Dell Inc. Retiree Medical Plan Summary Plan Description (Closed to New Entrants)

January 1, 2023

Retiree Health Benefits

About This Material

This Summary Plan Description (SPD) is provided to describe the Dell Inc. Retiree Medical Plan (the Plan) and how certain life events may affect your participation in this Plan. This SPD, which is incorporated by reference into the Dell Inc. Retiree Medical Plan document, together with the Plan document and other documents incorporated by reference into the Plan, constitute and contain the terms of the Plan. You and your dependents should take the time to read this SPD carefully.

The Plan includes medical, mental health and substance use disorder, and prescription drug benefits.

This SPD also includes a "Life Events" section that describes what to do when you experience various life events, such as marriage, divorce or birth of a child**.**

You can find the definitions for key terms used throughout this SPD in the "Glossary" section.

While it is the intent of Dell to continue the Plan indefinitely, Dell reserves the right to terminate or modify the Plan and any benefits hereunder even if the benefits are negotiated, including retiree and dependent eligibility for the Plan at any time. This SPD is not a contract for employment.

Note: Dell offers a variety of benefits, through various providers. The benefits for which you are eligible and the organizations that provide those benefits vary depending on where you live (for example, California; Massachusetts; Texas; etc.).

Enrolling, Making Changes and Getting Information

If you have questions or need information about the Dell Inc. Retiree Medical Plan, the following resources are available to you.

My Well at Dell

The My Well at Dell benefits portal is the central place to find tools to help you choose and use your benefits wisely and learn about your options. The benefits portal is available directly through the internet, by visiting MyWellatDell.com. You will need your benefits user ID and password to access the site externally. The My Well at Dell benefits portal provides you with the tools you need to:

- Make changes to your coverage due to a qualified status change;
- Access an up-to-date copy of this SPD, and other important Plan-related materials;
- Find answers to questions;
- Chat with a Benefits Representative;
- Connect with your Benefit Pro; and
- Sign up to receive personal action reminders.

On My Well at Dell you can also link to The Provider Search & Pricing Tool, view medical claims history and see up-to-date information on year-to-date deductible and out-of-pocket maximums.

Dell Benefit Pros

It's not always easy to navigate benefits, but you don't have to manage it alone. Your Benefit Pro will be your problem solver, so you can focus on what matters most.

Whenever you're dealing with a complicated benefits or health care issue, your Benefit Pro will lead a team of people working on your behalf to help you:

- Understand how you can make the most of your Dell medical benefits;
- Navigate Dell resources when major life events happen, like preparing for a new child or dealing with a new health diagnosis;
- Eliminate the complexities that come with health care by working on your behalf to:
  - Find high-quality doctors and estimate costs; and
  - Review medical bills and resolve errors.

You can reach out to your Benefit Pro from 7 a.m. to 6 p.m. CT, Monday through Friday. Simply log on to My Well at Dell and click the **Benefit Pro** link on the home page to connect with your Benefit Pro.

Nurse Ally
Nurse Ally is a program that gives you access to an experienced, registered nurse who can provide expertise and guidance when you have questions about your health.

Your Nurse Ally can help you:

- Understand your symptoms
- Decide where to go for care
- Learn more about a diagnosis
- Explore treatment options
- Understand how to take medications safely and effectively
- Work with your doctor to improve your health

You can register online to connect with a Nurse Ally, or contact your Benefit Pro, who will connect you with the right Nurse Ally for your unique situation. Register online at **mymedicalally.alight.com**.

To contact your Benefit Pro, be sure you're logged on to My Well at Dell, and click the **Benefit Pro** link on the home page to connect with your Benefit Pro.

Toll-Free Dell Benefits Center Number

The Dell Benefits Center toll-free number — **1-888-335-5663** — is another way for you to get general benefits information and make changes. **It is important to note that you must have your benefits user ID and password to access your personal account information.** You can change your password on My Well at Dell.

Once logged in, you can view and/or make changes to your benefits user ID and password by going to the **Your Profile** tab and choosing **Log On Information**, where you may also set security questions to quickly access your account on the phone, even if you do not remember your password. When you call **1-888-335-5663**, you may:

- Make changes to your coverage due to an eligible qualified status change; or
- Talk with a Benefits Representative.

Additional Contact Information

Benefit	Contact	Contact Information
Benefit Pros	Dell Benefits Center	1-888-335-5663
Chronic Condition Management Program (Diabetes, Hypertension, Prediabetes and Weight Management)	Livongo	1-800-945-4355 livongo.com/dell
COBRA Administrator	Dell Benefits Center	1-888-335-5663, Outside U.S.: 001-847-883-0936 My Well at Dell
Family Planning, Pregnancy, and Parenting Program	Ovia Health	support@oviahealth.com Download Ovia in the App Store or Google Play
Fertility Program	Progyny	1-833-278-1676
Medical Programs (includes mental health and substance use disorder):		
Aetna PPO, Health Fund and Indemnity	Aetna	1-800-522-6710 aetna.com or aetnaresource.com/n/dell-microsite
Blue Cross Blue Shield of Illinois PPO and Health Fund	Blue Cross Blue Shield of Illinois (BCBSIL)	1-888-907-7925 bcbsil.com/dell
Medicare	Centers for Medicare and Medicaid Services (CMS)	1-800-MEDICARE (633-4227) CMS: cms.gov Medicare: medicare.gov
Expert Medical Opinion	Teladoc Health Medical Experts	1-888-218-0146 Teladoc.com/Dell
Telemedicine/Virtual Visits	Teladoc Health	1-888-218-0146 Teladoc.com/Dell
Nurse Ally	MyWellatDell.com	To speak to a Nurse Ally, you'll first need to contact your Benefit Pro for a quick discussion about your health needs and questions. Then, your Benefit Pro will connect you with a Nurse Ally who's well suited to help with your concerns.
Prescription Drug Programs:		
Aetna PPO, Health Fund and Indemnity and BCBSIL PPO and Health Fund	CVS Caremark	1-855-248-3445 caremark.com

Contents

Plan Participation

Eligibility

Effective January 1, 2018, the Dell Inc. Retiree Medical Plan is closed to new participants. If you retired before January 1, 2018, your eligibility is defined according to the information in this section.

Eligible Retirees

You are eligible to participate in the Dell Inc. Retiree Medical Plan if you:

- Terminated employment with Dell;
- Were enrolled in the Dell Inc. Comprehensive Welfare Benefits Plan immediately before your retirement date from Dell;
- Were age 50 to 65 at the time of termination; and
- Completed at least five continuous years of service with Dell before your termination date.

If you did not enroll when you were initially eligible after retiring from Dell, you cannot enroll in the future. If you lose eligibility for this retiree coverage, you cannot reinstate coverage in the future.

Not Eligible

The following groups are not eligible for coverage:

- Retirees who chose to continue medical coverage through the Dell Inc. Comprehensive Welfare Benefits Plan's COBRA continuation coverage;
- Retirees whose termination was due to the commission of an act of misconduct;
- Individuals who are younger than age 50 or older than age 65 on their Dell termination date; or
- Retirees who are eligible to enroll in Medicare due to age.

Dependent Eligibility
Your dependents who were covered on your Dell medical plan while you were an active team member can continue coverage as a dependent on the Dell Inc. Retiree Medical Plan. In addition, you can add dependents during annual enrollment or if you have a qualified status change.

Dell requires documentation to prove your dependents' relationship or eligibility, either when you enroll or at any time while they are covered under the Plan. Failure to provide such documentation will be considered a failure to properly enroll your eligible dependent and will result in his or her termination of coverage. See the "Dependent Verification" section below for information. Eligible dependents include your:

- Spouse (same-sex or opposite-sex), if you:
    - Are legally married; or
    - Have a common law marriage as defined by applicable state law and you both state you are married on your federal tax return(s).

    Note: Ex-spouses and legally separated spouses are not considered spouses and are therefore not eligible for coverage under the Plan, regardless of any Qualified Domestic Relations Order (QDRO) directive, except where coverage is required by law.

- Domestic partner (same-sex or opposite-sex), if you are properly registered with a state or local government domestic partnership registry, or meet the following requirements:
    - You and your domestic partner both indicate that you have lived together in a relationship where you have been responsible for each other's welfare for at least six consecutive months;
    - You are the sole domestic partner of each other;
    - You are both at least age 18; and
    - You are not legally married to anyone else.
- Children who meet the criteria as eligible children shown below and who:
    - Are under age 26; or
    - Are any age if disabled and meet the Medical Claims Administrator's medical certification requirements (carrier verification and approval are required).

Note: Your dependent is not eligible for coverage if he or she is eligible to enroll in Medicare due to age.

Eligible Children

An eligible child includes your or your spouse's or domestic partner's biological child, foster child or adopted child, including a child placed for adoption, or a child for whom you or your spouse or domestic partner is appointed legal guardian.

If you are divorced or separated, you may still enroll your child if the child is in the legal custody of one or both parents.

In addition to the above, your child may be eligible for health care coverage from the Plan under the terms of a Qualified Medical Child Support Order (QMCSO), even if you do not have legal custody of the child or if any other enrollment restrictions might otherwise apply for the child. If the Plan receives a valid QMCSO and you do not enroll the child, the custodial parent or a state agency may enroll the child.

Federal law requires that a QMCSO meet certain form and content requirements to be valid. If you have any questions or you would like a copy of the written procedures for determining whether a QMCSO is valid, please contact the Dell Benefits Center at 1-888-335-5663.

A grandchild is considered an eligible child if he or she:

- Is living with you;
- Is the biological child of an eligible child who is enrolled in the Plan; and
- Qualifies as your or your spouse's or domestic partner's dependent for federal income tax purposes.

Domestic Partner Status

You may be required to submit a *Certificate of Domestic Partnership* from a state or local government domestic partnership registry or an *Affidavit of Domestic Partner Status*. In addition, certain Dell providers may require additional certification information, and it is your responsibility to submit information to these providers if requested. Information you provide regarding your domestic partnership will be disclosed only to Dell Benefits, financial services and human resources department personnel to implement and administer Dell's benefit plans and arrangements or as otherwise required by law.

Upon termination of the domestic partner relationship, or if a designated domestic partner no longer meets the criteria to qualify as your domestic partner, you must remove him or her and your domestic partner's children, if they are not otherwise eligible for coverage, from your coverage by reporting the life event (qualified status change). See the "Changing Your Election" section for more information.

Note: If you legally marry your domestic partner while he or she is covered under the Plan, you must report the marriage within 31 days. Call the Dell Benefits Center at 1-888-335-5663 to change your dependent from domestic partner to spouse.

Dependent Verification

You must provide proof of eligibility for all newly added dependents, including those added during your initial eligibility period. Documentation is required to prove the dependent's relationship to you and must be submitted within 45 days of adding the dependent to coverage.

Dependents will be initially added to coverage and will remain on coverage through the 45-day substantiation period. If approved documentation is not provided before the deadline, your dependent(s) will be dropped prospectively two weeks from when the Plan Administrator is notified of your failure to provide proof of eligibility.

Newborns will automatically receive medical coverage under the Plan for the first 31 days if you or your spouse is enrolled in a Dell Medical or Retiree Medical Program. You must enroll your newborn within 60 days of birth to continue coverage beyond 31 days. You are required to provide proof of eligibility for a newborn within 45 days of enrolling the newborn. If approved documentation is not provided within this 45-day period, your newborn will be dropped from coverage.

Specific information on the required documentation and substantiation deadline will be mailed to your home address and notification will be sent to your personal email account when a new dependent is added to your coverage. Please allow one to two weeks for this information to arrive.

If Your Spouse, Domestic Partner or Child Works at Dell

If your spouse, domestic partner or child works for Dell, you cannot have duplicate medical coverage. This means that neither you nor they may be enrolled as both a team member or retiree and a dependent for medical coverage. Likewise, if both parents are on a Dell plan individually, their dependent children may only be covered under the medical coverage of one parent. Eligible individuals cannot be covered as both a retiree or team member and a dependent.

For example, suppose your spouse works for Dell after your retirement. You may be covered as a dependent under your spouse's active medical coverage in the Dell Inc. Comprehensive Welfare Benefits Plan, or you could have your own coverage under the Plan. You cannot have both. If you and your spouse have children, and you are covered under the Plan, they may only be covered by one of you, not both. In this situation, your spouse can cover you as a dependent under dental, vision and life insurance.

Keep in mind that if you did not enroll when you were initially eligible or you lose eligibility for retiree coverage in the future, you cannot enroll or be reinstated with coverage. Once coverage under the Plan ends, it cannot be reinstated.

Enrollment

As noted above, the Plan has been frozen, and no new participants are eligible to enroll as of January 1, 2018.

Once you enroll, you will not be able to change your benefit elections until the next annual enrollment, unless you or your dependent experiences a qualified status change. See the “Changing Your Election” section for more information.

Social Security Numbers Needed: When you enroll, you will be required to provide Social Security numbers for yourself and all eligible family members you are enrolling. (For a newborn, if the Social Security number is not available when first enrolled, it may be provided later.)

Coverage Begins

Your coverage begins on:

- The date you become eligible for the Dell Inc. Retiree Medical Plan;
- January 1 following annual enrollment for current retirees making annual enrollment coverage choices; or
- The date of a status change if your coverage changes due to a qualified status change.

You must complete the enrollment process; your coverage will not begin automatically.

Cost of Benefit Coverage

You pay for the cost of your Retiree Medical Plan coverage through payment of monthly premiums.

Your monthly premiums are based on the type of plan and coverage category you elect. Your monthly premium amount is reflected on your invoice. You can also compare your premiums from year to year on My Well at Dell or by calling the Dell Benefits Center at 1-888-335-5663.

Changing Your Election

Generally, once enrolled, your coverage stays in effect for the rest of the plan year (January 1 through December 31) as long as you continue making timely premium payments. However, you can make changes to your coverage during the plan year if you have a qualified status change and report any such change within 31 calendar days of the qualified status change event. Any change in benefit coverage must be consistent with your status change.

Qualified Status Changes

Note: For more information on specific qualified status changes and how they may impact your benefits, refer to the “Life Events” section.

Qualified status changes include:

- Change in the number of dependents; for example, birth, adoption or placement for adoption of a child;
- Marriage, establishment of domestic partnership, divorce, legal separation, annulment of a marriage and termination of a domestic partnership;
- Death of an eligible spouse, domestic partner or dependent child;
- Loss of your dependent's eligibility (for example, a dependent child who no longer meets the Plan's age limitations);
- Changes in your, your spouse's, your domestic partner's or your child's employment status that affect the individual's coverage or eligibility for coverage under the Plan or his or her employer's plan;
- Changes in place of residence that could affect the availability of coverage in the service area;
- Changes in your or your eligible dependent's coverage (including coverage changes under Medicare, Children's Health Insurance Program [CHIP] or another employer plan). This would include changes due to an annual enrollment change, significant change in cost or coverage or significant change in level of benefits;
- You or your eligible dependent becomes entitled to coverage under Medicare or Medicaid, other than coverage consisting solely of benefits under section 1928 of the Social Security Act;
- A significant increase in the cost of health care coverage; and
- Any event that the Benefits Administration Committee determines will constitute a qualified status change and that will permit a change under section 125 of the Internal Revenue Code.

