospital	Same as inpatient hospital	Same as inpatient hospital
Home Birth	No charge after you have paid the deductible	40% coinsurance	No charge after you have paid the deductible	40% coinsurance	$100 copayment	40% coinsurance
Nurse midwife	No charge after you have paid the deductible	40% coinsurance	$10 copayment to confirm pregnancy	40% coinsurance	Presbyterian: $25 copayment to confirm pregnancy Kaiser: $10 copayment to confirm pregnancy	40% coinsurance
Services for Conception -Office visit and diagnosis -Inpatient Corrective Surgical Treatment (ICST)	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$25 copayment office visit $100 outpatient copayment $250 inpatient copayment	40% coinsurance
Expanded Services for	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$25 copayment	40% coinsurance

Features	Connected Care HDHP with HSA		Connected Care Primary Care Plus		Connected Care Copay	
conception e.g., Assisted Reproductive Technology (ART)	Expanded conception services limited to a combined in- and out-of-network lifetime maximum $40,000 Medical and $20,000 Pharmacy		Expanded conception services limited to a combined in- and out-of-network lifetime maximum $40,000 Medical and $20,000 Pharmacy		Expanded conception services limited to a combined in- and out-of-network lifetime maximum $40,000 Medical and $20,000 Pharmacy	
Outpatient physical, occupational, and speech therapy for short-term rehabilitative therapy	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$10 copayment	40% coinsurance
Outpatient physical, Occupational, and speech therapy for developmental delay diagnosis	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$10 copayment	40% coinsurance
Cardiac rehabilitation outpatient therapy	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$10 copayment if office visit; $100 copay if outpatient hospital visit	40% coinsurance
Pulmonary therapy	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$10 copayment if office visit; $100 copay if outpatient hospital visit	40% coinsurance
Dialysis treatment	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$25 copayment if office visit; $100 copay if outpatient hospital visit	40% coinsurance
Family planning services - Physician office visit - Vasectomy - Tubal Ligation - Abortion (elective or spontaneous)	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	Office visit: PCP $10 copayment Specialist $25 copayment Vasectomy - $25 copayment Tubal ligation - $100 copayment Abortion - $25 copayment	40% coinsurance

Features	Connected Care HDHP with HSA		Connected Care Primary Care Plus		Connected Care Copay	
Hearing services - Hearing exam - Hearing Aid (analog/digital) Limits on where you may purchase hearing aids may apply. contact your health plan for details	5% coinsurance Batteries covered	40% coinsurance Batteries covered	5% coinsurance Batteries covered	40% coinsurance Batteries covered	PCP $10 copayment Specialist $25 copayment for exam No copayment for hearing aid Batteries covered	40% coinsurance Batteries covered
Nutritional counseling	5% coinsurance Providence: First 2 visits covered at 100%	40% coinsurance	5% coinsurance Providence: First 2 visits covered at 100%	40% coinsurance	PCP $10 copayment Specialist $25 copayment	40% coinsurance
TMJ services	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	Benefits based on place of service	Benefits based on place of service
Transplant services	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$25 office visit $250 inpatient	40% coinsurance
Travel and living expenses	$10,000 lifetime maximum for expenses incurred in conjunction with authorized medical services or a transplant	See Covered Services	$10,000 lifetime maximum for expenses incurred in conjunction with authorized medical services or a transplant	See Covered Services	$10,000 lifetime maximum for expenses incurred in conjunction with authorized medical services or a transplant	See Covered Services
Weight reduction services	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$10 PCP copayment $25 Specialist copayment $250 copayment inpatient care	40% coinsurance
Tobacco cessation services	5% coinsurance Providence: 100% covered	40% coinsurance Providence: Not covered	100% covered	Not covered	$10 PCP copayment $25 Specialist copayment	40% coinsurance
Orthotics	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	No copayment	40% coinsurance

Features	Connected Care HDHP with HSA		Connected Care Primary Care Plus		Connected Care Copay	
Durable medical equipment	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	No copayment	40% coinsurance
	Annual in- and out-of-network combined wig allowance of $3,000		Annual in- and out-of-network combined wig allowance of $3,000		Annual in- and out-of-network combined wig allowance of $3,000	
External prosthetic appliances	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	No copayment	40% coinsurance
Other healthcare facilities (e.g., skilled nursing facilities, inpatient physical rehabilitation facilities)	5% coinsurance	40% coinsurance; limited to 100 days per calendar year;	5% coinsurance	40% coinsurance; limited to 100 days per calendar year;	$250 copayment	40% coinsurance; limited to 100 days per calendar year;
Home health care	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	No copayment	40% coinsurance
Hospice	100% covered after deductible	40% coinsurance	100% covered after deductible	40% coinsurance	No copayment	40% Coinsurance

[1] In the sections indicated, coinsurance percentages that are payable by you are charged once the deductible has been met.
[2] For the out-of-network provisions under the plans, once you meet the deductible you will be responsible for paying amounts in excess of the MAA—which are not included when calculating the out-of-pocket maximum. Prior authorization may be required for services received from providers outside of the Connected Care neighborhood and out of network providers.

6.9.3 Table: Connected Care - Mental Health Benefits

Features	Connected Care HDHP with HSA		Connected Care Primary Care Plus		Connected Care Copay	
Provisions[1]	In-Network[2] Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible	Out-of-Network[2] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible	In-Network[2] Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible	Out-of-Network[2] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible	In-Network[2]	Out-of-Network[12] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible
Deductible	No separate deductible; plan deductible applies		No separate deductible; plan deductible applies		No deductible	No separate deductible; plan out of network deductible applies
Inpatient or Alternate Care[2] Precertification required	5% coinsurance	40% coinsurance	5% coinsurance	40% coinsurance	$250 copayment per admission	40% coinsurance
Outpatient Care	5% coinsurance	40% coinsurance	$10 copayment	40% coinsurance	$10 copayment	40% coinsurance

[1] In the sections indicated, coinsurance percentages that are payable by you are charged once the deductible has been met.
[2] For the out-of-network provisions under the plans, once you meet the deductible you will be responsible for paying amounts in excess of the MAA—which are not included when calculating the out-of-pocket maximum. Prior authorization may be required for services received from providers outside of the Connected Care neighborhood and out of network providers.

6.9.4 Table: Connected Care - Chemical Dependency Benefits

Features	Connected Care HDHP with HSA		Connected Care Primary Care Plus		Connected Care Copay	
Provisions[1]	In-Network[2] Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible	Out-of-Network[2] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible	In-Network[2] Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible	Out-of-Network[2] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible	In-Network [2]	Out-of-Network[12] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible
Deductible	No separate deductible; plan deductible applies		No separate deductible; plan deductible applies		No deductible	No separate deductible; plan out of network deductible applies)

Features	Connected Care HDHP with HSA		Connected Care Primary Care Plus		Connected Care Copay	
Inpatient or Alternate Care	5% coinsurance	40% coinsurance;	5% coinsurance	40% coinsurance	$250 copayment per admission	40% coinsurance
Outpatient care	5% coinsurance	40% coinsurance;	$10 copayment per visit	40% coinsurance	$10 copayment per visit	40% coinsurance
[1] In the sections indicated, coinsurance percentages that are payable by you are charged once the deductible has been met. [2] For the out-of-network provisions under the plans, once you meet the deductible you will be responsible for paying amounts in excess of the MAA—which are not included when calculating the out-of-pocket maximum. Prior authorization may be required for services received from providers outside of the Connected Care neighborhood and out of network providers.						

6.9.5 Table: Connected Care - Prescription Benefits

Features	Connected Care HDHP with HSA		Connected Care Primary Care Plus		Connected Care Copayment	
Provisions	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible	No separate deductible; plan deductible applies		No deductible Prescriptions drug copayments expenses do not count toward the plan deductible		No deductible Prescription drug copayments do not count toward the plan deductible	
Retail Pharmacy Program* 30-day supply	5% coinsurance	40% coinsurance	Generic: $10 copayment Preferred brand: $20 copayment Non-preferred brand: $35 copayment	40% coinsurance	Generic: $10 copayment Preferred brand: $20 copayment Non-preferred brand: $35 copayment	Member pays the amount above allowable cost plus the following: Generic: $10 copayment Preferred brand: $20 copayment Non-preferred brand: $35 copayment
Mail Service Program Limited to a 90-day supply	5% coinsurance	Not available	Generic: $20 copayment Preferred brand: $50 copayment Non-preferred brand: $105 copayment	Not available	**Presbyterian** Generic: $20 copayment Preferred brand: $50 copayment Non-preferred brand $105 copayment	Not available

Features	Connected Care HDHP with HSA		Connected Care Primary Care Plus		Connected Care Copayment	
					Kaiser Generic: $20 copayment Preferred brand: $50 copayment Non-preferred brand $90 copayment	

Certain medications are covered at 100%. These drugs are used to treat conditions such as high blood pressure, high cholesterol, and diabetes. For a list of medications covered at 100%, contact your medical coverage option.

Dispensing Limitation: If you request a brand-name 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 drug and the generic medication.

***Connected Care Primary Care Plus and Copayment Plans:** You may be able to purchase up to a 90-day supply at select retail pharmacies. The medical plan may have an arrangement with a preferred retail pharmacy providing 90-day supply at a reduced copay. Contact your Connected Care plan for more information.

6.10 Benefit Coverage Chart for Anthem Blue Cross (non-Connected Care Options)

Topics

6.10.1 Table: Anthem Blue Cross Overview
6.10.2 Table: Anthem Blue Cross Medical Benefits
6.10.3 Table: Anthem Blue Cross Mental Health Benefits
6.10.4 Table: Anthem Blue Cross Chemical Dependency Benefits
6.10.5 Table: Anthem Blue Cross Prescription Benefits

The Comparison Charts provide key features (e.g., copayments, coinsurance, and deductibles) for each medical coverage option's medical, mental health, chemical dependency, and prescription benefits. For details on comparison chart provisions, see Covered Medical Services and General Exclusions and Limitations.