Any benefit change made due to a qualified status change must be reported and elections made within **31 calendar days** of the status change (except that elections must be made within 60 days for medical coverage if the event is the birth of a child, loss of CHIP or Medicaid coverage, or eligibility for a state's premium assistance program under Medicaid or CHIP). Any change will be implemented as soon as administratively possible. If you do not report the status change and make your elections within 31 or 60 calendar days (as applicable), you will not be allowed to make changes to your coverage until the following annual enrollment period, or you experience a separate qualified status change.

Changes Due to a QMCSO

When the Plan receives a Medical Child Support Order (MCSO) or National Medical Support Notice (NMSN), the Dell Benefits Center will provide written notice to you and each of your dependents named in the MCSO or NMSN that it has been received and what the applicable procedures are for administering the order. The Dell Benefits Center will determine, in its sole discretion, if an order meets the requirements for a QMCSO and will notify you and your dependents of its decision. Children who qualify for coverage under the terms of a QMCSO will be treated as any other dependent covered under the Plan.

If you have questions about submitting a QMCSO, please call the Dell Benefits Center at 1-888-335-5663. You can fax your QMCSO order to 1-847-442-0899 or mail it to:

Qualified Order Center
P.O. Box 1542
Lincolnshire, IL 60069-1542

How to Make Changes

All changes must be made within **31 calendar days** (or 60, as applicable) of your qualified status change or event.

In addition, changes can be made during annual enrollment each year. To do so, go to My Well at Dell and click on the E**nrollment** tile. Follow the steps to view/change your elections. Read the instructions carefully, and make your elections.

When Coverage Ends

For Retirees

Coverage under the Plan ends on the earliest of the:

- Date you become eligible for Medicare due to age;
- Date you resume enrollment in the Dell Inc. Comprehensive Welfare Benefits Plan;
- Last day of any period for which you failed to pay any required premium on or before its applicable due date;
- Date you die;
- Date you cease to fulfill any eligibility condition of the Dell Inc. Retiree Medical Plan;
- Date your written election for such retiree coverage terminates or is revoked under the Dell Inc. Retiree Medical Plan;
- Date on which Dell amends the Dell Inc. Retiree Medical Plan to terminate retiree coverage with respect to the class of individuals to which you belong; or
- Date the Dell Inc. Retiree Medical Plan terminates.

For Eligible Dependents

Coverage for your eligible dependents ends under the Plan on the earliest of the:

- Date your dependent becomes eligible for Medicare due to age;
- Date your coverage terminates;
- Date he or she dies;
- Date he or she no longer meets the Plan's definition of an eligible dependent or as otherwise required by law;
- Date you elect to stop coverage for your eligible dependent under the Plan;
- Date on which you fail to pay any required premium for dependent coverage;
- Date on which Dell terminates dependent coverage with respect to all similarly situated covered dependents; or
- Date the Dell Inc. Retiree Medical Plan terminates.

Coverage for dependents who are no longer eligible for the Plan because they turn age 26 will continue through the end of the month of their 26th birthday. For example, if your dependent child turns age 26 on June 15, his or her coverage will end on June 30.

Medicare Overview

Typically, you become eligible for Medicare upon reaching age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker, a dependent widow or have chronic End-Stage Renal Disease (ESRD). You should be aware that even if you do not choose to begin receiving Social Security monthly payments at age 65, you are eligible to apply for Medicare. Since Medicare Part A is ordinarily free, you should apply for it as soon as you are eligible. You will be required to pay a monthly premium for Medicare Part B, and most likely for Parts C and D.

For more information, see the definition of Medicare in the "Glossary" section or visit the Medicare website at http://medicare.gov.

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, you and your dependents who are otherwise eligible may be eligible to temporarily extend group health care coverage under the Plan. The Dell Inc. Retiree Medical Plan is considered a group health plan that is subject to COBRA.

As a former employee of Dell and previously enrolled in the Dell Inc. Comprehensive Welfare Benefits Plan, your retirement and loss of coverage in the Dell Inc. Comprehensive Welfare Benefits Plan qualified as a qualifying event. However, as a requirement for eligibility in the Dell Retiree Medical Plan, you and your covered dependents must have waived your COBRA continuation coverage rights under the Dell Inc. Comprehensive Welfare Benefits Plan. Because this Plan is considered "alternative coverage," there are limited circumstances that qualify as a qualifying event and trigger COBRA continuation coverage under the Dell Inc. Retiree Medical Plan.

Your rights and obligations under the law are summarized below. Separate rules apply to you, as the retiree, and your spouse and dependents. Domestic partners are not eligible for COBRA; however, Dell offers continuation coverage to domestic partners and their children, similar to COBRA coverage. Contact the Dell Benefits Center at 1-888-335-5663 for more information on this coverage.

The information in this section serves as your and your dependents' initial COBRA notice. If you do not understand these rules or the election process, contact the Dell Benefits Center at 1-888-335-5663.

If the Dell Benefits Center receives a notice from you of a qualifying event, as described below, and the Dell Benefits Center determines that you are not entitled to COBRA, the Dell Benefits Center will provide you with a notice explaining why COBRA continuation coverage is not available.

COBRA Qualifying Events

Continued coverage under the Plan can only be purchased as follows:

- **Spouse:** As the covered spouse of a covered retiree, you may elect COBRA continuation coverage for yourself for up to 36 months if:
  - Your covered retiree spouse dies;
  - You and the covered retiree divorce or legally separate; or
  - The covered retiree becomes entitled to coverage under Medicare due to age.

- **Dependent Children:** A covered dependent of a covered retiree may elect COBRA continuation coverage for up to 36 months if the:
    - Covered dependent no longer meets the Plan's definition of an eligible dependent;
    - Covered retiree dies; or
    - Covered retiree becomes entitled to coverage under Medicare due to age.

In addition to the above, if you lose your coverage within one year before or after the Company declares Chapter 11 bankruptcy, this is a qualifying event entitling you and any of your dependents covered under the Plan the day before the event to elect COBRA continuation coverage. In this situation, your coverage may continue until your death. Coverage for your dependents may continue until the earlier of:

- Their death; or
- 36 months after the date of your death.

If you or your dependents purchase COBRA continuation coverage, it will be the same as the coverage lost unless the Plan covering retirees changes. If the Plan changes, those changes will also apply to your COBRA continuation coverage.

Enrolling in COBRA

You or your dependents will only be eligible for COBRA if you or they lose coverage due to a COBRA qualifying event listed in the chart below.

Dell is responsible for notifying the COBRA Administrator — within 30 days of the event — of your covered dependents' right to purchase continued coverage through COBRA following your entitlement to Medicare or your death.

If there is a change in your spouse's or dependent's status because you become divorced or legally separated or your child no longer meets the eligibility requirements, you are responsible for notifying the Plan Administrator within 60 days of the event, at 1-888-335-5663.

Within 14 days after the COBRA Administrator is notified in writing that a COBRA qualifying event has occurred, the COBRA Administrator will notify you and your dependents of your rights to elect COBRA continuation coverage. You then have 60 days from the later of the day the COBRA Administrator mails notice of your COBRA election rights to you or the day your regular coverage ends to return your written COBRA election to the COBRA Administrator.

If you elect to continue coverage, you have 45 days from the date of your election to make your first payment. Once your COBRA continuation coverage begins, payment is due on the date indicated on the monthly billing notice. There is a 30-day grace period from that day; however, if payment is not received within that grace period, your coverage will be terminated.

You do not have to provide evidence of good health to elect COBRA continuation coverage.

Under state insurance law, you may be eligible to enroll in an individual conversion health plan, if otherwise generally available under the Plan and if coverage ends because of the expiration of the 36-month COBRA period. Generally, the Dell health plans do not offer conversion coverage.

If you change your marital status or if you, your spouse and/or your dependent change addresses, notify the COBRA Administrator immediately at 1-888-335-5663.

COBRA Notification Requirement

- Dell is required to provide certain types of COBRA notices: **An Initial Notice.** This SPD serves as your and your dependents' initial COBRA notice.
- **Notice Following a Qualifying Event.** You will receive a COBRA notice within 30 days after you experience a qualifying event.
- **Notice of Unavailability of COBRA Coverage.** If the Dell Benefits Center receives a qualified beneficiary's notice of qualifying event and determines the qualified beneficiary is not entitled to COBRA coverage, the Dell Benefits Center will provide notice within 14 days after being notified of the qualifying event to the qualified beneficiary explaining why COBRA coverage is not available.
- **Notice of Termination of COBRA Coverage.** You will receive a notice notifying you of the termination of your COBRA coverage for any termination of COBRA coverage that takes effect earlier than the end of the maximum period of COBRA coverage applicable to your qualifying event.

Failure to provide timely notice in accordance with this "COBRA Continuation Coverage" section may result in your loss of COBRA continuation coverage.

If you have any questions about COBRA notices, you should contact the Dell Benefits Center at 1-888-335-5663.

You Must Enroll and Pay Required Premium to Receive COBRA Benefits

If you elect continuation coverage, you or your dependents must pay the full cost of coverage (your share plus Dell's share) plus an additional 2% administrative fee. Your contributions are made on an after-tax basis.

The Plan will not pay any benefits for any care or treatment you receive after your termination of coverage date and you will not be enrolled in COBRA coverage until you:

- Call the COBRA Administrator at 1-888-335-5663 and complete the required enrollment procedures (a team member, former team member or parent may call on behalf of a dependent child); and
- Pay your COBRA premium within the period stated in your COBRA notice.

Once you have enrolled and your premium is paid, coverage will begin effective the day after your coverage ended under the Plan. If you do not complete the election procedures within the required period, you will not be eligible to enroll in COBRA at a later date.

Ending COBRA Continuation Coverage

If COBRA continuation coverage ends before the completion of the maximum continuation of coverage period, you will receive a notice of the termination.

Your COBRA continuation coverage will end before completion of the maximum continuation of coverage period for any of the following reasons:

- Dell no longer provides group health coverage;
- You do not pay the premium for your coverage;
- You become entitled to Medicare; or
- You become covered under another group health plan.

For More Information About COBRA

If you have any questions or would like additional information about COBRA, contact the Dell Benefits Center at 1-888-335-5663. In addition, the Department of Labor has a booklet called *Health Benefits under the Consolidated Omnibus Budget Reconciliation Act (COBRA)*. You can request this booklet free of charge by calling 1-866-444-3272. The booklet is also available on the internet at dol.gov.

Alternatives to COBRA Continuation Coverage

There may be other medical coverage options available through the Health Insurance Marketplace, Medicaid or other group health plan coverages (such as a spouse's plan). You should compare your coverage options and choose the coverage that is best for you. You can access the Marketplace for your state and learn more about coverage and available tax credits at healthcare.gov.

You have 60 days from the time you lose your job-based coverage to enroll in the Marketplace. In addition, during a Marketplace open enrollment period, anyone can enroll in Marketplace coverage.

If you sign up for COBRA continuation coverage, there are restrictions on when you can change to Marketplace coverage. If you sign up for Marketplace coverage instead of COBRA continuation coverage, you cannot switch to COBRA continuation coverage.

Medical Program

Overview

The Dell Inc. Retiree Medical Plan offers you the following medical coverage options:

- PPO (Aetna or Blue Cross Blue Shield of Illinois [BCBSIL] depending on where you live);
- Health Fund (Aetna or BCBSIL depending on where you live); or
- Indemnity Plan (Aetna Indemnity if you don't have a PPO or Health Fund network in your area).

If you elect medical coverage through an Aetna or BCBSIL plan, your coverage includes mental health and substance use disorder coverage through Aetna or BCBSIL, prescription drug coverage through CVS Caremark and fertility coverage through Progyny, as described in separate sections. Covered expenses you incur for mental health and substance use disorder treatment apply toward your medical deductible and out-of-pocket maximum, the same as other covered medical expenses. Covered expenses you incur for eligible prescription drug expenses apply toward your overall deductible and out-of-pocket maximum in the Health Fund; they don't apply toward your overall deductible and out-of-pocket maximum in the PPO or the Indemnity Plan.

Medical Program Option Summaries

Each Medical Program option contains additional coverage limitations and exclusions that may limit the benefits provided to you or your dependents. Contact your Medical Claims Administrator directly for specific information on covered services, pre-certification, and exclusions and limitations.

Telemedicine Visits

Dell offers telemedicine (virtual) visits through Teladoc Health to Dell members covered under the Retiree Medical Plan.

Teladoc Health enables you to get the care you need without a trip to the doctor's office. Teladoc Health lets you speak directly with a U.S. board-certified physician over the phone or by video. It doesn't replace your primary care physician, but it's a convenient and affordable option since it's less than you would pay at an urgent care center or an emergency room.

Teladoc Health doctors can diagnose, recommend treatment and prescribe medication (when appropriate) for many non-emergency conditions such as: sinus problems, bronchitis, allergies, cold and flu symptoms, respiratory infections, ear infections and more. **Note:** Teladoc Health providers cannot write prescriptions for controlled substances.

Service	**PPO/Indemnity**	**Health Fund** Members pay the full cost per visit until they've satisfied their deductible, then coinsurance applies
	Cost Per Consult	
General Medical	$10	$49
Global Care (Access to a U.S. provider while traveling outside the U.S.)	$10	$49
Dermatology	$10	$75

For more information about Teladoc Health, call 1-888-218-0146 or visit Teladoc.com/Dell.

Expert Medical Opinion

Dell offers the Expert Medical Opinion program at no cost through Teladoc Health Medical Experts, to help you gain assurance from world-leading medical experts when you or your family members have medical concerns. No matter where you are in your diagnosis or treatment plan, the Expert Medical Opinion program can help you, your covered spouse or domestic partner and dependent children.

Once your case has been reviewed, you'll receive an Expert Medical Opinion report that includes a recommended course of treatment.

To access this program, retirees and their dependents must be enrolled in a Dell U.S. medical plan. Retirees can also initiate an Expert Medical Opinion review for extended family members (this includes parents, in-laws and siblings).

To get an expert second opinion, call 1-888-218-0146 to speak to a physician, or visit Teladoc.com/Dell. Registration is required on the Teladoc Health website before you can begin using services.

Manage Diabetes and Chronic Conditions With Advanced Support

Livongo is a free and confidential diabetes and chronic care management program that gives you access to advanced tools, personalized insights and one-on-one coaching to help you live a better, healthier life.

Whether you're focused on prevention or managing a condition, Livongo has solutions to support you with easy-to use digital tools paired with help from a coach. Here are some features of the program:

- **Diabetes.** Get an advanced blood glucose meter, unlimited strips, personalized tips, 24/7 support for out-of-range readings, and shareable reports. Talk to a Certified Diabetes Educator to discuss blood sugar, nutrition, meal planning and more.
- **High blood pressure.** Take charge of your blood pressure with a connected blood pressure monitor, personalized tips after every reading, shareable reports, and coaching that's tailored to you.

- **Prediabetes, weight management and a healthy lifestyle.** Get a free connected scale that automatically sends data to your Livongo app. Build healthy habits with mini in-app challenges/interactive digital lessons. Connect with a coach to discuss healthy eating, weight loss and more.

Prescription Benefits

Members enrolled in the diabetes management program will receive pharmacy copay waivers and reductions on diabetes medications and supplies when all program requirements are met.