6.10.1 Table: Anthem Blue Cross Overview

<table>
<tr><th>Features</th><th colspan="2">Anthem Blue Cross HDHP
with HSA</th><th colspan="2">Anthem J1-Visa</th></tr>
<tr><td>Provisions</td><td>In-Network</td><td>Out-of-Network[1]</td><td>In-Network</td><td>Out-of-Network[1]</td></tr>
<tr><td>Where Available</td><td colspan="2">Nationwide</td><td colspan="2">Nationwide</td></tr>
<tr><td>How the plan works</td><td>Must use BlueCard Network Providers to receive the maximum benefit</td><td>May use any covered licensed practitioner of your choice</td><td>Must use Cigna OAP Providers to receive the maximum benefit</td><td>May use any covered licensed practitioner of your choice</td></tr>
<tr><td rowspan="2">Deductible
Whenever coinsurance percentages are payable by you, you must first meet the deductible</td><td colspan="2">$1,570 individual
$3,150 you and one or more children
$3,940 you and your spouse or you, your spouse and one or more children

You may use HSA funds to pay for eligible out-of-pocket medical expenses (e.g., deductible or coinsurance).</td><td>$500 individual
$1,000 family</td><td>$500 individual
$1,000 family</td></tr>
<tr><td colspan="2">Deductibles do not combine for in and out-of-network.

An individual is only required to satisfy his/her own individual amount.</td></tr>
<tr><td colspan="4">Note: See the Extra Bucks section for information on how Extra Bucks may be used to cover the cost of eligible medical services after your deductible is met.</td></tr>
<tr><td>Optional Health Savings Account (HSA)</td><td colspan="2">Participants may be eligible to fund a Health Savings Account (HSA) with pre-tax dollars to cover out-of-pocket eligible medical expenses. Please see the HSA section of this chapter for more information.

The HSA may be funded up to an annual maximum amount of $3,600 if you have single coverage or $7200 if you have family coverage. There is no limit on rollover amounts.</td><td colspan="2">N/A</td></tr>
<tr><td rowspan="2">Out-of-Pocket Maximum</td><td colspan="2">$2,355 individual
$4,710 you and one or more children
$5,830 you and your spouse or you, your spouse and one or more children</td><td colspan="2">$1,500 individual
$3,000 family</td></tr>
<tr><td colspan="2">Coinsurance and deductible apply toward the out-of-pocket maximum</td><td colspan="2">Coinsurance and deductible apply toward the out-of-pocket maximum</td></tr>
</table>

Features	Anthem Blue Cross HDHP with HSA	Anthem J1-Visa
		An individual is only required to satisfy his/her own individual amount.
Pre-existing conditional limitation	Does not apply	Does not apply
Lifetime maximum per covered member	There is no lifetime limit on the dollar value of benefits. Specific coverage provisions may be subject to a lifetime maximum.	
In-hospital Preadmission Certification, Continued Stay Review (CSR), or Surgical Pre-certification	Member or provider must obtain authorization from Anthem Blue Cross	Member or provider must obtain authorization

[1] In the sections indicated, coinsurance percentages that are payable by you are charged once the deductible has been met. For the out-of-network provisions under the plans, once you meet the deductible you will be responsible for paying amounts in excess of the MAA—which are not included when calculating the out-of-pocket maximum.

6.10.2 Table: Anthem Blue Cross - Medical Benefits

Features	Anthem Blue Cross HDHP with HSA		Anthem J1-Visa	
Provisions[2]	In-Network Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible and you are using Traditional Health Coverage	Out-of-Network[1] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible and you are using Traditional Health Coverage	In-Network Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible	Out-of-Network[1] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible and you are using Traditional Health Coverage
Primary Care - Office visit services	10% coinsurance	40% coinsurance	$15 Copay	40% coinsurance
Preventive Care Services	Covered at 100%	40% coinsurance	Covered at 100%	40% coinsurance
Specialist Physician Services	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Acupuncture	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
	Acupuncture limited to 30 visits per year; combined in- and out –of-network		Acupuncture limited to 30 visits per year; combined in- and out-of-network	

Features	Anthem Blue Cross HDHP with HSA		Anthem J1-Visa	
Naturopath	10% coinsurance	40% coinsurance	$15 PCP copay; then Plan pays 100% or for Specialist, Plan pays 90% coinsurance	40% coinsurance
Chiropractic Services	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
	Limited to 30 visits per year; combined in- and out-of-network		Limited to 30 visits per year; combined in- and out-of-network	
Second Surgical Opinions	No charge	No charge	No charge	No charge
Outpatient^ Laboratory and X-ray Services Prior authorization may be required	10% coinsurance	40% coinsurance	$15 copay preformed in PCP office; otherwise, 90% coinsurance	40% coinsurance
Outpatient^^ Hospital/Surgical Services Prior authorization may be required	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Inpatient Hospital Services - Semiprivate Room and Board Preadmission Certification is required	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Inpatient^^^ Hospital Services Preadmission Certification is required.	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Hospital Emergency Room	10% coinsurance	10% of billed charges	10% coinsurance	10% of billed charges
Urgent care facility	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Ambulance Coinsurance based on bill charges	10% coinsurance	10% coinsurance	10% coinsurance	10% coinsurance
Maternity Services -Pre/Post Delivery Exams -Professional Services (physician charges)	No charge after you have paid the deductible	40% coinsurance	$15 Copay for initial office visit to confirm pregnancy; no copayment thereafter	40% coinsurance
Maternity Services -Facility charges	See inpatient schedule	See inpatient schedule	No charge after you have paid	See inpatient schedule

Features	Anthem Blue Cross HDHP with HSA		Anthem J1-Visa	
			the deductible	
Home Birth	No charge after you have paid the deductible	40% coinsurance	$100 Copay	40% coinsurance
Newborn care	No charge after you have paid the deductible	40% coinsurance	No charge after you have paid the deductible	40% coinsurance
Birthing centers	Same as inpatient hospital	Same as inpatient hospital	No charge after you have paid the deductible	Same as inpatient hospital
Nurse midwife	No charge after you have paid the deductible	40% coinsurance	No charge after you have paid the deductible	40% coinsurance
Services for Conception -Office visit and diagnosis -Inpatient Corrective Surgical Treatment (ICST) Prior authorization may be required	10% coinsurance	40% coinsurance	Office Visit: PCP: $15 copay Specialist: 10% coinsurance Facility: 10% coinsurance	40% coinsurance
Expanded Services for Conception e.g., Assisted Reproductive Technology (ART) Prior authorization may be required	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
	Expanded conception services limited to a combined in- and out-of-network lifetime maximum $40,000 Medical and $20,000 Pharmacy		Expanded conception services limited to a combined in- and out-of-network lifetime maximum $40,000 Medical and $20,000 Pharmacy	
Outpatient physical, occupational, and speech therapy for short-term rehabilitative therapy Prior authorization may be required	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Outpatient physical, Occupational, and speech therapy for developmental delay diagnosis	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Cardiac rehabilitation outpatient therapy Prior authorization may be required	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance

Features	Anthem Blue Cross HDHP with HSA		Anthem J1-Visa	
Pulmonary therapy Prior authorization may be required	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Dialysis treatment Prior authorization may be required	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Family planning services - Physician office visit - Vasectomy - Tubal Ligation - Depo-Provera - Abortion (elective or spontaneous)	10% coinsurance	40% coinsurance	Office visit: PCP: $15 copay Specialist: 10% coinsurance after you have paid the deductible Facility: 10% coinsurance after you have paid the deductible	
Hearing services - Hearing exam - Hearing Aid (analog/digital) Limits on where you may purchase hearing aids may apply. Contact your health plan for details	10% coinsurance; Batteries also covered	40% coinsurance Batteries also covered	10% coinsurance; Batteries also covered	40% coinsurance Batteries also covered
Vision therapy	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Nutritional counseling	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
TMJ services Prior authorization required	10% coinsurance	40% coinsurance	Office Visit: PCP: $15 copay Specialist: 10% coinsurance after you have paid the deductible Facility: 10% coinsurance after you have paid the deductible	40% coinsurance
Transplant services Prior authorization required	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance

Features	Anthem Blue Cross HDHP with HSA		Anthem J1-Visa	
Travel and living expenses Prior authorization required	$10,000 lifetime maximum for expenses incurred in conjunction with authorized medical services or a transplant	See Covered Services	$10,000 lifetime maximum for expenses incurred in conjunction with authorized medical services or a transplant	See Covered Services
Weight reduction services Prior authorization required	10% coinsurance	40% coinsurance	Office Visit: PCP: $15 copay Specialist: 10% coinsurance after you have paid the deductible	40% coinsurance
Tobacco cessation services	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Orthotics	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Durable medical equipment Prior Authorization may be required	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
	Annual in- and out-of-network combined wig allowance of $3,000		Annual in- and out-of-network combined wig allowance of $3,000	
External prosthetic appliances Prior Authorization may be required	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Other healthcare facilities (e.g., skilled nursing facilities, inpatient physical rehabilitation facilities) Prior Authorization Required	10% coinsurance	40% coinsurance; limited to 100 days per calendar year;	10% coinsurance	40% coinsurance; limited to 100 days per calendar year;
Home health care Prior Authorization Required	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Hospice Prior Authorization Required	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance

6.10.3 Table: Anthem Blue Cross Mental Health Benefits

Features	Anthem Blue Cross HDHP with HSA		Anthem J1-Visa	
Provisions	In-Network Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible and you are using Traditional Health Coverage	Out-of-Network[1] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible and you are using Traditional Health Coverage	In-Network Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible	Out-of-Network[1] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible
Deductible	No separate deductible; plan deductible applies		No deductible for office visit. No separate deductible for all other services; plan in-network deductible applies	No separate deductible; plan out of network deductible applies
Inpatient or Alternate Care[2]	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Outpatient care	10% coinsurance	40% coinsurance;	Office Visit: $15 copay Facility: 10% coinsurance after you have paid the deductible	40% coinsurance

6.10.4 Table: Anthem Blue Cross Chemical Dependency Benefits

Features	Anthem Blue Cross HDHP with HSA		Anthem J1-Visa	
Provisions	In-Network Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible and you are using Traditional Health Coverage	Out-of-Network[1] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible and you are using Traditional Health Coverage	In-Network Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible	Out-of-Network[1] Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible
Deductible	No separate deductible; plan deductible applies		No separate deductible; plan in-network deductible applies	No separate deductible; plan out of network deductible applies
Inpatient or Alternate Care[2]	10% coinsurance	40% coinsurance	10% coinsurance	40% coinsurance
Outpatient care	10% coinsurance	40% coinsurance	Office Visit: $15 copay Facility: 10% coinsurance	40% coinsurance

6.10.5 Table: Anthem Blue Cross Prescription Benefits

Features	Anthem Blue Cross HDHP with HSA		CIGNA J1-Visa	
Provisions	In-Network Unless otherwise indicated, your coinsurance is based on discounted fees after you have paid the deductible and you are using Traditional Health Coverage	Out-of-Network Unless otherwise indicated, your coinsurance is based on MAA after you have paid the deductible and you are using Traditional Health Coverage	In-Network	Out-of-Network
Deductible	No separate deductible; plan deductible applies		No deductible; prescription drug expenses do not count toward the plan deductible	No deductible; prescription drug expenses do not count toward the plan deductible

Features	Anthem Blue Cross HDHP with HSA		CIGNA J1-Visa	
Retail Pharmacy Program for Non-maintenance drugs and Retail Refill Allowance. **Limited to a 34-day supply**	10% coinsurance	40% coinsurance	Generic: $10 copay Preferred brand: $20 copay Non-Preferred brand: $35 copay	Member pays the amount above allowable cost plus the following: Generic: $10 copay Preferred brand: $20 copay Non-Preferred brand: $35 copay
Retail Pharmacy Program for Maintenance drugs. **Limited to a 34-day supply**	40% coinsurance	40% coinsurance	Generic: $25 copay Preferred brand: $50 copay Non-preferred brand: $90 copay	Member pays the amount above allowable cost plus the following: Generic: $25 copay Preferred brand: $50 copay Non-preferred brand: $90 copay
Mail Service / Costco /Walgreens Program **Limited to a 90- day supply**	10% coinsurance	Not available	Generic: $25 copay Preferred brand: $50 copay Non-preferred brand: $90 copay	Not available

6.11 Extra Bucks Accounts

Overview of Extra Bucks

If you were enrolled in a Consumer Driven Health Plan (CDHP) in 2013, had an unused Health Reimbursement Account (HRA) balance, and changed to a High Deductible Health Plan (HDHP) during Annual Enrollment, your HRA balance automatically converted into an Extra Bucks account. The Extra Bucks account is integrated with your HDHP and may only be used for you and your eligible dependents enrolled in a HDHP.

If you are enrolled in an HDHP, and have an Extra Bucks account, funds in the Extra Bucks account may be used to pay for, or get reimbursed for eligible unreimbursed vision, dental and medical expenses incurred by you or your IRS-qualified dependents who are enrolled in the HDHP.

How Extra Bucks Works

Extra Bucks may be used before and after you have met your HDHP deductible depending on the type of expense. Extra Bucks can be used for unreimbursed eligible vision and dental out of pocket expenses **before your deductible** has been met. Alternatively, Extra Bucks can be used to pay for out-of-pocket or unreimbursed eligible vision, dental and medical expenses (i.e., your coinsurance responsibility) **after your deductible** has been met,

Note: In the event that you have an Extra Bucks Account **and** a Limited Use Health Flexible Spending Account (FSA) for dental or vision expenses only, you may seek reimbursement from the Extra Bucks Account only after there are no remaining amounts available in your Limited Use Health FSA. If applicable, please ensure your auto pay feature is not activated for your Health Savings Account (HSA) or Extra Bucks so that claims are not paid from your HSA or Extra Bucks until your Limited Use FSA is exhausted.

Getting Reimbursed from Extra Bucks

When you incur an eligible **dental or vision** expense during the current plan year, you must submit the claim in order to receive Extra Bucks reimbursement. The expense is incurred when the care is provided, not when you are billed or pay for care.

Generally, out of pocket medical expenses (e.g., coinsurance) you incur after you have met your deductible will be paid automatically from your Extra Bucks account, however some exceptions may apply. Contact your Extra Bucks claims administrator for information on when a medical claim must be submitted for reimbursement or when it will take place automatically. Contact information for the Extra Bucks claims administrators can be found below in section 6.16.1, Filing a Claim under "Table: Claim Administrators."

You may submit reimbursement for eligible expenses incurred during the current plan year only. You have until March 31 after the close of the plan year to submit claims for reimbursement. **Note**: Connected Care Presbyterian HDHP follows a 356 day from Date of Service filing limit.

Extra Bucks is a type of medical plan. Therefore, the procedures for claims described in this chapter also apply to your claims for Extra Bucks benefits. (See "Types of Claims" and "Claim Determination

Process" in this chapter). For purposes of the claims procedures, your Extra Bucks claims are post-service claims.

Eligible Expense Criteria

- Eligible expenses must be incurred from your coverage effective date through your coverage end date.
- Eligible expenses must be incurred during the current plan year.
- You may only submit reimbursement claims for eligible dependents* enrolled in your HDHP.
- Eligible expenses are limited to services rendered in the U.S. only.

If you leave Intel or your participation in a HDHP as the primary enrollee ends for any reason (e.g. you change to a non-HDHP option or you move to dependent status as a spouse or dependent of another Intel employee in a HDHP either at Annual Enrollment or due to a qualified change in status event), funds in your Extra Bucks account are forfeited.

* Expenses reimbursement for a domestic partner who is not your tax dependent or a domestic partner's child(ren) are generally treated as taxable income. Intel will provide you with a Form 1099 for any expense reimbursement for a domestic partner or domestic partner's children.

Extra Bucks Eligible Expenses

Refer to the detailed list of eligible Extra Bucks expenses by searching Circuit or contact your health plan administrator.

For Extra Bucks reimbursement for vision or dental, you must submit the claim to the Extra Bucks claims administrator for payment. To find out your Extra Bucks account balance, you should contact the Extra Bucks claim administrator. Contact information for the Extra Bucks claims administrators can be found below in section 6.16.1, Filing a Claim, under "Table: Claim Administrators."

6.12 Health Saving Account ††

Topics

6.12.1 HSA Contributions
6.12.2 HSA Eligibility
6.12.3 HSA Distributions
6.12.4 IRS Reporting
6.12.5 Qualified Medical Expenses
6.12.6 Using your HSA to Pay Your HDHP Deductible

Health Savings Accounts are available to members enrolling in a High Deductible Health Plan (HDHP). Upon enrollment in a HDHP, and if you meet the HSA eligibility requirements, you may contribute to an HSA. For administrative convenience, Intel has partnered with Fidelity, an HSA administrator, to establish HSAs for participants of the Intel HDHPs. The monthly administration fee is paid by Intel while you are enrolled in one of the HDHP options under the Intel Group Health Plan.

Below is an overview of services provided by an HSA administrator:

- **Debit card:** Upon establishing your HSA, you will receive a debit card that may be used to disburse the funds. You may also request checks or access an online bill-pay function, which may be used to disperse the funds.
- **Interest and Fees:** The HSA is an interest-bearing account. Upon enrollment in the HDHP, you will receive information about the account including the HSA Supplemental Agreement, which will include specific details about the interest and fees associated with the account.
- **HSA Investments:** HSA funds may be invested. To learn more about investment options, rules, and limitations, contact the HSA administrator directly.

The HSA offers three forms of tax savings.

- You may elect to contribute to the HSA through pretax payroll deductions** or contribute on your own for an "above-the-line" tax deduction.
    - **Note:** If you enrolled in the HDHP and are covering an adult child, be aware that the Affordable Care Act provision extending coverage to children to age 26 does not apply to HSAs. Children ages 19 until age 26 must be considered a tax dependent in order for an adult child's medical expenses to qualify for payment from a parent's HSA.
- You may use your HSA funds to pay for certain medical care expenses on a tax-free basis.
- Earnings on HSA balances are generally not taxed while held in the HSA, which means that these accounts can grow on a tax-free basis.

HSA balances are non-forfeitable and automatically carry forward from year to year. Once the contributions have been deposited in your HSA, or upon termination of coverage in the HDHP, you may request distributions of those funds or move them to another HSA provider. For details on transferring funds, contact your HSA administrator.

†† The HSA is not an Intel-sponsored benefit or an ERISA welfare benefit plan but is available for eligible participants in the HDHPs.

**Some state's tax laws do not conform to federal HSA tax rules; therefore, HSA contributions are currently subject to state income tax in the following states: California, Alabama, New Jersey, and Wisconsin. Some states may also tax earnings. Please consult with your tax advisor for complete and current information on the taxation of HSAs in your state.

6.12.1 HSA Contributions

For 2021, you can contribute up to an annual maximum amount of $3,600 if you have individual coverage in the HDHP, or $7,200 if you have family coverage in the HDHP. If you are married and both you and your spouse have HSAs, the family limit is divided between you both. An additional "catch-up" amount of up to $1,000 may be contributed by employees between the ages of 55 and 65. For information on making a "catch-up" contribution, contact your HSA administrator.