- $0 generic medications and diabetes supplies
- $15 brand medications (30-day supply)
- $40 mail order (90-day supply)

To get your pharmacy discounted medications and supplies, you must complete the following:

- Annual eye exam
- Annual foot exam
- Lipid panel
- Urine protein test
- A1c check (two times per year)
- Five blood glucose checks per month, or activate your CGM with Livongo
- Share your Livongo Health summary report, and create an action plan in your Livongo account.

Results are shared with Livongo through claims data and/or actions in your Livongo account. CVS administers the pharmacy discounts for members who are compliant with the diabetes management program.

Who Can Participate?

Dell retirees and their covered dependents, including spouses/domestic partners and/or child(ren) who are enrolled in the Retiree Medical Plan. Children under age 18 are eligible only for the diabetes management program. Adults 18 and over are eligible for all Livongo programs.

Livongo provides benefits to those who have a diagnosis of prediabetes or diabetes, such as:

- Diabetes mellitus
- Type 1 or Type 2 diabetes
- Prediabetes
- Elevated or high blood sugar
- Hyperglycemia
- Low insulin levels
- Gestational diabetes

For More Information

Visit Livongo or call 1-800-945-4355 and use registration code DELL**.**

Coverage Tiers

When you enroll in the Medical Program, you must also select a coverage tier, indicating which family members will be covered. Your choices are:

- You only;
- You plus your spouse or domestic partner;
- You plus your child(ren); or
- You plus your family.

PPO

The Preferred Provider Organization (PPO) includes the following components:

- **Copay:** For certain covered services, such as doctor's office visit, you pay a copay per visit and then the Plan pays the rest. Copays for medical and mental health and substance use disorder benefits do not apply toward the annual deductible.

- **Annual Deductible:** A deductible is the amount of covered expenses that you and your family pay each calendar year before the Plan's Medical Program begins to pay a percentage of covered expenses that are subject to the deductible.
    - There are separate individual and family deductibles. You are responsible for meeting the individual or family deductible. No one family member can apply more than the individual deductible amount toward meeting the family deductible. However, payments toward the individual deductibles are limited to the family deductible; so once payments toward the individual deductibles for all family members reach the family deductible, individual deductibles for all family members will automatically be satisfied for that year.
    - There are separate in-network and out-of-network deductibles. In-network and out-of-network expenses do not cross apply. That means that amounts you pay for in-network covered expenses apply to the in-network deductibles and amounts you pay for out-of-network covered expenses only apply to the out-of-network deductible.
    - Medical copays, including those for mental health and substance use disorder office visits, do not apply toward the deductible.
    - If you are covered under the Dell PPO, Health Fund or Indemnity Plan and transfer mid-year from one carrier to another, the deductible satisfied can be carried over to your new health plan. Call the number on the back of your One Card or medical ID card for more information.

- **Coinsurance:** Once you or your family meets the annual deductible, the Plan pays a percentage of covered expenses and you pay the rest. The amount the Plan pays varies depending on whether you use in-network or out-of-network providers.

- **Out-of-Pocket Maximum:** The Plan limits the amount you pay out-of-pocket in a calendar year for covered expenses, including mental health and substance use disorder. Once the copay, deductible, and coinsurance amounts you pay for most covered expenses reach the individual or family out-of-pocket maximum, the Plan pays 100% of most covered expenses for that individual or family, as applicable, for the remainder of the year.
    - There are separate individual and family maximums. You are responsible for meeting the individual or family maximum. No one family member can apply more than the individual maximum amount toward meeting the family maximum. However, payments toward the individual maximum are limited to the family maximum; so once payments toward the individual maximum for all family members reach the family maximum, individual maximums for all family members will automatically be satisfied for that year.
    - There are separate in-network and out-of-network maximums. Out-of-network covered expenses do not cross apply. That means that amounts you pay for in-network covered expenses apply to the in-network maximum and amounts you pay for out-of-network covered expenses only apply to the out-of-network maximum.
    - The out-of-pocket maximum includes copays, deductibles and coinsurance amounts you pay for covered expenses. Amounts you pay for non-covered services, pre-certification penalties and charges that exceed the covered charge do not apply toward meeting your maximum.

Note: The PPO Plan includes mental health and substance use disorder benefits. Mental health and substance use disorder benefits are subject to, and apply toward meeting, your PPO Plan deductibles and out-of-pocket maximums. In addition, this option includes prescription drug benefits, provided by CVS Caremark. Prescription drug benefits don't apply toward meeting your medical plan deductibles and out-of-pocket maximums. You have a separate prescription drug out-of-pocket maximum.

Health Fund

The Health Fund is a high-deductible health plan that works like a PPO with in-network and out-of-network providers and includes the following components:

- **Annual Deductible:** A deductible is the amount of covered expenses that you and your family pay each calendar year before the Plan's Medical Program begins to pay a percentage of covered expenses that are subject to the deductible.
    - There are no individual deductibles under family coverage. All covered family members pay toward the family deductible. The family deductible must be met before the plan begins to pay coinsurance.
    - There are separate in-network and out-of-network deductibles. In-network and out-of-network expenses do not cross apply. That means that amounts you pay for in-network covered expenses apply to the in-network deductibles and amounts you pay for out-of-network covered expenses only apply to the out-of-network deductible.

Note: Amounts you pay out of pocket for medical, prescription drug, and mental health and substance use disorder covered expenses apply toward your deductible.

- **Coinsurance:** Once you or your family meets the annual deductible, the Plan pays a percentage of covered expenses and you pay the rest. The amount the Plan pays varies depending on whether you use in-network or out-of-network providers.

- **Out-of-Pocket Maximum:** This is the maximum amount you will pay for covered expenses in a plan year (in addition to any paycheck contributions).
    - There are separate in-network and out-of-network maximums. Out-of-network covered expenses do not cross apply. That means that amounts you pay for in-network covered expenses apply to the in-network maximum and amounts you pay for out-of-network covered expenses only apply to the out-of-network maximum.
    - The out-of-pocket maximum includes deductibles and coinsurance amounts you pay for covered expenses. Amounts you pay for non-covered services, pre-certification penalties and charges that exceed the covered charge do not apply toward meeting your maximum.

    Note: Amounts you pay out of pocket for medical, prescription drug, and mental health and substance use disorder covered expenses apply toward your out-of-pocket maximum.

- **Eligibility for Health Savings Account (HSA):** If you enroll in the Health Fund, you may be eligible to contribute to an HSA. If you would like to contribute to an HSA, you are responsible for working directly with a bank of your choice to open an HSA and set up your contributions.

Note: The Health Fund Plan includes mental health and substance use disorder benefits. Mental health and substance use disorder benefits are subject to, and apply toward meeting, your Health Fund Plan deductibles and out-of-pocket maximums. In addition, this option includes prescription drug benefits, provided by CVS Caremark. Prescription drug benefits also are subject to, and apply toward meeting, your medical plan deductibles and out-of-pocket maximums.

Medical Carriers

There are two national medical carriers—Aetna and Blue Cross Blue Shield of Illinois (BCBSIL). The medical carrier available to you is based on your home ZIP code and the carriers' service areas. Refer to the "Additional Contact Information" chart in the "About This Material" section for information on how to contact your carrier. The chart below shows the states that each carrier covers:

Aetna	**Blue Cross Blue Shield of Illinois (BCBSIL)**
Alaska	Alabama
Arizona	Arkansas
Colorado	California
Connecticut	Idaho
Delaware	Illinois
District of Columbia	Indiana
Florida	Iowa
Georgia	Kentucky
Kansas	Louisiana
Maryland	Massachusetts
Maine	Michigan

Aetna	**Blue Cross Blue Shield of Illinois (BCBSIL)**
Montana	Minnesota
Nebraska	Mississippi
Nevada	Missouri
New Jersey	New Hampshire
New York	New Mexico
North Carolina	North Dakota
Oklahoma	Ohio
Texas	Oregon
Washington	Pennsylvania
West Virginia	Rhode Island
Wisconsin	South Carolina
	South Dakota
	Tennessee
	Utah
	Vermont
	Virginia
	Wyoming

In some remote ZIP codes, neither the PPO or Health Fund network is readily available. In those designated areas, the Aetna Indemnity Plan is the only option offered. Refer to the “Indemnity Plan” section for more information.

Network of Providers

The PPO and Health Fund plans provide benefits through a network of providers. Each time you receive care, it is your decision whether to use an in-network or out-of-network provider. You always have the final say about the providers you and your family use.

When you use an in-network provider (a provider that participates in the network), you pay less because in-network providers have agreed to charge negotiated rates and the Plan pays a higher percentage of covered expenses. In addition, when you use in-network providers, your provider will file claims for you.

When you use out-of-network providers, the Plan pays a lower percentage of the cost of covered expenses; plus the Plan pays based on the covered charge, which is defined as either the recognized charge or eligible expense, depending on your Medical Claims Administrator, as defined in the “Glossary” section. That means that you pay any costs over the covered charge. In addition, while some out-of-network providers may file claims for you, it is your responsibility to file claims. You should contact your Medical Claims Administrator with any questions on how to submit claims for out-of-network expenses.

Check Out The Provider Search & Pricing Tool
The Provider Search & Pricing Tool can help you find great doctors using factors like location, patient reviews and quality ratings.

The tool also estimates the cost of services so you can shop around for the best price.

You’ll select a specialty and the reason you need to see the doctor. If that reason is a procedure, such as an ACL repair, colonoscopy or new-patient office visit, you’ll get a cost estimate for that procedure. If the reason is more diagnostic in nature, such as an illness, pain or an injury, you’ll get a doctor recommendation.

Find it at My Well at Dell **> The Provider Search & Pricing Tool**.

Note: Eligible services will be covered at the in-network rate if no in-network provider is available within 30 miles. You must contact your Medical Claims Administrator for approval before receiving services. However, if you are outside the U.S., coverage is limited to emergency and unexpected care only.

Examples: How the Deductibles and Out-of-Pocket Maximums Work

Chris: Individual coverage under the PPO Plan		
In-Network	**Deductible: $500**	**Out-of-Pocket Maximum: $2,500**
Individual	Once Chris pays $500 of **in-network** covered expenses, the Plan will begin paying 90% of **in-network** covered expenses, until Chris meets the in-network out-of-pocket maximum.	Once Chris pays $2,500 of **in-network** covered expenses (including his $500 in-network deductible), the Plan will pay 100% of most **in-network** covered expenses for the remainder of the year.
Out-of-Network	**Deductible: $1,000**	**Out-of-Pocket Maximum: $5,000**
Individual	Once Chris pays $1,000 of **out-of-network** covered expenses, the Plan will begin paying 60% of **out-of-network** covered expenses, until Chris meets the out-of-network out-of-pocket maximum.	Once Chris pays $5,000 of **out-of-network** covered expenses (including his $1,000 out-of-network deductible), the Plan will pay 100% of most **out-of-network** covered expenses for the remainder of the year.

Pat: Family coverage for himself, his wife and his daughter under the PPO Plan		
In-Network	**Deductible:** **$500 per person; $1,000 family maximum**	**Out-of-Pocket Maximum:** **$2,500 per person; $5,000 family maximum**
Individual	Once Pat, his wife or his daughter pays $500 of **in-network** covered expenses, the Plan will begin paying 90% of **in-network** covered expenses for that individual until he or she meets the in-network out-of-pocket maximum.	Once Pat, his wife or his daughter pays $2,500 of **in-network** covered expenses (including his or her $500 in-network deductible), the Plan will pay 100% of most **in-network** covered expenses for him or her for the remainder of the year.
Family	Once Pat, his wife and his daughter **combined** pay $1,000 of **in-network** covered expenses, the Plan will begin paying 90% of **in-network** covered expenses for the entire family. No more than $500 from any one individual may be used toward meeting the family deductible. For example: ▪ Both Pat and his wife could pay $500 toward meeting the family deductible; or ▪ Pat could pay $450, his wife $300 and his daughter $250. Since the total amount of covered expenses paid is $1,000, Pat's family has met the family deductible even though no one individual has met	Once Pat, his wife and his daughter **combined** pay $5,000 of **in-network** covered expenses (including the $1,000 in-network deductible), the Plan pays 100% of most **in-network** covered expenses for the entire family for the remainder of the year. No more than $2,500 from any one individual may be used toward meeting the family maximum. For example: ▪ Both Pat and his wife could pay $2,500 toward meeting the family maximum; or ▪ Pat could pay $2,400, his wife $2,000 and his daughter $600. Since the total amount of covered expenses paid is $5,000, Pat's family has met the family maximum even though no one individual has

Pat: Family coverage for himself, his wife and his daughter under the PPO Plan		
	their individual in-network deductible.	met their individual in-network maximum.
Out-of-Network	**Deductible:** **$1,000 per person; $2,000 family maximum**	**Out-of-Pocket Maximum:** **$5,000 per person; $10,000 family maximum**
Individual	Once Pat, his wife or his daughter pays $1,000 of **out-of-network** covered expenses, the Plan will begin paying 60% of **out-of-network** covered expenses for that individual until he or she meets the out-of-network out-of-pocket maximum.	Once Pat, his wife or his daughter pays $5,000 of **out-of-network** covered expenses (including his or her $1,000 out-of-network deductible), the Plan will pay 100% of most **out-of-network** covered expenses for him or her for the remainder of the year.
Family	Once Pat, his wife and his daughter **combined** pay $2,000 of **out-of-network** covered expenses, they will begin paying 60% of **out-of-network** covered expenses for the entire family. No more than $1,000 from any one individual may be used toward meeting the family deductible. For example: ▪ Both Pat and his wife could pay $1,000 toward meeting the family deductible; or ▪ Pat could pay $800, his wife $900 and his daughter $300. Since the total amount of covered expenses paid is $2,000, Pat's family has met the family deductible even though no one individual has met their individual out-of-network deductible.	Once Pat, his wife and his daughter **combined** pay $10,000 of **out-of-network** covered expenses (including the $2,000 out-of-network deductible), the Plan pays 100% of most **out-of-network** covered expenses for the entire family for the remainder of the year. No more than $5,000 from any one individual may be used toward meeting the family maximum. For example: ▪ Both Pat and his wife could pay $5,000 toward meeting the family maximum; or ▪ Pat could pay $3,000, his wife $4,500 and his daughter $2,500. Since the total amount of covered expenses paid is $10,000, Pat's family has met the family maximum even though no one individual has met their individual out-of-network maximum.

Ann: Individual coverage under the Health Fund Plan		
In-Network	**Deductible: $1,500**	**Out-of-Pocket Maximum: $3,500**
Individual	Once Ann pays $1,500 of **in-network** covered expenses, the Plan will begin paying 85% of **in-network** covered expenses, until Ann meets the in-network out-of-pocket maximum.	Once Ann pays $3,500 of **in-network** covered expenses (including her $1,500 in-network deductible), the Plan will pay 100% of most **in-network** covered expenses for the remainder of the year.

Out-of-Network	Deductible: $3,000	Out-of-Pocket Maximum: $7,000
Individual	Once Ann pays $3,000 of **out-of-network** covered expenses, the Plan will begin paying 60% of **out-of-network** covered expenses, until Ann meets the out-of-network **out-of-pocket** maximum.	Once Ann pays $7,000 of **out-of-network** covered expenses (including her $3,000 out-of-network deductible), the Plan will pay 100% of most **out-of-network** covered expenses for the remainder of the year.

Ann: Family coverage for herself, her husband and her daughter under the Health Fund Plan		
In-Network	**Deductible:** **$3,000 per family**	**Out-of-Pocket Maximum:** **$7,000 per family**
Individual	There are no individual deductibles under family coverage.	There is no individual out-of-pocket maximum under family coverage.
Family	Once Ann, her husband and daughter pay $3,000 of combined **in-network** covered expenses, the Plan will begin paying 85% of **in-network** covered expenses for all covered family members until the in-network out-of-pocket maximum is met.	Once Ann, her husband and daughter pay $7,000 of combined **in-network** covered expenses, the Plan pays 100% of most **in-network** covered expenses for the entire family for the remainder of the year.
Out-of-Network	**Deductible:** **$6,000 per family**	**Out-of-Pocket Maximum:** **$14,000 per family**
Individual	There are no individual deductibles under family coverage.	There is no individual out-of-pocket maximum under family coverage.
Family	Once Ann, her husband and daughter pay $6,000 of combined **out-of-network** covered expenses, the Plan will begin paying 60% of **out-of-network** covered expenses for all covered family members until the out-of-network out-of-pocket maximum is met.	Once Ann, her husband and daughter pay $14,000 of combined **out-of-network** covered expenses, the Plan pays 100% of most **out-of-network** covered expenses for the entire family for the remainder of the year.

Indemnity Plan

If you do not have a PPO or Health Fund network available where you live, you can elect coverage under the Aetna Indemnity Plan. The Indemnity Plan covers the same expenses as the PPO and Health Fund plans, but works like a traditional insurance plan. You must meet an annual deductible (except in the case of preventive care), and then you and the Plan share in the cost of covered services and supplies through coinsurance.

The Indemnity Plan allows you go to any qualified provider and receive the same level of benefits. However, there are advantages to using Aetna's National Advantage Program (NAP).

Doctors and hospitals that participate in this program charge at discounted rates. These discounted rates mean your coinsurance and other costs are based on a lower rate. This can mean **savings for you**.

NAP providers have agreed to accept the Aetna determined recognized charge and/or negotiated rates for covered services. You will not be billed for costs that exceed the agreed amount.

If you use a non-NAP provider and the amount charged exceeds the amount allowed under the Indemnity Plan, the non-NAP provider can bill you for the excess amount and you are responsible for payment.

To identify providers in the NAP network, use the DocFind tool at aetnaresource.com/n/dell-microsite. Start a "New Search" and choose "National Advantage Program – Indemnity Plan," or call 1-800-522-6710.

Note: The Indemnity Plan option includes mental health and substance use disorder benefits. Mental health and substance use disorder benefits are subject to, and apply toward meeting, your Indemnity Plan's deductibles and out-of-pocket maximums.

Here's how the Indemnity Plan works. Each year between January 1 and December 31, the Plan pays benefits as follows:

- **Deductible:** A deductible is the amount of covered expenses that you and your family pay each calendar year before the Plan's Medical Program begins to pay a percentage of covered expenses.
    - There are separate individual and family deductibles. You are responsible for meeting the individual or family deductible.
    - No one family member can apply more than the individual deductible amount toward meeting the family deductible. However, payments toward the individual deductibles are limited to the family deductible; so once payments toward the individual deductibles for all family members reach the family deductible, individual deductibles for all family members will automatically be satisfied for that year.
    - If you are covered on the Dell PPO, Health Fund or Indemnity Plan and transfer mid-year from one carrier to another, the deductible satisfied can be carried over to your new health plan. Call the number on the back of your One Card or medical ID card for more information.
- **Coinsurance:** Once you or your family meets the annual deductible, the Plan pays a percentage of covered expenses and you pay the rest, as shown in the chart under "Indemnity Plan Benefit Summary."
- **Out-of-Pocket Maximum:** The Plan limits the amount you pay out-of-pocket in a calendar year for covered expenses, including mental health and substance use disorder benefits. Once the coinsurance amounts you pay for most covered expenses reach the individual or family out-of-pocket maximum, the Plan pays 100% of most covered expenses for that individual or family, as applicable, for the remainder of the year.
    - There are separate individual and family maximums. You are responsible for meeting either the individual or family maximum.
    - No one family member can apply more than the individual maximum amount toward meeting the family maximum. However, payments toward the individual maximum are limited to the family maximum; so once payments toward the individual maximum for all family members reach the family maximum, individual maximums for all family members will automatically be satisfied for that year.
    - The out-of-pocket maximum includes deductibles and coinsurance amounts you pay for covered expenses. Amounts you pay for non-covered services, pre-certification penalties and charges that exceed the covered charge do not apply toward meeting your maximum.
- **Benefit Maximums:** The Plan pays certain covered expenses up to specific limits, as shown in the chart under "Indemnity Plan Benefit Summary." There is no overall lifetime maximum amount the Plan will pay (except as described for Fertility/Infertility Services, i.e., Progyny Smart Cycle limits).

The deductibles and out-of-pocket maximums do not apply to every covered service, as shown in the "Indemnity Plan Benefit Summary." Some expenses may be covered differently or are subject to benefit maximums.

Examples: How the Deductibles and Out-of-Pocket Maximums Work

Kelly: Individual coverage under the Indemnity Plan		
	Deductible: $500	**Out-of-Pocket Maximum: $2,500**
Individual	Once Kelly pays $500 of covered expenses, the Plan will begin paying 90% of covered expenses, until Kelly meets the out-of-pocket maximum.	Once Kelly pays $2,500 of covered expenses (including the $500 deductible), the Plan will pay 100% of most covered expenses for the remainder of the year.

Tim: Family coverage for himself, his wife and his daughter under the Indemnity Plan		
	Deductible: **$500 per person; $1,000 family maximum**	**Out-of-Pocket Maximum:** **$2,500 per person; $5,000 family maximum**
Individual	Once Tim, his wife or his daughter pays $500 of covered expenses, the Plan will begin paying 90% of covered expenses for that individual until he or she meets the out-of-pocket maximum.	Once Tim, his wife or his daughter pays $2,500 of covered expenses (including his or her $500 deductible), the Plan will pay 100% of most covered expenses for him or her for the remainder of the year.
Family	Once Tim, his wife and his daughter **combined** pay $1,000 of covered expenses, the Plan will begin paying 90% of covered expenses for the entire family. No more than $500 from any one individual may be used toward meeting the family deductible. For example: ▪ Both Tim and his wife may pay $500 toward meeting the family deductible; or ▪ Tim could pay $450, his wife $350 and his daughter $200. Since the total amount of covered expenses paid is $1,000, Tim's family has met the family deductible even though no one individual has met their individual deductible.	Once Tim, his wife and his daughter **combined** pay $5,000 of covered expenses (including the $1,000 deductible), the Plan pays 100% of most covered expenses for the entire family for the remainder of the year. No more than $2,500 from any one individual may be used toward meeting the family maximum. For example: ▪ Both Tim and his wife may pay $2,500 toward meeting the family maximum; or ▪ Tim could pay $1,600, his wife $1,900 and his daughter $1,500. Since the total amount of covered expenses paid is $5,000, Tim's family has met the family maximum even though no one individual has met their individual maximum.

PPO, Health Fund and Indemnity Plan Pre-Certification

See the “Medical Programs’ Compliance” section for additional information relating to the emergency services and pre-certification.

Pre-certification may be necessary to obtain certain in-network and out-of-network benefits, and to avoid penalties. You should carefully review this summary and contact the Medical Claims Administrator directly to verify when pre-certification is required and how to request it.

Certain services, including surgeries, will always require pre-certification. You or your provider must contact your Medical Claims Administrator before you receive the service to request pre-certification.

Pre-certification for non-emergency admissions and outpatient non-emergency medical services for Aetna members must be done 14 days prior to the inpatient confinement or scheduled date to receive the services, or as soon as is reasonably possible for an inpatient admission following receipt of emergency services. Generally, within 48 hours or on the day of admission, if reasonably possible, is considered as soon as reasonably possible. For an urgent admission, pre-certification must be done before you are scheduled to be admitted. For BCBSIL members, report any emergency room admissions within 24 hours and non-emergency admissions with 48 hours.

In general, in-network providers are responsible for notifying the Medical Claims Administrator to obtain pre-certification before they provide these services to you. However, you are responsible for obtaining pre-certification for these services if you receive the services from an out-of-network provider. You should confirm with your Medical Claims Administrator that these services have been pre-certified as required. Additionally, before receiving these services from an in-network provider, you may want to contact the Medical Claims Administrator to verify that the in-network provider has notified the Medical Claims Administrator to obtain the required pre-certification. The pre-certification phone number is on the back of your One Card or medical ID card.

If pre-certification is not requested when required, the claim for the service will be denied if the provider is out-of-network or the Medical Claims Administrator determines that the service is not covered. If the Medical Claims Administrator does not pre-certify a service because the service is not considered to be medically necessary or otherwise not a covered service when pre-certification was requested, and you choose to receive the non-covered service, you are responsible for payment and a provider may bill you for the service and there will be no benefit paid under the Plan. For Aetna, if you do not pre-certify, a $500 benefit reduction will be applied separately to each type of eligible health service. The $500 benefit reduction does not apply to members enrolled in the Indemnity Plan.

Services that may require pre-certification include, but are not limited to:

- Cardiac rhythm implantable devices;
- Clinical trials/cancer clinical trials;
- Congenital heart disease surgery;
- Outpatient dialysis services;
- Durable medical equipment and prosthetic devices that meets certain criteria as defined by the Medical Claims Administrator;
- Genetic testing—BRCA;
- Home health care (for BCBSIL members);
- Hospice care;
- Inpatient admissions, including those resulting from emergency health services;

- Lab, X-ray and major diagnostics—CT, PET scans, MRI, MRA and nuclear medicine;
- Limb prosthetics;
- Manipulative treatment as described under “Rehabilitation and Habilitation Services” in the “PPO, Health Fund and Indemnity Plan Covered Expenses” section;
- Maternity care;
- Medically necessary cosmetic and reconstructive surgery;
- Non-emergency transportation by fixed-wing airplane;
- Obesity surgery;
- Orthognathic surgery procedures, bone grafts, osteotomies and surgical management of the temporomandibular joint;
- Reconstructive procedures;
- Skilled nursing and inpatient rehabilitation services;
- Sleep studies (Polysomnography);
- Surgery—diagnostic catheterization and electrophysiology implant and sleep apnea;
- Surgery Outpatient—cardiac catheterization, pacemaker insertion, implantable cardioverter defibrillators;
- Therapeutics—outpatient dialysis treatments, intensity modulated radiation therapy and MR-guided focused ultrasound;
- Transgender services; and
- Transplant procedures.

See the “Mental Health and Substance Use Disorder Pre-Certification and Notification” section for mental health and substance use disorder services that require pre-certification.

Note: Under the Indemnity Plan, only hospital services need to be pre-certified. Contact your Medical Claims Administrator for medical and mental health and substance use disorder pre-certification requirements.

Non-Notification Penalty: If you are in the PPO or Health Fund Plan, and you use an out-of-network provider and you do not notify your Medical Claims Administrator when required, you will have to pay a $500 non-notification penalty (which does not apply toward your deductible or out-of-pocket maximum) or your claim may be denied in its entirety.

Once you request pre-certification, you may receive information on other services that may be available to you such as:

- Disease management programs;
- Health education;
- Pre-admission counseling; and
- Patient advocacy.

Benefit Summary Charts

The following benefit summary charts are intended as an overview only and all benefits described therein are subject to the medically necessary requirement. More information or a complete list of covered expenses can be obtained by contacting your Medical Claims Administrator directly. Additional information can also be found in the “PPO, Health Fund and Indemnity Plan Covered Expenses” and “PPO, Health Fund and Indemnity Plan Exclusions and Limitations” sections. In addition, refer to the “Medical Programs’ Compliance” section for additional information regarding emergency services.

The Dell Medical Program will only cover services and supplies that are medically necessary, as defined in the “Glossary” section.

The following chart applies to both Aetna and BCBSIL; any differences between carriers are noted in the chart. All out-of-network provider charges are paid based on the covered charge, which is referred to as recognized charge or eligible expense, depending on your Medical Claims Administrator, as defined in the “Glossary” section. If you receive services from an out-of-network provider, you are responsible for submitting a claim for reimbursement. Additionally, the out-of-network provider will balance bill you for any amount above the covered charge.

PPO and Health Fund Benefit Summary

	PPO		**Health Fund**	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Plan Facts				
Annual Deductible	$500 individual $1,000 family	$1,000 individual $2,000 family	$1,500 individual $3,000 family	$3,000 individual $6,000 family
Hospital Admission Deductible	Plan deductible	Plan deductible, then $200 copay per confinement (Aetna waives this copay for newborn hospital charges) and 60% of covered charge	Plan deductible	Plan deductible, then 60% of covered charge after deductible
Primary Care Office Visits	$20 copay per visit (copay does not apply to deductible; copay applies to the out-of-pocket maximum)	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible
Specialist Office Visits	$50 copay per visit (copay does not apply to deductible; copay applies to the out-of-pocket maximum)	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible
Coinsurance (Plan Pays)	90% after deductible (unless noted otherwise)	60% of covered charge after deductible (unless noted otherwise)	85% after deductible (unless noted otherwise)	60% of covered charge after deductible (unless noted otherwise)

	PPO		Health Fund	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Annual Out-of-Pocket Maximum (covered in-network expenses, including copays in the PPO Plan, count toward the in-network out-of-pocket maximum, and covered out-of-network expenses count toward the out-of-network out-of-pocket maximum)	$2,500 individual $5,000 family	$5,000 individual $10,000 family	$3,500 individual $7,000 family	$7,000 individual $14,000 family
Lifetime Maximum[1]	Unlimited	Unlimited	Unlimited	Unlimited
Family Planning				
Female Contraceptive Counseling Services	***Office Visits:*** 100% covered per visit	60% after deductible	***Office Visits:*** 100% covered per visit	60% after deductible
Female Contraceptive Counseling Services Visit Limit	100% for 2 visits per year; applicable physician/specialist cost share thereafter.	Contact your health plan for visit limits.	100% for 2 visits per year; applicable physician/specialist cost share thereafter.	Contact your health plan for visit limits.
Female Tubal Ligation	100%, no deductible (reversal not covered)	60% after deductible	100%, no deductible (reversal not covered)	60% after deductible
Fertility/Infertility Services	Member cost share will align to your selected medical plan. See the "Progyny Fertility Program" section for additional information.	Not covered	Member cost share will align to your selected medical plan. See the "Progyny Fertility Program" section for additional information.	Not covered
Fertility/Infertility Limit	Two Smart Cycles per lifetime per family	Not covered	Two Smart Cycles per lifetime per family	Not covered
Male Vasectomy	***Primary Care Office Visit:*** $20 copay	60% of covered charge after deductible (reversal not covered)	85% after deductible (reversal not covered)	60% of covered charge after deductible (reversal not covered)

[1] A lifetime maximum applies for Fertility services.