6.12.2 HSA Eligibility

To be eligible to open and contribute to the HSA, you must be enrolled in a qualified HDHP. At the same time, you must meet all of the following requirements:

- You are not covered under any other medical plan that is not a high deductible health plan (e.g., family coverage that is not an HDHP through your spouse's employer)- except for certain limited types of "permitted insurance or coverage" discussed below.
- You are not enrolled in Medicare.
- You are not claimed as another person's tax dependent.

Permitted insurance or coverage is:

- Coverage for accidents, disability, dental care, vision care, or long-term care
- Insurance where substantially all of the coverage relates to liabilities incurred under Workers' Compensation laws, tort liabilities, liabilities relating to ownership or use of property (e.g., homeowner or auto insurance), or similar liabilities as specified by the IRS.
- Insurance for a specified disease or illness (e.g., cancer insurance)
- Insurance that pays a fixed amount per day (or other period) of hospitalization (e.g., hospital indemnity insurance)

Note: You are not eligible to participate in the HSA if your spouse participates in a general purpose Health FSA through your spouse's employer. You cannot participate in Intel's Health Flexible Spending Account (Health FSA) if you are enrolled in the HDHP but can participate in the Limited Use Health FSA (dental and vision expense reimbursement only).

6.12.3 HSA Distributions

Distributions from your HSA will be tax-free if they are for expenses incurred for your medical care (as defined in Section 213(d) of the Internal Revenue Code) or the medical care of your spouse or tax

dependents. Children ages 19 until age 26 must be considered a tax dependent in order for an adult child's medical expenses to qualify for payment from a parent's HSA.

Expenses must have been incurred after you established your HSA.

Note: If you spend your HSA funds for non-medical reasons, such distributions must be included in your taxable income and generally will be subject to an additional 20 percent excise tax.

6.12.4 IRS Reporting

You are responsible for reporting contributions made to your HSA and for reporting distributions from your HSA. You must determine whether your HSA distributions are taxable or whether they are used for qualified medical expenses and should maintain records sufficient to show that any distributions that you do not report as taxable were made exclusively for qualified medical expenses.

6.12.5 Qualified Medical Expenses

In addition to using your HSA to pay for the types of medical expenses defined as covered under your Traditional Health Care Coverage, you can use it to cover the cost of certain qualified medical expenses not usually covered by traditional medical plans. Qualified medical expenses are a subset of medical care expenses (as defined under Section 213(d) of the Internal Revenue Service Code), and any other expense determined to be a reimbursable medical expense under federal law. Expenses for domestic partners are not eligible to be paid out of the HSA.

Note: Refer to HSA Distributions for information on penalties associated with use of HSA funds for non-qualified medical expenses.

6.12.6 Using your HSA to Pay Your HDHP Deductible

You may use your HSA to reduce your out-of-pocket medical expenses toward your deductible. With careful planning, you may reduce your out-of-pocket expenses and still have funds in your HSA to pay for medical expenses that are not covered by traditional health care coverage. For instance, if you contribute the annual maximum to your HSA and use those funds toward your deductible, only for medical expenses covered under traditional health care coverage, you will satisfy the deductible without additional out-of-pocket expenses. If you have rollover funds in your HSA from a prior year, you would have a contribution greater than your annual deductible amount which can be used for non-covered medical services.

6.13 HMO Options

Topics

6.13.1 Table: HMOs Available by Site
6.13.2 Table: HMO General Features Chart
6.13.3 HMO Provider Access
6.13.4 HMO Services and Service Area
6.13.5 HMO Out of Pocket Cost
6.13.6 HMO Emergency Care Claims Submission
6.13.7 HMO Eligibility and Enrollment
6.13.8 HMO Benefit Coverage
6.13.9 HMO Comparison Charts
6.13.10 Notice of Right to Designate a Primary Care Provider

Intel classifies the Health Maintenance Organizations (HMOs) as traditional plans. HMOs typically have higher paycheck contributions and you pay a copayment at the time of services. HMOs encourage preventive care and promote wellness programs (e.g., smoking cessation, health club discounts) and offer benefit coverage levels similar to the national plans. Intel offers HMOs at most major U.S. Intel sites. The HMOs are self-funded.

This section provides an overview of common HMO plan terms. For specific information on HMO plan coverage, features and conditions, refer to HMO's Benefit Booklet. Contact the HMO directly for a Benefit Booklet.

In most cases, an HMO option is available to you if you live or work within the HMO's service area. Service areas are usually defined by county or state. Check with the HMO to see if you are eligible for the plan based on your home and/or work ZIP code, as this will impact the providers you are able to select

6.13.1 Table: HMOs Available by Site

State/Site	HMO
Arizona	Aetna
California (Northern and Southern CA.)	Kaiser Permanente
New Mexico	Presbyterian Health Plan

6.13.2 Table: HMO General Features Chart

Feature	HMO
PCP/Referral Process	HMOs require you to select a PCP for each covered family member. Your PCP is responsible for directing your care. No authorization or referral requirements for OB/GYN care by in-network OB/GYN provider.
In-Network vs. Out-of-Network Care	Benefits are only available when utilizing the services of HMO network providers. No coverage is available when using out-of-network providers unless specifically authorized by the medical plan claim administrator.
Copayment/Out-of-Pocket Maximum	Copayments for services and out-of-pocket maximums vary by HMOs
Filing a Claim	No claim forms are required.
Hospital/ Surgical Authorization	Your physician will be responsible for obtaining preauthorization for hospital stays and any outpatient surgical treatment.
Worldwide Travel	HMOs provide benefits worldwide only in urgent and emergency situations. Multi-state Guesting privileges may apply. Check with your local HMO.

6.13.3 HMO Provider Access

HMOs offer hospital, surgical, and medical services, as well as other services, from a specified set of physicians, clinics, and hospitals. In addition, HMOs provide general coverage for medical tests, devices, and procedures (see Benefits Booklet provided by your HMO for any specific exclusions or limitations to the plan or plans offered in your area).

Because you are expected to access care through the specified group of physicians and hospitals of the HMO, you are generally not provided any benefit if you decide to use a provider who is not affiliated with and contracted by the HMO.

Before electing a plan, check the size of the network. Does the network of physicians offer enough selection near your home or work location? Does the plan cover services at hospitals nearby your home or work location?

You might use a non-contract provider through a referral from your HMO doctor, or if you need urgent or emergency care outside your HMO's regular service area. When an HMO is available in multiple states, members may be able to access all providers of that HMO for routine, emergency, and urgent care as if they were in their home state.

Follow your HMO's procedures for using non-contract providers. If you do not properly follow procedures, you may be liable for payment to the non-contract provider. Carefully read any information provided to you by non-contract providers regarding responsibility for payment. Make sure these providers agree to look solely to the HMO for payment.

Intel does not assume responsibility for unpaid charges incurred by members of an HMO. If you have any questions about providers, ask your HMO for a list of providers and for Guesting coverage

information, if applicable to your HMO. “Guesting” may enable you to access care outside your home state.

6.13.4 HMO Services and Service Area

HMOs encourage preventive care by covering such services as routine physical examinations. In addition, most HMOs have a gatekeeper requirement, which requires you to select a PCP to coordinate all of your health care needs.

HMOs can differ in the services they provide and conditions they cover. For instance, some HMOs provide chiropractic care or eyewear benefits, and others do not. If you are considering a HMO, be sure to review the services that are provided by the plan, including preauthorization and utilization review requirements.

HMOs typically do not have out-of-network or out-of-area service provisions. HMO coverage is generally available only on an urgent or emergency basis outside your service area and includes international travel.

Exception: Kaiser Permanente does have multi-state Guesting privileges available within the United States. Guesting privileges allow members to access routine, as well as urgent and emergency care from Kaiser Permanente medical plan outside their home state.

6.13.5 HMO Out of Pocket Cost

HMOs generally do not have a deductible requirement. Most services are covered at 100% after you have paid a copayment

6.13.6 HMO Emergency Care Claims Submission

Claim submission processes for urgent or emergency care access outside your service area may slightly differ for each HMO. Contact your HMO directly for more information.

6.13.7 HMO Eligibility and Enrollment

You must enroll in an HMO through Intel and not through the HMO.

Intel's eligibility requirements and enrollment procedures still apply for HMO members and supersede the HMO's requirements.

For detailed information on when you and your dependents are eligible for coverage, see Eligibility.

For detailed information on when coverage begins, when coverage can be changed, or when coverage ends, see Health and Insurance Benefits Enrollment Chapter.

If your HMO coverage ends, you and your dependents may be eligible for continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Some HMOs may have a

conversion option once COBRA ends; check with the HMO directly. For additional information, see: *Pay, Stock and Benefits Handbook*, COBRA Continuation Coverage.

6.13.8 HMO Benefit Coverage

The benefit coverage provided by HMOs is similar to that of other Plans options offered to employees. The HMO Comparison Charts below summarize the general benefit coverage for each HMO. For additional information, you may request a Benefits Booklet from your HMO describing information on how to access care, descriptions of covered services, and any limitations or exclusions.

6.13.9 Temporary Coverage for COVID-19 Testing, Treatment and Preventive Services

The Intel Group Health Plan is temporarily covering COVID-19 testing/diagnostics, treatment and preventive services as described below. This temporary coverage continues only during the COVID-19 Public Health Emergency Period (the "Emergency Period"). *

- **Testing/diagnostics****: Medical care services described below, whether provided by an in or out-of-network provider, for COVID-19 testing/diagnostics are temporarily covered during the Emergency Period with applicable deductibles and copays/coinsurance waived under the Intel Group Health Plan. The testing services are:
    - Emergency Room services with the purpose of testing
    - Urgent Care services with the purpose of testing
    - Office visit services (including in-person, telehealth visits and drive-through screening and testing) for the purpose evaluation and management with the purpose of testing.