	PPO		Health Fund	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	Specialist Office Visit: $50 copay (as applicable) ***Outpatient Facility:*** 90% after deductible (reversal not covered)			
Hospital Services				
Inpatient Hospital Visits	90% after deductible	Plan deductible, then $200 copay per confinement and 60% of covered charge	85% after deductible	60% of covered charge after deductible
Inpatient Surgeon	90% after deductible	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible
Emergency Services				
Ambulance Services	90% after deductible	90% of covered charge after deductible	85% after deductible	85% of covered charge after deductible
Emergency Room	90% after deductible	90% after deductible	85% after deductible	85% after deductible
Emergency Room Detail	See “Emergency Health Services” in the “PPO, Health Fund and Indemnity Plan Covered Expenses” section.	See “Emergency Health Services” in the “PPO, Health Fund and Indemnity Plan Covered Expenses” section.	See “Emergency Health Services” in the “PPO, Health Fund and Indemnity Plan Covered Expenses” section.	See “Emergency Health Services” in the “PPO, Health Fund and Indemnity Plan Covered Expenses” section.
Urgent Care Center	$50 copay per visit	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible
Maternity Care				
Birthing Centers	90% after deductible	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible

	PPO		Health Fund	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Birthing Centers Limitation	Center must be licensed and certified; services must be supervised by a contracted OB-GYN	Center must be licensed and certified; services must be supervised by a contracted OB-GYN	Center must be licensed and certified; services must be supervised by a contracted OB-GYN	Center must be licensed and certified; services must be supervised by a contracted OB-GYN
Midwives	$20 copay; midwife charges are reimbursed as part of the global maternity benefit. After the first office visit copay is paid, no other office visit copay would be required.	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible
Midwives Limitation	Must be licensed and certified nurse-midwives practicing in an accredited hospital or birthing center	Must be licensed and certified nurse-midwives practicing in an accredited hospital or birthing center	Must be licensed and certified nurse-midwives practicing in an accredited hospital or birthing center	Must be licensed and certified nurse-midwives practicing in an accredited hospital or birthing center
Mother—Facility Services	90% after deductible	Plan deductible, then $200 copay per confinement and 60% of covered charge	85% after deductible	60% of covered charge after deductible
Mother—Physician Services (including pre-natal and post-natal care) *Cost sharing does not apply for preventive services	**Office Visits*:** $20 copay **Physician Services:** 90% after deductible	60% of covered charge after deductible	**Office Visits*:** 85% after deductible **Physician Services:** 85% after deductible	60% of covered charge after deductible
Newborn Services	90% after deductible	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible
Comprehensive Lactation Support and Counseling Services	***Lactation Counseling Services Facility or Office Visits:*** 100% per visit. No copay or deductible applies.	Not covered	***Lactation Counseling Services Facility or Office Visits:*** 100% per visit. No copay or deductible applies.	Not covered

	PPO		Health Fund	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Other Services				
Acupuncture	100%, no deductible (after $50 copay)	Not covered	85% of covered charge after deductible	Not covered
Acupuncture Limit	25 visits per calendar year	Not covered	25 visits per calendar year	Not covered
Allergy Tests, Treatment and Injections	**In Conjunction with Office Visit** ***Primary Care Office Visit*** $20 copay ***Specialist Office Visit:*** $50 copay (as applicable) ***Otherwise;*** Allergy shots and vials in an office setting will be paid at 100%, if no office visit charge is made. ***Independent Lab:*** 90% after deductible	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible
Clinical Trials/Cancer Clinical Trials	90% after deductible	Plan deductible, then $200 copay per confinement and 60% of covered charge	85% after deductible	60% of covered charge after deductible
Chiropractic/Spinal Manipulation	***Office Visit:*** $20 copay ***Outpatient Facility:*** 90% after deductible	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible
Chiropractic/Spinal Manipulation Limit	25 visits per calendar year, combined in- and out-of-network	25 visits per calendar year, combined in- and out-of-network	25 visits per calendar year, combined in- and out-of-network	25 visits per calendar year, combined in- and out-of-network
Diabetes Treatment	***Primary Care Office Visit*** $20 copay ***Specialist Office Visit:*** $50 copay (as applicable) ***Otherwise;*** 90% after deductible	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible

	PPO		Health Fund	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Durable Medical Equipment (DME)	90% after deductible Breast-feeding equipment: 100%, no deductible	60% of covered charge after deductible Breast-feeding equipment: Not covered	85% after deductible Breast-feeding equipment: 100%, no deductible	60% of covered charge after deductible Breast-feeding equipment: Not covered
Hearing Aids	90% after deductible	60% after deductible	85% after deductible	60% after deductible
Hearing Aid Limit	$5,000 maximum per year	$5,000 maximum per year	$5,000 maximum per year	$5,000 maximum per year
Hearing Exam/Screening (Routine) (newborn hearing screening covered under preventive care)	***Primary Care Office Visit:*** $20 copay ***Specialists Office Visit:*** $50 copay (as applicable)	60% of covered charge after deductible	85% after deductible	60% after deductible
Hearing Exam Limit	1 visit each calendar year	1 visit each calendar year	1 visit each calendar year	1 visit each calendar year
Home Health Care	90% after deductible	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible
Home Health Care Limit	100 visits combined in- and out-of-network per calendar year			
Hospice Care	90% after deductible	Plan deductible, then $200 copay per confinement and 60% of covered charge	85% after deductible	60% of covered charge after deductible
Hospice Care Limit	Contact your health plan for information on coverage limits.			
Obesity Surgery	90% after deductible	Not covered	85% after deductible	Not covered
Obesity Surgery Limitations	One surgical procedure per lifetime Pre-certification required Only covered at designated facility	Not covered	One surgical procedure per lifetime Pre-certification required Only covered at designated facility	Not covered

	PPO		Health Fund	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Occupational Therapy	***Office Visit:*** $20 copay ***Outpatient Facility:*** 90% after deductible	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible
Occupational Therapy Limit (Limit does not apply to visits for autism/mental health diagnosis)	120 visits combined in- and out-of-network per calendar year; subject to additional review and approval by the Medical Claims Administrator after 25 visits			
Physical Therapy	***Office Visit:*** $20 copay ***Outpatient Facility:*** 90% after deductible	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible
Physical Therapy Limit (Limit does not apply to visits for autism/mental health diagnosis)	120 visits combined in- and out-of-network per calendar year; subject to additional review and approval by the Medical Claims Administrator after 25 visits			
Private Duty Nursing	Not covered	Not covered	Not covered	Not covered
Skilled Nursing Facility	90% after deductible	Plan deductible, then $200 copay per confinement and 60% of covered charge	85% after deductible	60% of covered charge after deductible
Skilled Nursing Facility Limit	100 days combined in- and out-of-network per calendar year; includes inpatient convalescent and rehabilitation centers and facilities			
Speech Therapy	***Office Visit:*** $20 copay ***Outpatient Facility:*** 90% after deductible	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible
Speech Therapy Limit (Limit does not apply to visits for autism/mental health diagnosis)	120 visits combined in- and out-of-network per calendar year; subject to additional review and approval by the Medical Claims Administrator after 25 visits			

	PPO		Health Fund	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Transgender Surgery	90% after deductible	Plan deductible, then $200 copay per confinement and 60% of covered charge	85% after deductible	60% of covered charge after deductible
Transgender Surgery Detail	Pre-certification required for Aetna members. Pre-certification and pre-determination review required for BCBSIL members; must meet medical necessity before services are rendered; reversal of gender reassignment surgery is not covered.			
Transplants	***Primary Care Office Visit (pre- and post-surgery office visits):*** $20 copay ***Specialist Office Visit (pre- and post-surgery office visits):*** $50 copay (as applicable) ***Outpatient Facility (actual surgery):*** 90% after deductible	Not covered	85% after deductible	Not covered
Transplants Detail	Pre-certification required; only covered at a designated facility	Not covered	Pre-certification required; only covered at a designated facility	Not covered
Vision Exam/Screening (Routine) as Part of Health Care Reform	100% preventive exam (as part of wellness exam); 90% after deductible for injury or illness	Not covered (60% after deductible for injury or illness)	100% preventive exam (as part of wellness exam); 85% after deductible for injury or illness	Not covered (60% after deductible for injury or illness)
Vision Exam (applies to children under age 5)	Limited to 1 preventive visit per calendar year (no limit if due to injury or illness)	60% after deductible	Limited to 1 preventive visit per calendar year (no limit if due to injury or illness)	60% after deductible
Outpatient Care				
Outpatient Surgery	90% after deductible	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible
MRI, CT Scans and Laboratory Services	***Preventive:*** 100%*, no deductible	***Preventive:*** Not covered	***Preventive:*** 100%*, no deductible	***Preventive:*** Not covered

	PPO		Health Fund	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	Diagnostic: 90% after deductible for imaging, lab, X-ray at independent freestanding facilities; 70% after deductible for lab, CT scan, MRI's at hospitals or hospital-affiliated outpatient facilities ***Complex imaging services that take place in an office setting:*** 90%, after deductible	60% of covered charge after deductible	***Diagnostic:*** 85% after deductible for imaging, lab, X-ray at independent freestanding facilities; 70% after deductible for lab, CT scan, MRI's at hospitals or hospital-affiliated outpatient facilities ***Complex imaging services that take place in an office setting:*** 85%, after deductible	60% of covered charge after deductible
Diagnostic X-Ray, PET Scans and Other Nuclear Imaging Services	***Preventive:*** 100%*, no deductible ***Diagnostic:*** 90% after deductible	***Preventive:*** Not covered 60% of covered charge after deductible	***Preventive:*** 100%*, no deductible ***Diagnostic:*** 85% after deductible	***Preventive:*** Not covered 60% of covered charge after deductible
Walk-In Clinics Non-Emergency Visit	$20 visit copay, then the Plan pays 100%; no calendar year deductible applies	60% of covered charge per visit after deductible	85% after deductible	60% of covered charge per visit after deductible
*Call the number on the back of your One Card or medical ID card if you have a question on whether a specific service is considered preventive care.				
Preventive Care				
Preventive care is covered at 100%, with no deductible, when you use in-network providers. Preventive care is subject to the age and/or gender guidelines of the United States Preventive Services Task Force (USPSTF) and other organizations and agencies. Contact your health plan if you have a question on whether a specific service is considered preventive care.				
Annual Adult Physical Exam	100%, no deductible	Not covered	100%, no deductible	Not covered
Annual Well-Woman Exam	100%, no deductible	Not covered	100%, no deductible	Not covered
Cancer Screenings	100%, no deductible	Not covered	100%, no deductible	Not covered
Cardiovascular Screenings	100%, no deductible	Not covered	100%, no deductible	Not covered
Colonoscopy	***Preventive:*** 100%, no deductible	***Preventive:*** Not covered	***Preventive:*** 100%, no deductible	***Preventive:*** Not covered

	PPO		Health Fund	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	Diagnostic: 90% after deductible	***Diagnostic:*** 60% of covered charge after deductible	***Diagnostic:*** 85% after deductible	***Diagnostic:*** 60% of covered charge after deductible
Immunizations	100%, no deductible	Not covered	100%, no deductible	Not covered
Mammogram	***Preventive:*** 100%, no deductible ***Diagnostic:*** 90% after deductible	***Preventive:*** Not covered ***Diagnostic:*** 60% of covered charge after deductible	***Preventive:*** 100%, no deductible ***Diagnostic:*** 85% after deductible	***Preventive:*** Not covered ***Diagnostic:*** 60% of covered charge after deductible
Pap Smear	***Preventive:*** 100%, no deductible ***Diagnostic:*** 90% after deductible	***Preventive:*** Not covered ***Diagnostic:*** 60% of covered charge after deductible	***Preventive:*** 100%, no deductible ***Diagnostic:*** 85% after deductible	***Preventive:*** Not covered ***Diagnostic:*** 60% of covered charge after deductible
Screening and Counseling Services *Call the number on the back of your One Card or medical ID card if you have a question on whether a specific service is considered preventive care.	***Obesity; Misuse of Alcohol and/or Drugs and Use of Tobacco Products; Sexually Transmitted Infections; Genetic Risk for Breast and Ovarian Cancer:*** 100% per visit; no copay or deductible applies. Contact your Medical Claims Administrator for information on covered services and visit limits.*	Not covered	***Obesity; Misuse of Alcohol and/or Drugs and Use of Tobacco Products; Sexually Transmitted Infections; Genetic Risk for Breast and Ovarian Cancer:*** 100% per visit; no copay or deductible applies. Contact your Medical Claims Administrator for information on covered services and visit limits.	Not covered
Well-Child Exams	100%, no deductible	Not covered	100%, no deductible	Not covered

	PPO		Health Fund	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
Well-Man Prostate-Specific Antigen (PSA)	***Preventive:*** 100%, no deductible ***Diagnostic:*** 90% after deductible	***Preventive:*** Not covered ***Diagnostic:*** 60% of covered charge after deductible	***Preventive:*** 100%, no deductible ***Diagnostic:*** 85% after deductible	***Preventive:*** Not covered ***Diagnostic:*** 60% of covered charge after deductible

Note: For some services, whether you pay an office visit copay (PPO only) or coinsurance depends on how your provider submits a claim. To determine how the Plan will pay benefits, ask your provider how he or she is going to "code" your visit.

Indemnity Plan Benefit Summary

Expenses are paid based on the recognized charge; as defined in the “Glossary” section.

Medical Benefits	Indemnity Plan
Plan Facts	
Annual Deductible	$500 individual $1,000 family
Hospital Admission Deductible	Annual deductible
Primary Care Office Visits	90% after deductible
Specialist Office Visits	90% after deductible
Coinsurance (Plan Pays)	90% after deductible (unless noted otherwise)
Annual Out-of-Pocket Maximum (includes deductible)	$2,500 individual $5,000 family
Lifetime Maximum[2]	Unlimited
Family Planning	
Female Contraceptive Counseling Services	***Office Visits:*** 100% per visit. No copay or deductible applies. Call the number on the back of your One Card or medical ID card for visit limits.
Female Tubal Ligation	100%, no deductible (reversal not covered)
Fertility/Infertility Services	Member cost share will align to your selected medical plan. See the “Progyny Fertility Program” section for additional information.
Fertility/Infertility Limit	Two Smart Cycles per lifetime per family; you must be enrolled in the Progyny fertility program to receive coverage.
Male Vasectomy	90% after deductible (reversal not covered)
Hospital Services	
Inpatient Hospital Visits	90% after deductible
Inpatient Surgeon	90% after deductible
Emergency Services	
Ambulance Services	90% after deductible
Emergency Room	90% after deductible
Emergency Room Detail	See “Emergency Health Services” in the “PPO, Health Fund and Indemnity Plan Covered Expenses” section
Urgent Care Center	90% after deductible

[2] A lifetime maximum applies for Fertility services.

Medical Benefits	Indemnity Plan
Maternity Care	
Birthing Centers	90% after deductible
Birthing Centers Limitation	Center must be licensed and certified; services must be supervised by a contracted OB-GYN
Midwives	90% after deductible
Midwives Limitation	Must be licensed and certified nurse-midwives practicing in an accredited hospital or birthing center
Mother—Facility Services	90% after deductible
Mother—Physician Services (including pre-natal and post-natal care)	90% after deductible Routine pre-natal care: 100%, no deductible
Newborn Services	90% after deductible
Comprehensive Lactation Support and Counseling Services	***Lactation Counseling Services Facility or Office Visits****:* 100% per visit. No copay or deductible applies.
Other Services	
Acupuncture	90% after deductible
Acupuncture Limit	25 visits per calendar year
Allergy Tests, Treatment and Injections	90% after deductible
Clinical Trials/Cancer Clinical Trials	90% after deductible
Chiropractic/Spinal Manipulation	90% after deductible
Chiropractic/Spinal Manipulation Limit	25 visits per calendar year
Durable Medical Equipment (DME)	90% after deductible
Hearing Aids	90% after deductible
Hearing Aid Limit	$5,000 maximum per year
Hearing Exam/Screening (Routine)	90% after deductible
Hearing Exam Limit	1 visit each calendar year
Home Health Care	90% after deductible
Home Health Care Limit	100 visits per calendar year
Hospice Care	90% after deductible
Hospice Care Limit	Unlimited
Obesity Surgery	90% after deductible
Obesity Surgery Limitations	One surgical procedure per lifetime

Medical Benefits	Indemnity Plan
	Pre-certification required Only covered at designated facility
Occupational Therapy	90% after deductible
Occupational Therapy Limit (Limit does not apply to visits for autism/mental health diagnosis)	120 visits per calendar year; subject to additional review and approval by the Medical Claims Administrator after 25 visits
Physical Therapy	90% after deductible
Physical Therapy Limit (Limit does not apply to visits for autism/mental health diagnosis)	120 visits per calendar year; subject to additional review and approval by the Medical Claims Administrator after 25 visits
Private Duty Nursing	Not covered
Skilled Nursing Facility	90% after deductible
Skilled Nursing Facility Limit	100 days per calendar year; includes inpatient convalescent and rehabilitation centers and facilities
Speech Therapy	90% after deductible
Speech Therapy Limit (Limit does not apply to visits for autism/mental health diagnosis)	120 visits per calendar year; subject to additional review and approval by the Medical Claims Administrator after 25 visits
Transgender Surgery	90% after deductible
Transgender Surgery Detail	Pre-certification required; reversal of gender reassignment surgery is not covered
Transplants	90% after deductible
Transplants Detail	Pre-certification required
Vision Exam/Screening (Routine)	***Screening:*** Covered at 100% when part of routine preventive exam. ***Exam:*** For children under age 5: 90% after deductible, limited to one preventive visit per calendar year.
Outpatient Care	
Outpatient Surgery	90% after deductible
MRI, CT Scans and Laboratory Services *Call the number on the back of your One Card or medical ID card if you have a question on whether a specific service is considered preventive care.	***Preventive:*** 100%*, no deductible ***Diagnostic:*** 90% after deductible ***Complex imaging services that take place in an office setting:*** 90%, after the deductible
Diagnostic X-Ray, PET Scans and Other Nuclear Imaging Services	***Preventive:*** 100%*, no deductible ***Diagnostic:*** 90% after deductible

Medical Benefits	Indemnity Plan
Walk-In Clinics Non-Emergency Visit	90% after deductible
*Call the number on the back of your One Card or medical ID card if you have a question on whether a specific service is considered preventive care.	
Preventive Care	
Preventive care is covered at 100%, with no deductible. Preventive care is subject to the age and/or gender guidelines of the USPSTF and other organizations and agencies. Call the number on the back of your One Card or medical ID card if you have a question on whether a specific service is considered preventive care.	
Annual Adult Physical Exam	100%, no deductible
Annual Well-Woman Exam	100%, no deductible
Cancer Screenings	100%, no deductible
Cardiovascular Screenings	100%, no deductible
Colonoscopy	***Preventive:*** 100%, no deductible ***Diagnostic:*** 90% after deductible
Immunizations	100%, no deductible
Mammogram	***Preventive:*** 100%, no deductible ***Diagnostic:*** 90% after deductible
Pap Smear	***Preventive:*** 100%, no deductible ***Diagnostic:*** 90% after deductible
Screening and Counseling Services*	***Obesity; Misuse of Alcohol and/or Drugs and Use of Tobacco Products; Sexually Transmitted Infections; Genetic Risk for Breast and Ovarian Cancer:*** 100% per visit. No deductible applies. Call the number on the back of your One Card or medical ID card for information on covered services and visit limits.
Well-Child Exams	100%, no deductible
Well-Man Prostate-Specific Antigen (PSA)	***Preventive:*** 100%, no deductible ***Diagnostic:*** 90% after deductible

*Call the number on the back of your One Card or medical ID card if you have a question on whether a specific service is considered preventive care.

PPO, Health Fund and Indemnity Plan Covered Expenses

The following are covered expenses under the PPO, Health Fund and Indemnity Plan to the extent medically necessary, as determined by the Medical Claims Administrator, and not excluded or limited under the Plan. See the “PPO, Health Fund and Indemnity Plan Exclusions and Limitations” section for details regarding when limitations and exclusions may apply.

Ambulance Services

Ground ambulance transportation is covered in the following situations:

- To the first hospital where treatment is given in a medical emergency;
- From one hospital to another hospital in a medical emergency when the first hospital does not have the required services or facilities to treat your condition;
- From hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition;
- From home to hospital for covered inpatient or outpatient treatment when other means of transportation would be considered unsafe due to your medical condition (transport is limited to 100 miles); and
- When, during a covered inpatient stay at a hospital, skilled nursing facility or acute rehabilitation hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Air or water ambulance transportation is covered in the following situations:

- When ground ambulance transportation is not available;
- Your condition is unstable, and requires medical supervision and rapid transport; and
- In a medical emergency, transportation from one hospital to another hospital; when the first hospital does not have the required services or facilities to treat your condition and you need to be transported to another hospital; and the two conditions above are met.

Bereavement Counseling

Counseling benefits for the immediate family are available upon the death of a participant receiving covered hospice care.

Clinical Trials/Cancer Clinical Trials

Benefits are available for routine patient care costs incurred during participation in a qualifying clinical trial for the treatment of cancer or other life-threatening disease or condition. For purposes of this benefit, a life-threatening disease or condition is one from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits include the reasonable and medically necessary items and services used to prevent, diagnose and treat complications arising from participation in a qualifying clinical trial to the extent otherwise covered under the Plan.

Benefits are available only when the covered person is eligible for participation in the qualifying clinical trial according to the trial protocol and either: (1) the referring health care professional is a participating provider in the trial and has concluded that the covered person's participation in such trial would be appropriate; or (2) the covered person provides medical and scientific information establishing that the covered person's participation in such trial would be appropriate.

Covered expenses include charges made for experimental or investigational drugs, devices, treatments or procedures "under an approved clinical trial" only when you have cancer or a terminal illness, and ***all*** of the following conditions are met:

- Standard therapies have not been effective or are inappropriate;
- The health plan determines, based on published, peer-reviewed scientific evidence that you may benefit from the treatment; and
- You are enrolled in an approved clinical trial that meets these criteria.

An "approved clinical trial" is a clinical trial that meets these criteria:

- The U.S. Food and Drug Administration (FDA) has approved the drug, device, treatment or procedure to be investigated or has granted it investigational new drug (IND) or group c/treatment IND status. This requirement does not apply to procedures and treatments that do not require FDA approval.
- The clinical trial has been approved by an Institutional Review Board that will oversee the investigation.
- The clinical trial is sponsored by the National Cancer Institute (NCI) or similar federal organization.
- The trial conforms to standards of the NCI or other, applicable federal organization.
- The clinical trial takes place at an NCI-designated cancer center or takes place at more than one institution.
- You are treated in accordance with the protocols of that study.

Routine patient care costs for qualifying clinical trials include:

- Covered health services for which benefits are otherwise provided under the Plan absent a clinical trial;
- Covered health services required solely for the provision of the investigational item or service, the clinically appropriate monitoring of the effects of the item or service, or the prevention and treatment of complications; and
- Covered health services needed for reasonable and medically necessary care arising from the provision of an Investigational item or service.

Routine costs for clinical trials do not include the items below. Contact your Claims Administrator for more information:

- The experimental or investigational service or item. The only exceptions to this are:
    - Certain Category B devices;
    - Certain promising interventions for patients with terminal illnesses; and
    - Other items and services that meet specified criteria in accordance with the Claims Administrator's medical and drug policies;
- Routine patient care services provided outside of the Plan's network area unless out-of-network benefits are otherwise provided under the Plan;
- Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient;
- A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis; and
- Items and services provided by the research sponsors free of charge for any person enrolled in the trial.

With respect to cancer or other life-threatening diseases or conditions, a qualifying clinical trial is a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection or treatment of cancer or other life-threatening disease or condition and which meets any of the following criteria in the bulleted list below:

- Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:
    - National Institutes of Health (NIH) (includes National Cancer Institute [NCI]);
    - Centers for Disease Control and Prevention (CDC);
    - Agency for Healthcare Research and Quality (AHRQ);
    - Centers for Medicare and Medicaid Services (CMS);
    - A cooperative group or center of any of the entities described above or the Department of Defense (DOD) or the Department of Veterans Affairs;
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants; or
    - The Department of Veterans Affairs, the Department of Defense or the Department of Energy, as long as the study or investigation has been reviewed and approved through a system of peer review that is determined by the Secretary of Health and Human Services to meet both of the following criteria:
        - Comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and
        - Assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review;
    - The study or investigation is conducted under an investigational new drug application reviewed by the U.S. FDA;
    - The study or investigation is a drug trial that is exempt from having such an investigational new drug application;
    - The clinical trial must have a written protocol that describes a scientifically sound study and have been approved by all relevant institutional review boards (IRBs) before participants are enrolled in the trial. The Medical Claims Administrator may, at any time, request documentation about the trial; or
    - You are treated in accordance with the protocols of that study.

The Medical Claims Administrator may, at any time, request documentation about the clinical trial.

Please remember that you must obtain pre-certification from your Medical Claims Administrator as soon as the possibility of participation in a clinical trial arises. Pre-certification is not required for routine patient costs that do not otherwise need to be pre-certified under the Plan. If pre-certification is not obtained and services are provided out-of-network, you will be responsible for paying all charges and no benefits will be paid.

Dental Services—Accident Only (unless otherwise noted under "Oral and Maxillofacial Treatment" later in this section)

Dental services may be covered if all of the following apply:

- Dental damage that occurs due to normal activities of daily living or extraordinary use of the teeth is not considered an accident;
- Dental services are received from a Doctor of Dental Surgery (D.D.S.) or Doctor of Medical Dentistry (D.M.D.);

- Dental services for final treatment to repair the damage is initiated within 12 months of the accident; and
- Treatment is necessary because of accidental damage.

The Plan pays for treatment of accidental injury only for:

- Emergency examination;
- Endodontic (root canal) treatment;
- Extractions;
- Necessary diagnostic X-rays;
- Post-traumatic crowns if they are the only clinically acceptable treatment;
- Prefabricated post and core;
- Replacement of lost teeth due to the injury by implant, dentures or bridges;
- Simple minimal restorative procedures (fillings); and
- Temporary splinting of teeth.

Diabetes Treatment

Diabetes equipment, supplies and self-management training programs are covered when provided or coordinated by your physician.

Equipment is limited to blood glucose monitors, insulin pumps, infusion devices and podiatric appliances to prevent complications of diabetes.

Self-management training includes training provided after the initial diagnosis for the care and management of diabetes, including nutritional counseling and proper use of equipment and supplies. Additional and continuing training may be covered if a significant change in medical condition indicates a change in the self-management regime or if warranted due to the development of new techniques and treatments. Contact your Medical Claims Administrator for information on nutritional counseling benefits.

Additional benefits for diabetes supplies may be offered at a reduced cost for some conditions for retirees who are participating in Well at Dell programs (such as diabetes management with Livongo).

Disposable Medical Supplies

Disposable medical supplies are a covered benefit if ordered by a physician as part of the treatment of an illness or injury; for example, sterile supplies for the home care of an open wound. This benefit does not apply to over-the-counter self-care items. Certain exclusions apply. Contact your Medical Claims Administrator for information on covered disposable medical supplies.

Durable Medical Equipment, Prosthetic Devices and Orthotics

Durable medical equipment is covered if it is:

- Ordered or provided by a physician for outpatient use;
- Used for medical purposes;
- Not consumable or disposable;
- Not of use to a person in the absence of a disease or disability;
- Durable enough to withstand repeated use; and
- Appropriate for use in the home.

If more than one piece of durable medical equipment can meet your needs, you will receive benefits only for the most cost-effective piece of equipment (as defined in the “Glossary” section). The Medical Claims Administrator will determine the equipment that is most cost-effective.

Examples of durable medical equipment include:

- Equipment to assist mobility, such as a standard wheelchair;
- A standard hospital-type bed;
- Oxygen concentrator units and the purchase or rental of equipment to administer oxygen;
- Delivery pumps for tube feedings, including tubing and connectors (contact your Medical Claims Administrator for breast pump coverage and approval requirements);
- Braces that stabilize an injured body part, including necessary adjustments to shoes to accommodate braces subject to pre-certification for certain orthotics; dental braces and braces that straighten or change the shape of a body part are not covered;
- Mechanical equipment necessary for the treatment of chronic or acute respiratory failure or conditions; and
- Wigs for replacement of hair loss due to medical treatment.

Your Medical Claims Administrator will decide if equipment should be purchased or rented. You must purchase or rent durable medical equipment from the vendor that your Medical Claims Administrator identifies. Certain durable medical equipment and prosthetic devices may require pre-certification. Contact your Medical Claims Administrator for more information.

Benefits are provided for:

- A single unit of durable medical equipment (example, one insulin pump) and unlimited repair of that unit necessary due to normal usage.
- For BCBSIL, the replacement of durable medical equipment/prosthetics no more than every three calendar years unless replacement is needed sooner due to a change in the covered person’s medical condition (for example, pediatric growth) or normal wear and tear. For Aetna, the replacement of durable medical equipment/prosthetics occurs when replacement is needed or sooner due to a change in the covered person’s medical condition (for example, pediatric growth) or normal wear and tear.
- Prosthetic devices that replace a limb or body part, including artificial limbs, artificial eyes and breast prostheses, as required by the Women’s Health and Cancer Rights Act of 1998. If more than one prosthetic device can meet your functional needs, your Medical Claims Administrator will determine the equipment to be covered. Prosthetic devices must be ordered or provided by a physician or under the direction of a physician.
- A single purchase, including repairs, of a type of prosthetic device.
- Orthotics if they are custom-fit or custom-made for the specific medical need of the member and are rigid or semi-rigid in structure. Certain orthotics are specifically excluded as outlined in the “PPO, Health Fund and Indemnity Plan Exclusions and Limitations” section.

Emergency Health Services

See the “Medical Programs’ Compliance” section for additional information relating to the emergency services.

Emergency health services are covered if received at a hospital or emergency facility.

In Case of a Medical Emergency

When emergency care is necessary, please following these guidelines:

- Seek the nearest emergency room, or dial 911 or your local emergency response service for medical and ambulatory assistance. If possible, call your physician, provided a delay would not be detrimental to your health.
- After assessing and stabilizing your condition, the emergency room should contact your physician to obtain your medical history to assist the emergency physician in your treatment.
- If you are admitted to an inpatient facility, notify your physician as soon as reasonably possible.