  Treatment: Medical care services for COVID-19 treatment are temporarily covered for in-network services during the Emergency Period with applicable deductibles and copays/coinsurance waived. Prior authorization requirements are temporarily suspended.
  Note: Out-of-network providers and facilities are not covered.

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

* The Emergency Period is the period declared an emergency or disaster by the President of the U.S. and a public health emergency declared by the Secretary of Health and Human Services pursuant to applicable laws.
** Tests that are approved, cleared, or authorized by the US Food and Drug Administration (FDA), including tests that are in development under the auspices of the FDA, states, and the US Department of Health and Human Services (HHS).
± A qualifying coronavirus preventive service means an item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is, with respect to the individual involved—

(1) an evidence-based item or service that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); or (2) an immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices (regardless of whether the immunization is recommended for routine use).

Note: Information provided by the HMO is subject to change without notice and does not represent a commitment by Intel. Detailed benefit and provider information is available by calling the HMO directly. For contact information, from Circuit, search Benefits Directory.

6.13.10 HMO Comparison Charts

The HMO Comparison Charts summarize benefit coverage for the HMO options, for a complete description of benefit coverage please contact the HMO directly. From Circuit, search Benefit Directory for contact information. See section 6.13.19 for information on temporary coverage for COVID related services.

6.13.10.1: HMO Overview

Features	AETNA*	Kaiser Permanente*	Presbyterian Health Plan*
Locations	AZ	CA	NM
Where available	Worldwide for urgent and emergency care and within each state for in-network coverage	Worldwide for urgent and emergency care and within each state for in-network coverage	Worldwide for urgent and emergency care and within New Mexico for in-network coverage
How the plan works	Must use a primary care physician (PCP) to direct your care. PCP selection is done through plan.	Members are encouraged but not required to select a primary care physician to direct care.	Must select a primary care physician (PCP) to coordinate your care. PCP selection is done through plan.
Deductible	None	None	None
Out-of-pocket (OOP) maximum individual/family	$1,500/$3,000	$1,500/$3,000	Two times full annual premium paid for by Intel and employees
Pre-existing condition limitation	None	None	None
Lifetime maximum per covered member	There is no lifetime limit on the dollar value of benefits. Specific coverage provisions may be subject to a lifetime maximum	There is no lifetime limit on the dollar value of benefits. Specific coverage provisions may be subject to a lifetime maximum.	There is no lifetime limit on the dollar value of benefits. Specific coverage provisions may be subject to a lifetime maximum.
In-hospital preadmission certification, continued stay review, surgical pre-certification	Handled by your PCP	Handled by your PCP	Handled by your PCP or participating provider

6.13.10.2 Table: HMO Medical Benefits

Features	AETNA*	Kaiser Permanente*	Presbyterian Health Plan*
Locations	AZ	CA	NM
Primary care physician - Office visit services (including medical eye care) - adult medical care - injections	$15 copayment per office visit	$15 copayment per visit Injections only (materials and administration) are $0 copayment	$15 copayment per office visit
Specialist physician services, referral physician services,	$35 copayment per office visit	$35 copayment per visit	$35 copayment per office visit
Preventive care services - Preventive care - routine immunizations and injections - Well-child care (up to 18th birthday)	No Copayment	No Copayment	No Copayment
Allergy testing and treatment	$15 copayment	Allergy test: $35 copayment; Allergy Injections only (Material and administration) $0 copayment; otherwise office visit copayments apply	20% coinsurance
Chiropractic services	$15 copayment; 20 visit maximum per calendar year	$15 copayment, 20 visit maximum per calendar year; benefit available through network providers.	$25 copayment; 20 visit maximum per calendar year. Preauthorization required
Naturopath and acupuncture services by a licensed practitioner	Not covered; discount available through Natural Alternatives	Acupuncture only: $15 copayment; 20 visit maximum per calendar year	$25 per office visit for the following services: acupuncture services by a licensed practitioner (20 visit maximum per calendar year). Note: Naturopath is not covered
Second surgical opinions	$15 copayment if PCP; $35 if specialist	$15 copayment if PCP; $35 if specialist	$15 copayment if PCP; $35 if specialist
Outpatient laboratory and X-ray services (including preadmission testing) in physician's office or in dedicated lab/X-ray facility	$15 copayment with PCP referral (at facility) No copayment if billed as part of office visit	No copayment required	No copayment required: $50 copayment on MRI Benefit Certification is required for MRI, PET and CT Scans

Features	AETNA*	Kaiser Permanente*	Presbyterian Health Plan*
Locations	AZ	CA	NM
Inpatient hospital services semiprivate room and board **Note: Preadmission Certification may be required.**	$250 copayment per admission	$250 copayment per admission	$250 copayment per admission
Inpatient hospital Services **Preadmission Certification required.**	$250 copayment per admission	$250 copayment per admission	$250 copayment per admission
Outpatient hospital/surgical services **Note: Preadmission Certification may be required.**	$100 copayment $15 copayment for radiation therapy	$100 copayment per visit	$100 copayment per visit; no copayment for chemotherapy; 15% copayment up to max of $250 per prescription (yearly max of $1,500) for specialty pharmaceuticals in Oral inhalation or Self-administered forms Benefit Certification applies to certain procedures – see plan for details
Hospital emergency room	$100 copayment per visit (waived if admitted into a hospital, then hospital copayment applies)	$100 copayment per visit (waived if admitted into a hospital, then hospital copayment applies)	$100 copayment per visit (waived if admitted into a hospital, then hospital copayment applies)
Urgent care facility	$50 copayment per visit	$15 copayment per visit	$50 copayment per visit
Ambulance	No charge	$50 copayment per use	Ground: $50 copayment per occurrence; No charge for inter-facility transfer via ground transport Air: $100 copayment per occurrence
Maternity services **- Pre/Post-delivery exams** **- Professional services (physician charges)**	$35 copayment for initial office visit to confirm pregnancy and no charge thereafter	$35 copayment for initial office visit to confirm pregnancy; no copayment per visit thereafter	$35 copayment per visit up to a maximum of $150 per pregnancy $35 copayment per visit
Maternity services - Facility charges	See inpatient schedule	See inpatient schedule	See inpatient services
Newborn care	No charge; newborn must be enrolled for continuation of coverage	No charge; newborn must be enrolled for continuation of coverage	No charge; newborn must be enrolled for continuation of coverage Note: If newborn remains in the hospital after the mother is discharged, an additional copayment of $250 may apply.
Birthing centers	Same as hospital	Same as hospital	Same as hospital
Nurse midwife	Covered as any other provider	Covered as any other provider through a Kaiser plan facility	Covered as any other provider
Services for infertility	$35 copayment per office visit; no copayment for ICST	Diagnosis and treatment covered at 50%; infertility drugs, in vitro	50% Coinsurance for office visit

Features	AETNA*	Kaiser Permanente*	Presbyterian Health Plan*
Locations	AZ	CA	NM
- Office visit and diagnosis **- Inpatient corrective surgical treatment (ICST)**	Check with plan for details	fertilization, ZIFT, GIFT, and ovum transplants are not covered; donor services are excluded.	50% for ICST, including drugs and injections Check with plan for details
Inpatient physical, occupational, and speech therapy (short-term rehabilitative therapy)	See Inpatient Hospital Services	See Inpatient Hospital Services.	See Inpatient Hospital Services.
Outpatient physical, occupational, and speech therapy for short-term rehabilitative therapy	$15 copayment per visit; 60-day consecutive visits/injury additional visits available with medical appropriateness determination benefit analysis	$15 copayment per visit; limited to 20 visits per calendar year.	$25 copayment per visit; after prior authorization, up to two months per condition; additional visits available with medical appropriateness determination benefit analysis
Outpatient physical, occupational, and speech therapy for developmental delay diagnosis	$15 copayment per visit	$15 copayment per visit; Kaiser Permanente does not base coverage of ST, PT, and OT on a particular diagnosis. Rather, Kaiser provides coverage of ST, PT, and OT based on the specific health care needs of each individual.	$25 copayment per visit; after prior authorization, up to two months per condition; additional visits available with medical appropriateness determination benefit analysis. Developmental therapy not covered on long term basis for chronic or incurable conditions
Cardiac rehabilitation outpatient therapy	$15 copayment if office visit; no charge if outpatient hospital visit	$35 specialist copayment per visit	$25 copayment per session; up to 12 sessions continuous ECG monitoring and 24 sessions intermittent ECG monitoring per calendar year
Pulmonary therapy	$15 copayment if office visit; no charge if outpatient hospital visit	$35 specialist copayment per visit copayment	$25 copayment per session (up to 24 sessions per year)
Dialysis treatment	$15 copayment if office visit; 100% if outpatient hospital visit	$35 specialist copayment per visit	20% coinsurance
Family planning services **- Physician office visit**	$15 copayment per visit	$15 copayment per visit	$15 PCP / $ 35 specialist copayment per visit
- Vasectomy	$15 copayment if billed as part of office visit; no copayment if performed as outpatient surgery	$15 copayment primary care $35 specialist copayment	$15 PCP / $ 35 specialist copayment if office visit; otherwise $100 copayment
- Tubal ligation	$15 copayment if billed as part of office visit; no copayment if performed as outpatient surgery	$100 copayment	$15 PCP / $35 specialist copayment if office visit; otherwise $100 copayment
- Abortion (elective or spontaneous)	$15 copayment if billed as part of office visit; no copayment if performed as outpatient surgery	Place of service copayment applies: - $15 primary care copayment - $35 specialist copayment -$100 outpatient copayment	$15 PCP / $35 specialist copayment if office visit; otherwise $100 copayment
- Depo-Provera	$15 copayment / vial; five vials/year	$15 primary care copayment $35 specialist copayment	$15 PCP / $35 specialist copayment if office visit
Hearing services **- Hearing examination** **- Hearing aid**	Covered as part of annual physical only Not covered	$15 copayment for PCP / $35 copayment for specialist Not covered	$15 PCP / $35 specialist copayment for screening Hearing aids covered for school-aged children up to a maximum of $2,200