A hospital admission following emergency care is covered under hospital benefits. If you are admitted to a hospital after receiving emergency services, your Medical Claims Administrator must be notified within 48 hours or on the day of admission, if reasonably possible. If you are admitted to an out-of-network hospital, the Medical Claims Administrator may transfer you to an in-network hospital as soon as it is appropriate.

In the case of a surprise bill from an out-of-network provider, where you had no control of their participation in your covered services, you will pay the same cost share you would have if the covered services were received from an in-network provider. The cost share will be based on the median contracted rate. Contact your Medical Claims Administrator immediately if you receive such a bill.

The out-of-network plan rate does not apply to involuntary services. Involuntary services are services or supplies that are one of the following:

- Performed at a network facility by certain out-of-network providers
- Not available from a network provider
- Emergency services

Your Medical Claims Administrator calculates your cost share for involuntary services in the same way as if you had received the services from a network provider. If you receive a surprise bill, your cost share will be calculated at the median contracted rate.

If you are placed in an observation bed for the purpose of monitoring your condition, rather than being admitted to the hospital as an inpatient, the deductible and coinsurance for emergency services will apply.

Follow-Up Care After Treatment of an Emergency Medical Condition

Follow-up care is not considered an emergency condition and is not covered as part of any emergency care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for illness or injury.

You may use an out-of-network provider for your follow-up care. You will be subject to the deductible and payment percentage that apply to out-of-network expenses, which may result in higher out-of-pocket costs to you.

Important Notice: Follow up care, which includes (but is not limited to) suture removal, cast removal and radiological tests such as X-rays, should not be provided by an emergency room facility.

Eye Examinations

Eye examinations in an optometrist's, ophthalmologist's or other health care provider's office related to an injury or illness of the eye are covered.

Routine eye exams for children under the age of five are covered once every calendar year. Expenses for the purchase or fitting of eyeglasses or contact lenses are not covered.

The Plan will cover eyeglasses or contact lenses needed due to a medical diagnosis.

Services outside the U.S. are limited to emergency and unexpected care only.

Family Planning Services
Female Contraceptives

For females with reproductive capacity, covered expenses include those charges incurred for services and supplies that are provided to prevent pregnancy. All contraceptive methods, services and supplies are covered as a preventive care benefit and must be approved by the U.S. FDA.

Coverage includes counseling services on contraceptive methods provided by a physician, obstetrician or gynecologist. Such counseling services are covered expenses when provided in either a group or individual setting and are subject to the contraceptive counseling services visit maximum.

The following contraceptive methods are covered expenses under the preventive care benefit:

- Voluntary sterilization—Covered expenses include charges billed separately by the provider for female voluntary sterilization procedures and related services and supplies including, but not limited to, tubal ligation and sterilization implants.
- Covered expenses under this preventive care benefit would not include charges for a voluntary sterilization procedure to the extent that the procedure was not billed separately by the provider or because it was not the primary purpose of a confinement.
- Contraceptives—Covered expenses include charges made by a physician for:
    - Prescription contraceptives and non-prescription contraceptives when prescribed (generic and formulary contraceptives are covered at 100%); and
    - Female contraceptive devices including the related services and supplies needed to administer the device.

Other Family Planning Services

Other family planning services are covered by the Plan at the regular benefit amount (not at the preventive care benefit amount) and include:

- Voluntary sterilization for males; and
- Voluntary termination of pregnancy.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this Plan or any other group plan sponsored by your employer;
- Services which are for the treatment of an identified illness or injury;
- Services that are not given by a physician or under his or her direction;
- Psychiatric, psychological, personality or emotional testing or exams;
- Any contraceptive methods that are only "reviewed" by the FDA and not "approved" by the FDA;
- Male contraceptive methods or devices;
- The reversal of voluntary sterilization procedures, including any related follow-up care; and
- Charges incurred for family planning services while confined as an inpatient in a hospital or other facility for medical care.

Home Health Care

Skilled home health care includes services from skilled nursing, skilled teaching and skilled rehabilitation services as long as they:

- Are delivered or supervised by licensed technical or professional medical personnel to obtain the specified medical outcome and provide for the safety of the patient;
- Are ordered by a physician;
- 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;
- Require clinical training to be delivered safely and effectively; and
- Are not custodial care.

The Medical Claims Administrator will determine if skilled home health care is required by reviewing both the nature of the service and the need for physician-directed medical management. A service will not be determined to be skilled simply because there is not an available caregiver.

Services from a home health care agency are only available when the home health care agency services are provided on a part-time, intermittent schedule and when skilled home health care is required.

Benefits are limited to 100 visits per calendar year. One visit equals four hours of skilled care services. Pre-certification is required.

Hospice Care

Hospice care is covered when recommended by a physician and received from a licensed hospice agency. Hospice care includes physical, psychological, social and spiritual care for the terminally ill person and short-term grief counseling for immediate family members. Pre-certification is required. Contact your Medical Claims Administrator for information on limits.

Covered expenses include charges made by the following furnished to you for hospice care when given as part of a hospice care program.

Facility Expenses

The charges made by a hospital, hospice or skilled nursing facility for:

- Room and board and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management; and
- Services and supplies furnished to you on an outpatient basis.

Outpatient Hospice Expenses

Covered expenses include charges made on an outpatient basis by a licensed hospice care agency for:

- Part-time or intermittent nursing care by a R.N. or L.P.N.
- Part-time or intermittent home health aide services to care for you.
- Medical social services under the direction of a physician. These include but are not limited to:
    - Assessment of your social, emotional and medical needs, and your home and family situation;
    - Identification of available community resources; and
    - Assistance provided to you to obtain resources to meet your assessed needs.
- Physical and occupational therapy.
- Consultation or case management services by a physician.
- Medical supplies.
- Prescription drugs.
- Dietary counseling.
- Psychological counseling.

Charges made by the providers below if they are not an employee of a licensed hospice care agency; and such agency retains responsibility for your care:

- A physician for a consultation or case management;
- A physical or occupational therapist;
- A home health care agency for:
    - Physical and occupational therapy;
    - Part time or intermittent home health aide services for your care under the supervision of an R.N.;
    - Medical supplies;
    - Prescription drugs;
    - Psychological counseling; and
    - Dietary counseling.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Daily room and board charges over the semi-private room rate.
- Funeral arrangements.
- Pastoral counseling.
- Financial or legal counseling. This includes estate planning and the drafting of a will.

- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

Important Reminder: Inpatient hospice care and home health care must be pre-certified by your Medical Claims Administrator.

Progyny Fertility Program

The Progyny fertility program is available to those enrolled in the Retiree Medical Plan.

The Plan's fertility benefits include:

- Expanded fertility and egg freezing benefits for covered members seeking treatment
- Two smart cycles per lifetime per family
- Comprehensive coverage customized to your needs leveraging the latest technologies and treatments
- High-quality care through Progyny's premier network of the nation's top fertility specialists
- Fertility preservation if your plans for the future include a family, but now isn't the right time

Throughout the process, you'll be guided by an experienced, dedicated Patient Care Advocate (PCA) who will provide personalized, concierge-like guidance and emotional support.

To receive fertility benefits, contact Progyny's PCAs and register by calling **1-833-278-1676**, 8 a.m. – 8 p.m. CT, Monday through Friday. Use the registration code **Dell**.

Progyny is the premier fertility benefit designed to provide all-inclusive comprehensive coverage for cutting-edge fertility treatments to assist any member wishing to have a child. Progyny's program includes a credentialed provider network and a personalized concierge-style member support team (PCAs) that offers education, support and coordinated care. If you have any questions about your fertility benefit, please call your dedicated PCA, or you can call the Progyny General Enterprise line at 1-844-470-1752.

Progyny's program does not require a medical diagnosis of infertility in order to access fertility treatment services.

Through Progyny's benefit, members have access to a full suite of fertility treatment options, which may include (but may not be limited to):

- Artificial insemination (IUI)
- Cryopreservation of oocytes and sperm
- FDA bloodwork and testing
- Fresh IVF cycle
- Frozen embryo transfer (FET)
- Frozen oocyte transfer (includes fertilization of previously frozen oocytes and transfer)
- IVF freeze-all
- PCA concierge support
- Pre-authorized fertility medications (via Progyny Rx)
- PGT-A (PGS or pre-implantation genetic screening) to assess embryo viability
- PGT-M (PGD or pre-implantation genetic diagnosis)

- Pregnancy gap coverage (pregnancy monitoring coverage until the in-network fertility clinic releases the member into the care of the member's OB-GYN medical provider)
- Tissue transportation (transportation of member's previously frozen reproductive tissue to in-network facilities)
- Purchase of donor tissue (eggs and sperm)

Progyny's benefit has the following standard exclusions:

- Home ovulation prediction kits
- Services and supplies furnished by an out-of-network provider, i.e., not a Progyny provider, or not listed as covered in the Progyny Member Guide
- All charges associated with a gestational carrier program for the person acting as the carrier, including, but not limited to, fees for laboratory tests
- Treatments considered experimental by the American Society of Reproductive Medicine

Injections Received in Physician's Office

Benefits are available for injections received in a physician's office when no other health service is received (for example, allergy immunotherapy).

Inpatient Hospital Stay

Benefits are available for services and supplies received during an inpatient hospital stay and room and board in semi-private accommodations (a room with two or more beds).

Private rooms are covered only up to the hospital's highest semi-private accommodations room rate. However, the extra costs of a private room may be covered when:

- The hospital only has private rooms;
- The hospital's semi-private accommodations rooms are completely occupied and only private rooms are available; or
- When a private room is medically necessary for isolation.

Benefits for an inpatient stay in a hospital are available only when the inpatient stay is necessary to prevent, diagnose or treat an illness or injury.

Pre-certification is required for all inpatient stays; see the "PPO, Health Fund and Indemnity Plan Pre-Certification" section for more information.

Lab, X-Ray and Diagnostics—Outpatient

Services for illness and injury-related diagnostic purposes, received on an outpatient basis at a hospital or alternate facility or in a physician's office include, but are not limited to:

- CT scans, PET scans, MRI, MRA, nuclear medicine and major diagnostic services received on an outpatient basis at a hospital or alternate facility;
- Lab and radiology/X-ray; and
- Mammography.

Coverage includes:

- The facility charge and the charge for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Outpatient CT Scan, PET Scan, MRI, MRA and Nuclear Medicine/Cardiology

Covered services for CT scans, PET scans, MRI, MRA, nuclear medicine/cardiology and major diagnostic services received on an outpatient basis at a hospital or alternate facility include:

- Facility charges and charges for supplies and equipment; and
- Physician services for anesthesiologists, pathologists and radiologists.

Pre-certification may be required for the following advanced outpatient imaging services: CT scans, PET scans, MRIs, MRAs and nuclear medicine studies, including nuclear cardiology. Advanced imaging services ordered during emergency room visits, in an observation unit, in an urgent care facility or during an inpatient stay **do not** require pre-certification. However, for BCBSIL members, some of the services may require a pre-determination for medical necessity criteria to be met before coverage is eligible. Your coinsurance for outpatient diagnostic lab services and high-tech radiology such as MRI and CT scans will vary based on the place of service. Refer to the chart under the “PPO and Health Fund Benefit Summary” section for more information.

Maternity Services

Benefits for pregnancy will be paid at the same level as benefits for any other condition, illness or injury. This includes post-natal care, delivery and any related complications. Pre-natal care may be covered as preventive care as described below.

Benefits are payable for an inpatient hospital stay of at least:

- 48 hours for the mother and newborn child following a normal vaginal delivery; or
- 96 hours for the mother and newborn child following a cesarean section delivery.

Notify the Medical Claims Administrator if an inpatient stay will be longer than the above time frames, as pre-certification is required.

Ovia Health offers expanded support for your reproductive health and parenting journey at any stage, with a combination of user-friendly technology and on-demand, personalized coaching. Ovia's three apps (Ovia , Ovia Pregnancy and Ovia Parenting) can help you navigate through some of life's biggest transitions:

- Planning/starting a family or tracking your cycles
- Experiencing and navigating pregnancy
- Balancing life as a working parent

And while Ovia is there for all the big moments, they're also there for the little ones. That's why all three apps include access to expert content and tips, personalized health insights and health coaching with registered nurses — so you have support for your life and health whenever you need it. This includes support for dads and partners!

Nurses are available to chat in the Ovia apps 12 hours a day, seven days a week at no cost to you. For example, if you have general questions about lactation support or finding midwives, the chat feature is a good place to start.

Ovia is available to retirees enrolled in the Retiree Medical Plan.

Download Ovia, Ovia Pregnancy or Ovia Parenting, and be sure to note that you have Ovia Health as a benefit to access premium features.

For any troubleshooting, contact support@oviahealth.com.

Pre-Natal Care

Pre-natal care will be covered as preventive care for services received by a pregnant female in a physician's, obstetrician's or gynecologist's office but only to the extent described below.

Coverage for pre-natal care under this preventive care benefit is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure, uterine size and fetal heart rate check). Urine tests, glucose tolerance testing and screening for specific sexually transmitted infections and genetic or developmental conditions may also be covered as preventive care.

Unless specified above, not covered under this preventive care benefit are charges incurred for:

- Services which are covered to any extent under any other part of this Plan; and
- Pregnancy expenses (other than pre-natal care as described above).

Morbid Obesity

Morbid obesity is defined as weight over optimal weight that can result in significant complications and a shortened life span.

When conservative measures such as dietary and lifestyle changes fail to control morbid obesity, some patients consider surgical approaches. Surgery for morbid obesity falls into two general categories:

- Gastric restrictive:
  - Procedures that create a small gastric pouch resulting in weight loss by producing early fullness when eating thus decreasing dietary intake; and
  - Adjustable gastric banding (laparoscopic adjustable silicone gastric banding) such as gastric sleeve procedure (also known as a laparoscopic vertical gastrectomy or laparoscopic sleeve gastrectomy); or
- Malabsorptive:
  - Procedures which produce weight loss due to malabsorption caused by surgical alteration of the gastrointestinal tract without necessarily requiring changes in diet.

The surgical treatment of morbid obesity is a covered benefit when it is medically necessary and certain criteria are met as determined by the Medical Claims Administrator. These criteria are:

- You have a minimum body mass index (BMI) of 40; or
- You have a BMI of 35 with complicating co-morbidities (such as sleep apnea or diabetes) directly related to or exacerbated by obesity.

Subsequent surgical procedures to remove redundant skin and tissue, resulting from weight loss, will only be covered if the need for the surgery meets the reconstruction procedures criteria determined by the Medical Claims Administrator.

Coverage is included for one morbid obesity surgical procedure per person per lifetime, including related outpatient services when certain medically necessary criteria are met. Benefits are only available if the surgery is performed at a designated facility. Check with your Medical Claims Administrator for specific benefits and guidelines.

Nutritional Counseling

Services provided in a physician's office by an appropriately licensed or health care professional when education is required for medical conditions requiring a special diet are covered. Some examples of such medical conditions include:

- Diabetes mellitus;
- Gestational diabetes;
- Coronary artery disease;
- Heart failure;
- Severe obstructive airway disease;
- Gout;
- Renal failure;
- Phenylketonuria; and
- Hyperlipidemias.