Features	AETNA*	Kaiser Permanente*	Presbyterian Health Plan*
Locations	AZ	CA	NM
			every three years per hearing impaired ear.
Nutritional counseling	Not covered; discount available through Natural Alternatives	$15 primary care copayment $35 specialist copayment	$15 PCP / $35 specialist copayment
TMJ Services	Benefits based on place of service, if approved	Medical necessity applies; must refer to Benefits Booklet for this benefit.	$15 PCP / $35 specialist copayment; $250 copayment admission
Transplant services	No copayment required; covered under National Medical Excellence Program	Medical necessity applies; refer to Benefits Booklet for coverage	$15 PCP / $35 specialist copayment; $250 copayment per admission
Travel and living expenses	Refer to Benefits Booklet for coverage	Refer to Benefits Booklet for coverage	Refer to Benefits Booklet for coverage
Weight reduction services	Subject to medical necessity	Weight management classes offered through Health Education Program at reduced fees for members	$15 PCP / $35 specialist copayment
Tobacco cessation services	Tobacco Cessation programs offered through HealthMedia Simple Steps Program	Tobacco cessation programs offered through Health Education Program at reduced fees for members	$$15 PCP / $35 specialist copayment
Orthotics	Not covered	See policy for types and circumstances of coverage.	50% copayment Benefit Certification required.
Durable medical equipment (DME)	No copayment required	100% coverage; some annual maximums may apply	50% copayment Benefit Certification required.
External prosthetic appliances	No copayment required	Covered under DME; copayment may apply; see Benefits Booklet	50% copayment Benefit Certification required.
Other healthcare facilities (e.g., skilled nursing facilities (SNF), inpatient physical rehabilitation facilities)	$ 250 copayment	No copayment required up to 100 day maximum per calendar year	$250 copayment per admission, 60 day maximum per calendar year. Benefit Certification required.
Home health care	No copayment required	No copayment required; medical necessity applies up to 100 visits per calendar year.	No copayment required Benefit Certification required.
Hospice	$250 copayment	No copayment required.	Inpatient $250 copayment per admission; in-home no copayment Benefit Certification required.

* Self-funded

6.13.10.3 Table: HMO Prescription Benefits

Features	AETNA*	Kaiser Permanente*	Presbyterian Health Plan *
Locations	AZ	CA	NM
Network pharmacy program	Up to 30-day supply per copayment:	Up to a 30-day supply per copayment $10 copayment for generic	Up to 30-day supply per copayment:

Features	AETNA*	Kaiser Permanente*	Presbyterian Health Plan *
Locations	AZ	CA	NM
	$10 copayment for generic formulary $20 copayment for brand formulary $35 copayment for non-formulary	$20 copayment for brand formula	$10 copayment for generic $20 copayment for preferred brand if generic available must pay generic copayment plus difference between generic and brand. $35 copayment for all nonformulary Preferred and non-preferred, if generic available must pay copayment plus difference between generic and brand. Specialty drugs 15% copayment limited to $250 per prescription; $1,500 annual copayment max
Mail service program	90-day supply: $20 copayment for generic $30 copayment for brand formulary $70 copayment for non-formulary	Up to 90-day supply: $20 copayment for generic $40 copayment for preferred brand formulary $40 copayment for non-formulary brand and only covered if medically necessary and prescribed by plan physician Kaiser CA is for up to 100-day supply for maintenance drugs only	90-day supply: $20 copayment for generic $50 copayment for preferred brand, if generic available must pay generic copayment plus difference between generic and brand $105 copayment for non-preferred

*Self-funded

6.13.10.4 Table: HMO Mental Health Benefits

Features	AETNA*	Kaiser Permanente*	Presbyterian Health Plan*
Locations	AZ	CA	NM
Deductible	None	None	None
Inpatient or Alternate Care	$250 copayment, 30 days/year Pre-certification is required	$250 copayment per admit	$250 copayment pre admission Pre-certification is required
Outpatient	$25 copayment per visit Preauthorization required	$15 copayment per visit	$15 copayment per visit Preauthorization required

* Self-Funded

6.13.10.5 Table: HMO Chemical Dependency Benefits

Features	AETNA*	Kaiser Permanente*	Presbyterian Health Plan*
Locations	AZ	CA	NM
Deductible	None	None	None
Inpatient or Alternate Care	$250 copayment for detoxification and rehabilitative treatment, pre-certification required	$250 copayment per admit; pre-certification required.	$250 copayment per admit
Outpatient care	$15 copayment per visit; preauthorization required	$15 copayment per visit	$15 copayment per visit

* Self-funded

6.13.11 Notice of Right to Designate a Primary Care Provider

Aetna (AZ), Kaiser Permanente (No. CA) and Presbyterian Health Plan (NM) HMOs generally require the designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the HMO. HMO contact information is available in Chapter 3.

You do not need prior authorization from the HMO or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the HMO network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the HMO. HMO contact information is available in Chapter 3.

6.14 Medical Coverage When Traveling Abroad

International Personal Travel

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

International Business Travel

	Business Trip (0-90 days)	International Temporary Assignment (>90)
US - Intel Corporation Health and Welfare Plan	Although preferred provider networks are not available outside of the United States, you are eligible to receive in-network benefits for treatment of life-threatening emergencies or urgent care that cannot wait until you return home. Nonemergency coverage is paid at the out-of-network level of benefits.	N/A
Aetna International Plan*	The Aetna International World Traveler medical plan option is available to eligible U.S. employees on a short-term business trip outside of the United States. Aetna International Plan information is available from Circuit; My Benefits & Career > Career > Relocation > 2 Way International > Healthcare on Assignment. Print off your World Traveler ID card before your trip and take it with you. You may contact Aetna International Member Services for questions 24/7/365 anywhere in the world for assistance with your plan or to find a provider.	The Aetna International medical plan option is available to eligible U.S. employees on an assignment and residing outside of the United States greater than 90 days. Aetna International Plan information is available from Circuit; My Benefits & Career > Career > Relocation > 2 Way International > Healthcare on Assignment>

International SOS

The Intel Travelers Assistance Program, provided by International SOS, gives Intel travelers access to more than 3,000 professionals staffing 24-hour alarm centers, international clinics, and remote-site medical facilities across five continents. To access the service online, visit the International SOS website at www.internationalsos.com/private/intel/. From the website employees can print the International SOS ID card or sign up for e-mail updates on the countries to which they frequently travel. Intel's membership number is 11BCMA000094. The Intel dedicated phone number is (866) 868-2853 (within the U.S.) or (215) 701-2939 (outside the U.S. call collect).

6.15 Vision Care Benefits

Topics

6.15.1 Overview
6.15.2 Vision Care Benefits Comparison
6.15.3 How the Vision Care Benefit Works

This section provides you with important information about choosing, understanding and using your vision care benefits.

6.15.1 Overview

Intel sponsors the Intel Health and Welfare Plan (the Plan), which provides you a choice of vision care options to meet your needs. Once eligible, you may choose between two types of vision care options:

- The Basic Vision Plan or
- The Vision Plus Plan

Your medical and vision care coverage elections are separate. You may select a different coverage tier under each. For example, you can cover all eligible family members under the medical option, but only yourself under the vision care option.

Note: For information on when you and your dependents are eligible for coverage, see the *Pay, Stock and Benefits Handbook,* chapter 4, "Eligibility and Availability of Benefits." For information on when coverage begins, when coverage can be changed, or when coverage ends, see chapter 5, "Health Benefits and Insurance Enrollment."

If your vision care coverage ends, you and your dependents may be eligible for coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA). See chapter 11, "COBRA Continuation Coverage" in the Pay, Stock and Benefits Handbook.

6.15.2 Vision Care Benefits Comparison

You have the choice of two vision care options - the Basic Vision Plan or the enhanced Vision Plus Plan. The Vision Plus Plan provides an enhanced vision care offering lower copayments, more frequent services, and higher allowances than compared to the Basic Vision Plan. The chart below outlines the difference between the vision care options.

The Vision Care Benefit Comparison chart is a summary of vision services and copayments. For a complete listing of all services, you can refer to http://www.vsp.com or call VSP at (855) 663-2836.

Benefit	Description	Copay
Basic Plan Coverage with a VSP Provider		
WellVision Exam	• Comprehensive eye exam • Retinal screening • Every calendar year	$0 $25
PRESCRIPTION GLASSES		
Frame	• $130 allowance for a wide selection of frames • $180 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 Costco® frame allowance Every other calendar year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every calendar year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses Premium progressive lenses Custom progressive lenses • Average savings of 20-25% on other lens enhancements • Every calendar year	$0 $95 - $105 $150 - $175
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $55
	• Your VSP doctor can diagnose, treat, and monitor common eye	

Benefit	Description	Copay
Plus Plan Coverage with a VSP Provider		
WellVision Exam	• Comprehensive eye exam • Retinal screening • Every calendar year	$0 $25
PRESCRIPTION GLASSES		
Frame	• $200 allowance for a wide selection of frames • $250 allowance for featured frame brands • 20% savings on the amount over your allowance • $110 Costco® frame allowance Every calendar year	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every calendar year	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses Premium progressive lenses Custom progressive lenses • Average savings of 20-25% on other lens enhancements • Every calendar year$	$0 $95 - $105 $150 - $175
Contacts (instead of glasses)	• $200 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every calendar year	Up to $55
Primary EyeCare	• Your VSP doctor can diagnose, treat, and monitor	

Primary EyeCare	conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. • As needed	$15
Basic Plan Coverage with a VSP Provider		
EXTRA SAVINGS		
Glasses and Sunglasses • Extra $50 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

	common eye conditions like pink eye, and more serious conditions like sudden vision loss, glaucoma, diabetic eye disease, and cataracts. • As needed	$15
Plus Plan Coverage with a VSP Provider		
LASER VISIONCARE PREFERRED PROGRAM		
• $2000 allowance both eyes for Custom LASIK, Custom PRK, Bladeless LASIK, LASIK, or PRK • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities Once per lifetime		$0
EXTRA SAVINGS		
• **Glasses and Sunglasses** • Extra $50 to spend on featured frame brands. Go to vsp.com/offers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		

Basic Plan Coverage with a VSP Provider
YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS
Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Exam	up to $40		Lined Trifocal Lenses	up to $70
Frame	up to $70		Progressive Lenses	up to $50
Single Vision Lenses	Up to $30		Contacts	Up to $130
Lined Bifocal Lenses	Up to $50			

Plus Plan Coverage with a VSP Provider
YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS
Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Exam	up to $40		Lined Trifocal Lenses	up to $70
Frame	up to $110		Progressive Lenses	up to $50
Single Vision Lenses	up to $30		Contacts	up to $200
Lined Bifocal Lenses	up to $50		LASIK/PRK	up to $2000

Coverage with a retail chain may be different or not apply. Once your benefit is effective, visit vsp.com for details. VSP guarantees coverage from VSP network providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

*Only available to VSP members with applicable plan benefits. Frame brands and promotions are subject to change. Savings based on doctor's retail price and vary by plan and purchase selection; average savings determined after benefits are applied. Ask your VSP network doctor for more details.

Note: Allowances and out-of-network reimbursement apply to single purchase, no declining balance.

6.15.3 How the Vision Care Benefit Works

Both vision care options are administered by Vision Service Providers (VSP). Vision services are provided through the VSP network, or you may obtain out-of-network care from any licensed Provider.

Payable Benefits
Benefits for frames, lenses, and contact lenses are available per the plan designation after an annual eye exam. Any purchase amount above the plan allowance is to be covered by the member.
For both vision care options, 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.

Note: The Primary Eyecare Program offers you an alternative choice to seeing your VSP network provider for the conditions and symptoms mentioned above. If you prefer, you may seek treatment directly from your medical benefit rather than the Primary Eyecare Program. There is no out-of-network benefit for the Primary Eyecare Program.

Filing a Claim

In-network providers are paid directly for your covered vision services and generally, you do not need to file claim forms for reimbursement for in-network benefits. If you receive services from an out-of-network provider, you must submit a claim within one year of when the expense was incurred to the appropriate claims office listed below. Claims submitted more than one year from the date of service will be denied in full. You must follow these steps when submitting your claim:

- Pay the provider the full amount and request an itemized copy of the bill. The bill should separately detail the charges for the eye exam and materials including lens type.
- Include the following information with the bill:
    - The name, address and phone number of the provider
    - The covered member's ID number (the employee's Intel worldwide ID)
    - The covered member's name, address and phone number
    - The name of the group (Intel)
    - The patient's name, date of birth, address and phone number
    - The patient's relationship to the covered member (such as self, spouse, child, etc....)
- Write the information on the bill or use the printable claim form available when members sign on to vsp.com.
- Send a copy of the itemized bill(s) with the above information to VSP at:
  VSP
  PO Box 385018
  Birmingham, AL 35238-5018

6.16 Claim Administration

Topics

6.16.1 Filing a Claim
6.16.2 Types of Claims and Determination Process
6.16.3 Time Periods for Making Claim Determinations
6.16.4 Non-Claims Communications, Failed Claims
6.16.5 Appointing an Authorized Representative
6.16.6 Notice of Claim Determination
6.16.7 Overpayments

This section describes claim administration for the self-funded options under the Plan (medical, dental and vision) excluding the insured plans, (HMSA, Aetna International, and DHMOs). For claim administration for the insured plans, contact the plan directly. The claim administration for these plan options are also explained in the respective documents which can be requested, free of charge, directly from the plan.

Claims determinations are based only on whether or not benefits are available under the Plan for a proposed treatment or procedure. The determination as to whether the pending health service is necessary and/or appropriate for you is between you and your physician. However, just because you or your physician decides a service is necessary or appropriate does not mean that the service will be paid for by the Plan.

6.16.1 Filing a Claim

If you submit a claim, you must do so within one year of the date the service. **¥**

Filing an In-Network Claim

You are responsible for paying your copayment or coinsurance at the time of service.

In-network providers are paid directly for your covered medical services and generally, you do not need to file claim forms for reimbursement for in-network benefits. However, you may need to file a claim form if you have received emergency or urgent care services while traveling abroad and are seeking in-network benefits. If you receive a bill from a provider for an amount above your copayment or coinsurance, contact your medical plan for direction on what to do with the claim. You must submit a request for payment of benefits within one year of the date the service is provided. Claims filed after one year from the date of service may be denied in full.

Filing an Out-of-Network Claim

You are responsible to pay the full amount due for medical services at the time of service. You must submit a claim form each time you use out-of-network 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 is 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. You are responsible to assure claims are paid, and if a claim is not submitted to your plan 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. See the table below for how to obtain claim forms for the national plans.

If you disagree with how a claim has been paid, see the Appeals Procedures in the Administrative Information chapter of *Pay, Stock and Benefits Handbook*.

¥The federal rules regarding the time period for submitting claims has been extended in response to COVID-19. If you have a claim from 2019 and missed the May 31, 2020 deadline to submit 2019 claims, please contact My Health Benefits to determine whether you can submit them now. Currently, the deadline extension applies through the designated "Outbreak Period," which runs retroactively from March 1, 2020 to 60 days after the as yet-to-be announced end of the COVID-19 National Emergency, *not to exceed one year from March 1, 2020.*

Table: Claim Administrators		
	How to Obtain Claim Forms	**Submitting Claim Forms**
Anthem Blue Cross		
Medical and Mental Health	Call Anthem Blue Cross Customer Services at (800) 811-2711, or go to www.anthem.com/ca	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060
Prescription	Call Express Scripts Customer Service at (800) 899-2713, go to www.Express Scripts.com/	Express Scripts P.O. Box 14711 Lexington, KY 40512
Extra Bucks Reimbursement	Claim forms are available on the Anthem Blue Cross website at www.anthem.com/ca.	Anthem Blue Cross / Qualified Healthcare Expenses P.O. Box 4381, Woodland Hills, CA 91365-4381
Connected Care		
Connected Care Arizona Care Network (Arizona)	Connected Care ACN Customer Service @ 800-974-4517 or www.contectedcarehealth.com/az	Connected Care P.O. Box 419104 St. Louis, MO 63141-9104
Connected Care California	Connected Care CA Customer Service @ 800-971-4153 or https://www.contectedcarehealth.com/ca	Connected Care P.O. Box 419104 St. Louis, MO 63141-9104
	How to Obtain Claim Forms	**Submitting Claim Forms**
Connected Care Presbyterian (New Mexico) Medical, Mental Health, and Prescription claims, and Extra Bucks Reimbursements	Connected Care Customer Service at Presbyterian (505) 923-8000 or 1-855-780-7737 or www.phs.org	Presbyterian Health Plan Attn: Connected Care Claims P.O. Box 27489 Albuquerque, NM 87125-7489
Connected Care Presbyterian (New Mexico) - Extra Bucks Reimbursement	Connected Care Customer Service at Presbyterian (505) 923-8000 or 1-855-780-7737 or www.phs.org	Presbyterian Health Plan Attn: Connected Care Claims P.O. Box 27489 Albuquerque, NM 87125-7489

Connected Care Providence (Oregon) Medical, Mental Health, and Prescription claims	Connected Care Customer Service at Providence (855) 210-1590 www.providenceoregon.org/intel	Providence Health Plan (PHP) P.O. Box 3125 Portland, OR 97208-3125
Connected Care Providence (Oregon) - Extra Bucks Reimbursement	Connected Care Customer Service at Providence (855) 210-1590 www.providenceoregon.org/intel	Providence Health Plan (PHP) P.O. Box 3125 Portland, OR 97208-3125
Connected Care Kaiser (Oregon) Medical, Mental Health, and Prescription claims	Connected Care Customer Service at Kaiser (844) 533-2885 http://my.kp.org/connectedcare	KPIC Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547 Payer ID # 9432
Connected Care Kaiser (Oregon) - Extra Bucks Reimbursement	Connected Care Customer Service at Kaiser (844) 533-2885 http://my.kp.org/connectedcare	KPIC Self-Funded Claims Administrator P.O. Box 30547 Salt Lake City, UT 84130-0547 Payer ID # 9432
HMO		
AETNA US Health Care	1-888-218-0472 (member services)	Aetna Health Administrators P.O. Box 981106 El Paso, TX 79998-1106
Kaiser Permanente	Call Customer Service to request an appeal. No. CA – 800-663-1771 So CA – 800-533-1833	Kaiser Permanente - Appeals 3701 Boardman-Canfield Road Canfield, OH 44406 Or fax: 614-212-7110
Presbyterian	If you need a claim form, please contact the PHP Member Service Department. Claim forms are also available on our website at www.phs.org	Presbyterian Health Plan Attn: Claims P.O. Box 27489 Albuquerque, NM 87125-7489

Dental		
Intel Dental	Customer Service at (800) 765-9470	Delta Dental of California P.O. Box 997330 Sacramento, CA 95899-7330
Vision		
Vision Care	VSP customer service at (855) 663-2836 or www.vsp.com/advantage	VSP P.O. Box 997105 Sacramento, CA 95899-7105
Executive Health Program		
Executive Health Program	Claims should be submitted directly by the provider. For questions, contact Intel Health Benefits Services.	(800) 238-0486

6.16.2 Types of Claims and Determination Process

Any claim for health plan benefits (including Extra Bucks and the Executive Health Program), vision benefits, and dental 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. Extra Bucks claims for reimbursement for vision and dental expenses are post-service claims.

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 authorizations, are outlined in the respective sections for each plan option in this chapter. 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 could not 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 table below.

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.

For Extra Bucks reimbursement, you must submit the claim to the plan for reimbursement. Vision and dental claims for a nonparticipating providers (out-of-network providers) are post-service claims and must be submitted by you within one year from the date of service for claims processing.

6.16.3 Time Periods for Making Claim Determinations¥

The process for reviewing claims will depend on the claim type, as follows:

Table: Time Periods for Making Claim Determinations

	Urgent Care Claims	Pre-service Claims	Post-Service Claims±
General time period for deciding your claim	A decision will be made as soon as possible, taking into account the medical exigencies, but no later than 72 hours after your claim is received.	A decision will be made within a reasonable time, based on your medical circumstances, but no later than 15 days after your claim is received.	A decision will be made within a reasonable time, based on your medical circumstances, but no later than 30 days after your claim is received.
If claims administrator determines that more time is needed to decide your claim due to matters beyond its control	Your claims administrator 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 claims administrator will notify you of the circumstances requiring the extension of time and the date by which it expects to render a decision. The claims administrator may take up to 15 additional days to decide your claim.	Before the end of the initial 30 days, the claims administrator will notify you of the circumstances requiring the extension of time and the date by which it expects to render a decision. The claims administrator may take up to 15 additional days to decide your claim.
If your claims administrator determines that more time is needed to decide your claim because sufficient information was not received to determine whether benefits are covered or payable under the Plan	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 24 hours--without regard to whether all of the	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	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

	Urgent Care Claims	Pre-service Claims	Post-Service Claims±
	requested information is provided. If you request, the claims administrator may, within its sole discretion, provide you more time to submit information.	received, your claim will be decided within 15 days--without regard to whether all of the requested information is provided. If you request, the claims administrator may, within its sole discretion, provide you more time to submit information.	received, your claim will be decided within 15 days--without regard to whether all of the requested information is provided. If you request, the claims administrator may, within its sole discretion, provide you more time to submit information.

± Includes Extra Bucks, out-of-network vision and dental claims, and the Executive Health Program.

¥The federal rules regarding the time period for submitting claims has been extended in response to COVID-19. If you have a claim from 2019 and missed the May 31, 2020 deadline to submit 2019 claims, please contact My Health Benefits to determine whether you can submit them now. Currently, the deadline extension applies through the designated "Outbreak Period," which runs retroactively from March 1, 2020 to 60 days after the as yet-to-be announced end of the COVID-19 National Emergency, *not to exceed one year from March 1, 2020.*

6.16.4 Non-Claims Communications, Failed Claims

Communications that are not Claims for Benefits or are Failed Claims

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

- Questions concerning an individual's eligibility for coverage under the Plan without making a claim for benefits
- Requests for advance information on 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: (1) communicate with your claims administrator; and (2) 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 requests written notification.

Concurrent Care Claims

There may be situations where you are receiving an ongoing course of treatment that has been approved by your 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, your claims administrator will follow one of two time periods 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, your claims administrator 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 claims administrator 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 information on how to file an appeal, review "Appeals" in chapter 3, Administrative Information section, of the *Pay, Stock and Benefits Handbook*.

6.16.5 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 benefit determination. Contact your claims administrator of the Plan option you are enrolled 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--a health care professional with knowledge of your medical condition, such as your treating physician, can act as your authorized representative without going through your 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 claims administrator 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.

6.16.6 Notice of Claim Determination

For pre-service and urgent care claims, the claim administrator for the Plan option you are enrolled 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 claim determination.

Adverse Benefit Determination
An adverse benefit determination generally includes any denial, rescission, reduction, or termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, rescission, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in the plan. However, if benefit is approved by the claims administrator 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 claims administrator 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 benefit determination either in writing or electronically. However, for urgent care claims, you may be initially notified orally of the benefit determination. 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 benefit determinations will include the following information that applies to the determination on your claim:

- The date of service for the claim(s).
- The health care provider.
- The claim amount (if applicable).
- The denial code and its corresponding meaning, and any standards (if applicable) used in denying the 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.
- For a final adverse benefit determination, a discussion of the decision shall be included.
- 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.
- 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 your 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 or you are receiving an ongoing course of treatment.

You may request the diagnosis and treatment codes and the corresponding meanings.

6.16.7 Overpayments

Overpayments must be repaid to the Plan, including when:

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

The refund equals the amount paid in excess of the amount that should have been paid. If the overpayment is due from another person or organization, you will assist in obtaining a refund of the overpayment.

If you or your enrolled spouse or dependent, or any other person or organization that was paid, does not promptly refund the full amount of the overpayment, the Plan may reduce the amount of any future benefits that are payable. The reductions will equal the amount of the overpayment. The Plan may have other rights in addition to the right to reduce future benefits.

6.16. 8 Offsetting

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

6.17 Third-Party Responsibility for Medical Expenses

You, individually and on behalf of your enrolled family member(s), as a condition of receiving any benefits, agree that if a health and welfare 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 family member(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 family member(s) assign to the plan an amount equal to the benefits paid by the plan against any recovery you or your family member(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 Workers' 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 family member(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 family member(s); any attorney's fees or costs incurred by or on behalf of you or your family member(s); or whether or not you or your family member(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 family member(s). Any such decision shall not waive the plan's right to full reimbursement at any other time or grant you or your family member(s), or any other party, any right to such reduction.

6.18 Refund of Overpayments

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

- All or some of the expenses were not paid by the covered person or did not legally have to be paid by the covered person.
- All or some of the payment the Plan made exceeded the benefits under the plan.

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

If the covered person, 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.

6.19 Coordination of Benefits

Overview

Except for HMSA and Aetna International, if you or your dependent(s) are enrolled in this Plan and also have coverage through another medical plan; benefits (i.e., medical and prescription drug claims) will be coordinated based on the rules in this section. One plan will pay benefits first ("primary" plan), and the other plan ("secondary" plan) may pay additional benefits depending on its coordination-of-benefits provision. If this Plan is the primary plan, benefits will be paid without regard to the other plan coverage. When this Plan is the secondary plan, benefits will be limited to the amount normally payable under this Plan as the primary plan, minus the benefits paid under the other plan.

Please contact HMSA and Aetna International directly for information on Coordination of Benefits.

Determining the Primary Plan

Criteria for determining which plan is the primary plan are as follows:

- If the other plan does not have a provision coordinating its benefits with this Plan, then the other plan is always the primary plan.
- Employee and Spouse:
    - This Plan is the primary plan for the active Intel employee and secondary for a dependent that has coverage under this Plan and another plan (such as another employer's plan).
    - If an active Intel employee is also covered under another plan (such as a spouse's plan through another employer), the other plan is secondary for the active Intel employee.
- Children
    - If the children of an Intel employee have coverage under both parents' health plans – this Plan and another plan, the "birthday rule" applies. The birthday rule provides:
        - The plan of the parent whose birthday is earlier in the year (not necessarily the older parent) is considered the primary plan.
    - If both parents have the same birthday, the plan that has been in effect longer is the primary plan. Dependent child of legally separated or divorced parents:
        - If the specific terms of a court decree establish financial responsibility for medical, dental, or other healthcare expenses for children, and the plan covering the parent with such responsibility has actual knowledge of those terms, then the plan of the parent with such responsibility will be primary.
        - In the absence of a court decree, the plan of the parent with sole custody will be primary.
        - In the event of joint custody (and no court decree), the birthday rule will apply.
        - In the event of remarriage of a parent with sole custody, that parent's plan will remain primary, the plan (if any) of the stepparent will be secondary, and the plan of the parent without custody will be third.

- 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 active 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 his or her employer's health plan. You and your spouse are also enrolled in the Anthem HDHP option under this Plan. Your spouse incurs surgical expenses of $1,500. 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 90 percent of the surgery bill or $1,350. The Anthem HDHP in-network surgery benefit is 90 percent after the deductible is met. The Anthem HDHP in-network benefit is reduced by the amount paid by the primary plan:

- Anthem HDHP benefit: $1,350
- Less the benefit paid by the primary plan: $1,350
- Anthem HDHP coordinated benefit: $0 the other plan paid up to the maximum amount that would have been covered by Anthem's.

Continue with the same example but assume that your spouse incurs $1,500 in surgical expenses out-of-network and you have already met your deductible. The Anthem Blue Cross HDHP out-of-network reimburses surgery at 60 percent.

- Anthem HDHP benefit: $900
- Less the benefit paid by the primary plan: $1,350
- Anthem HDHP coordinated benefit: $0

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

Medicare and Children's Health Insurance Program ("CHIP") Coordination

All Intel medical options under the Plan are primary with respect to active employees age 65 and over and their spouses age 65 and over, unless such individuals have elected Medicare as their primary coverage. The Plan options are primary to CHIP. The Plan options are also primary for all active employees and dependents who are under age 65 and eligible for Medicare (except those who are eligible for Medicare due to end stage renal disease (ESRD), in which case the Plan options are only 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, visit: www.ssa.gov/mediinfo.htm or call (800) MEDICARE (633-4227).

How to File Claims if You Have Multiple Coverage

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

You must notify this Plan if you have other coverage. Failure to notify this Plan will result in the denial of claims for your enrolled spouse and/or dependents until you notify your medical plan as to whether or not other coverage is available for your covered dependents.