Contact your Medical Claims Administrator for more information regarding coverage for nutritional counseling for medical/mental health and substance use disorder conditions.

Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)

Covered expenses include charges made by a physician, a dentist and hospital for:

- Non-surgical treatment of infections or diseases of the mouth, jaw joints or supporting tissues.
- Services and supplies for treatment of, or related conditions of, the teeth, mouth, jaws, jaw joints or supporting tissues (this includes bones, muscles and nerves), for surgery needed to:
    - Treat a fracture, dislocation or wound;
    - Cut out teeth that are partly or completely impacted in the bone of the jaw; teeth that will not erupt through the gum; other teeth that cannot be removed without cutting into bone; the roots of a tooth without removing the entire tooth; cysts, tumors or other diseased tissues;
    - Cut into gums and tissues of the mouth (this is only covered when not done in connection with the removal, replacement or repair of teeth); or
    - Alter the jaw, jaw joints or bite relationships by a cutting procedure when appliance therapy alone cannot result in functional improvement;

- Hospital services and supplies received for a stay required because of your condition.
- Dental work, surgery and orthodontic treatment needed to remove, repair, restore or reposition:
    - Natural teeth damaged, lost or removed; or
    - Other body tissues of the mouth fractured or cut due to injury.

Any such teeth must have been free from decay or in good repair, and are firmly attached to the jaw bone at the time of the injury.

Contact your Medical Claims Administrator regarding requirements on treatment begin date. The treatment must be completed within 12 months of the injury or illness.

If crowns, dentures, bridges or in-mouth appliances are installed due to injury, covered expenses only include charges for:

- The first denture or fixed bridgework to replace lost teeth;
- The first crown needed to repair each damaged tooth; and
- An in-mouth appliance used in the first course of orthodontic treatment after the injury.

Oral Surgery

Services provided by a qualified practitioner in performing certain oral surgical operations due to bodily injury or illness are covered if initiated within 12 months of injury or illness as follows:

- Excision of partially or completely unerupted impacted teeth;
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examination;
- Surgical procedures when required to correct accidental injury of the jaws, cheeks, lips, tongue, roof and floor of the mouth (contact your Medical Claims Administrator for treatment begin date requirement);
- Reduction of fractures and dislocations of the jaw;
- External incision and drainage of cellulitis; and
- Incision of accessory sinuses, salivary glands or ducts.

Oral surgery needed due to a congenital anomaly is typically identified through a pre-determination review before the service is provided or through medical review once a claim is submitted. In certain cases, a congenital condition may be identified through the appeal review process.

Ostomy Supplies

Benefits for ostomy supplies are limited to:

- Pouches, face plates and belts;
- Irrigation sleeves, bags and ostomy irrigation catheters; and
- Skin barriers.

Outpatient Surgery, Diagnostic and Therapeutic Services

Covered services received on an outpatient basis at a hospital or outpatient facility include:

- Surgery and related services;
- Certain surgical scopic procedures (examples of surgical scopic procedures include arthroscopy, laparoscopy, bronchoscopy, hysteroscopy);
- Lab and radiology/X-rays;
- Mammography testing (may also be covered under Preventive Care Services);
- Physician services for anesthesiologists, pathologists and radiologists; and
- Other diagnostic tests and therapeutic treatments (including cancer chemotherapy or intravenous infusion therapy, radiation oncology and dialysis).

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

If multiple surgical procedures are performed at one operative session, the amount payable for these procedures is limited to the maximum covered charge for the primary procedure plus 50% of the maximum covered charge for subsequent procedures if they had been performed independently.

Contact your Medical Claims Administrator for pre-certification requirements for dialysis services.

Pharmaceutical Products—Outpatient

The Plan pays for pharmaceutical products that are administered on an outpatient basis in a hospital, alternate facility, physician's office or a covered person's home. Examples of what would be included under this category are antibiotic injections in the physician's office or inhaled medication in an urgent care center for treatment of an asthma attack.

Benefits under this section are provided only for pharmaceutical products that, due to their characteristics (as determined by the Medical Claims Administrator), must typically be administered or directly supervised by a qualified provider or licensed/certified health professional. Benefits under this section do not include medications that are typically available by prescription order or refill at a pharmacy. Benefits under this section do not include medications for the treatment of infertility. Fertility medications are administered by Progyny. Please contact your PCA at 1-833-278-1676 for additional information.

Physician's Office Services

Covered services in a physician's office include:

- Evaluation and treatment of an illness or injury;
- Voluntary family planning;
- Well-baby and well-child care;
- Routine well-woman examinations, including pap smears and mammograms;
- Routine physical examinations, including vision and hearing screenings; and
- Immunizations (as listed as covered under "Preventive Care Services" in this section).

Benefits for some of the above services may be paid at 100% as preventive care — see the "Preventive Care Services" section below.

Preventive Care Services

Preventive care is provided at 100%, with no copay or deductible required when you use in-network providers. Preventive care services are not covered if you use an out-of-network provider. Preventive care is subject to the age and/or gender guidelines of the USPSTF. These services, which may be provided in a physician's office or on an outpatient basis at an alternate facility or hospital:

- Encompass medical services that have been demonstrated by clinical evidence to be safe and effective in either the early detection of disease or in the prevention of disease;
- Have been proven to have a beneficial effect on health outcomes; and
- Include the following, as required under applicable law:
    - Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the USPSTF;
    - Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the CDC;
    - With respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) or services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents; and
    - With respect to women, additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA including, but not limited to, contraceptives (approved by the FDA), domestic violence screenings for interpersonal and domestic violence, human immunodeficiency virus (HIV) screenings, breast-feeding counseling and equipment (including breast pumps), screening for gestational diabetes in pregnant women, and deoxyribonucleic acid (DNA) tests for human papillomavirus (HPV) as part of cervical cancer screening.

Professional Fees for Surgical and Medical Services

Professional fees for surgical procedures and other medical care received in a hospital, skilled nursing facility, inpatient rehabilitation facility, alternate facility or physician house calls are covered.

Reconstructive Procedures

Services are considered reconstructive when a physical impairment exists due to an injury, illness or congenital anomaly and the primary purpose of the procedure is to improve or restore physiologic function to an organ or body part. An example of a reconstructive procedure is surgery on the inside of the nose so that breathing can be improved or restored.

Services are considered cosmetic when they improve appearance without making an organ or body part work better. The fact that a person may suffer psychological consequences from an impairment does not classify surgery and other procedures done to relieve such consequences as reconstructive. Reshaping a nose with a prominent bump is an example of a cosmetic procedure that improves appearance but does not affect a function like breathing. The Plan does not provide benefits for these cosmetic procedures. Some services are considered cosmetic in some cases and reconstructive in others. An example is upper eyelid surgery. At times, this procedure will improve vision, while on other occasions, improvement in appearance is the primary purpose.

Covered reconstructive procedures include:

- Correction of a congenital anomaly of a newborn; and
- Reconstructive surgery to improve the function of craniofacial abnormalities.

Reconstructive surgery due to an accidental injury must be completed within a certain time frame. For example, surgery for Aetna members must occur no more than 24 months after the original injury. Contact your Medical Claims Administrator for details.

In addition, all services mandated by the Women's Health and Cancer Rights Act of 1998 are covered under the Plan, including reconstructive procedures following a mastectomy and reconstruction of the non-affected breast to achieve symmetry. Contact your Medical Claims Administrator for more information about benefits for services related to a mastectomy.

Rehabilitation and Habilitation Services

Short-Term Rehabilitation

Covered expenses include charges for short-term rehabilitation services, as described below, when prescribed by a physician up to the benefit maximums listed in the chart under the "PPO and Health Fund Benefit Summary" section. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A hospital, skilled nursing facility or hospice facility;
- A home health care agency; or
- A physician.

Outpatient Cognitive Therapy, Physical Therapy, Occupational Therapy and Speech Therapy

Coverage is subject to the limits shown in the chart under the "PPO and Health Fund Benefit Summary" section. Inpatient rehabilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this Policy.

- Cognitive therapy associated with physical rehabilitation is covered when the cognitive deficits have been acquired as a result of neurologic impairment due to trauma, stroke or encephalopathy, and when the therapy is part of a treatment plan intended to restore previous cognitive function.
- Physical therapy (except for services provided in an educational or training setting) is covered provided that the therapy is expected to:
    - Significantly improve or restore physical functions lost as a result of an acute illness, injury or surgical procedure.
- Occupational therapy (except for vocational rehabilitation, employment counseling and services provided in an educational or training setting) is covered provided that the therapy is expected to:
    - Significantly improve or restore physical functions lost as a result of an acute illness, injury or surgical procedure; or
    - Relearn skills that significantly improve independence in the activities of daily living.

- Speech therapy (except for services provided in an educational or training setting, or to teach sign language) is covered provided that the therapy is expected to:
    - Significantly improve, develop or restore the speech function or correct a speech impairment as a result of an acute illness, injury or surgical procedure; or
    - Improve delays in speech function development as a result of a gross anatomical defect present at birth.

Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

A "visit" consists of no more than one hour of therapy. Refer to the chart under the "PPO and Health Fund Benefit Summary" section for visit maximums. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration;
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- Allows therapy services, provided in your home, if you are homebound.

Important Reminder: Refer to the chart under the "PPO and Health Fund Benefit Summary" section for details about the short-term rehabilitation therapy maximum benefit.

Habilitation Therapy Services

Covered expenses include charges for habilitation therapy services, as described below, when prescribed by a physician up to the benefit maximums listed in the chart under the "PPO and Health Fund Benefit Summary" section. The services have to be performed by:

- A licensed or certified physical, occupational or speech therapist;
- A hospital, skilled nursing facility, or hospice facility;
- A home health care agency; or
- A physician.

Outpatient Physical Therapy, Occupational Therapy and Speech Therapy

Coverage is subject to the limits shown in the chart under the "PPO and Health Fund Benefit Summary" section. Inpatient habilitation benefits for the services listed will be paid as part of your Inpatient Hospital and Skilled Nursing Facility benefits provision in this Policy.

- Physical therapy (except for services provided in an educational or training setting) is covered provided that the therapy is expected to:
    - Improve delays in impaired function development as a result of a gross anatomical defect present at birth; or
    - Develop an impaired function.
- Occupational therapy (except for vocational rehabilitation, employment counseling, and services provided in an educational or training setting) is covered provided that the therapy is expected to:
    - Improve delays in impaired function development as a result of a gross anatomical defect present at birth; or
    - Develop an impaired function.

- Speech therapy (except for services provided in an educational or training setting, or to teach sign language) is covered provided that the therapy is expected to:
    - Improve delays in speech function development as a result of a gross anatomical defect present at birth; or
    - Develop speech function.

Speech function is the ability to express thoughts, speak words and form sentences. Speech impairment is difficulty with expressing one's thoughts with spoken words.

A "visit" consists of no more than one hour of therapy. Refer to the chart under the "PPO and Health Fund Benefit Summary" section for visit maximums. Covered expenses include charges for two therapy visits of no more than one hour in a 24-hour period.

The therapy should follow a specific treatment plan that:

- Details the treatment, and specifies frequency and duration;
- Provides for ongoing reviews and is renewed only if continued therapy is appropriate; and
- Allows therapy services, provided in your home, if you are homebound.

Important Reminder: Refer to the chart under the "PPO and Health Fund Benefit Summary" section for details about the habilitation therapy maximum benefit.

The Plan excludes any type of therapy when the therapy is administered solely to maintain the current state of health and no additional health benefit is expected. For example, if, during a course of speech therapy, the provider determines that further progress cannot be expected, additional therapy sessions beyond that point would not be covered.

Benefits are subject to additional review after 25 visits and any additional visits must be approved by your Medical Claims Administrator to continue receiving benefits.

Speech Therapy

Benefits are available when provided by a licensed speech therapist and services are needed due to a congenital anomaly, stroke or injury. In addition, services provided by a licensed speech therapist are covered for developmental delay, including, but not limited to, Autism Spectrum Disorder, cerebral palsy, hearing impairment or major congenital anomalies that affect speech, such as cleft lip or palate.

Pulmonary Rehabilitation Therapy

Pulmonary rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient pulmonary rehabilitation is covered for the treatment of reversible pulmonary disease states. Contact your Medical Claims Administrator for information on plan limits.

Cardiac Rehabilitation Therapy

Cardiac rehabilitation benefits are available as part of an inpatient hospital stay. A limited course of outpatient cardiac rehabilitation is covered when following angioplasty, cardiovascular surgery, congestive heart failure or myocardial infarction. The plan will cover charges in accordance with a treatment plan as determined by your risk level when recommended by a physician. Contact your Medical Claims Administrator for information on plan limits.

Limits for Occupational, Physical and Speech Therapy

Benefits are limited to 120 visits per calendar year for physical, occupational and speech therapy (separate limits apply to each). Benefits are subject to review after the initial 25 visits and additional visits must be approved by your Medical Claims Administrator to continue receiving benefits. This 120-visit limit does not apply for autism/mental health diagnosis.

Screening and Counseling Services

Covered expenses include charges made by your physician in an individual or group setting for the following:

- Obesity—Screening and counseling services to aid in weight reduction due to obesity. Coverage includes:
    - Preventive counseling visits and/or risk factor reduction intervention;
    - Medical nutrition therapy;
    - Nutrition counseling; and
    - Healthy diet counseling visits provided in connection with hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease.
- Misuse of Alcohol and/or Drugs—Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance. Coverage includes preventive counseling visits, risk factor reduction intervention and a structured assessment.
- Use of Tobacco Products—Screening and counseling services to aid in the cessation of the use of tobacco products. Tobacco product means a substance containing tobacco or nicotine including: cigarettes, cigars, smoking tobacco, snuff, smokeless tobacco and candy-like products that contain tobacco. Coverage includes the following services to aid in the cessation of the use of tobacco products:
    - Preventive counseling visits;
    - Treatment visits; and
    - Class visits.
- Sexually Transmitted Infections—Expenses include the counseling services to help you prevent or reduce sexually transmitted infections.
- Genetic Risks for Breast and Ovarian Cancer—Expenses include the counseling and evaluation services to help you assess your breast and ovarian cancer susceptibility.

Benefits for the screening and counseling services above may be subject to the visit maximums. Contact your Medical Claims Administrator for details on covered services and visit limits.

Limitations

Unless specified above, not covered under this benefit are charges for:

- Services which are covered to any extent under any other part of this plan or other sources, such as schools;
- Services which are for diagnosis or treatment of a suspected or identified illness or injury;
- Exams given during your stay for medical care;
- Services not given by a physician or under his or her direction; and
- Psychiatric, psychological, personality or emotional testing or exams;

Skilled Nursing Facility/Inpatient Rehabilitation Facility Services

In general, a skilled nursing facility provides care for participants who are recovering from an injury or illness that require 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 a home setting.

Benefits are available when skilled nursing and/or rehabilitation services are needed on a daily basis and the participant is expected to improve to a predictable level of recovery. Custodial, domiciliary or maintenance care, including administration of enteral feeds, are not covered under this benefit.

Covered expenses include charges made by a skilled nursing facility during your stay for the following services and supplies, up to the maximums shown in the charts under the "PPO and Health Fund Benefit Summary" and "Indemnity Plan Benefit Summary" sections, including:

- Room and board, up to the semi-private room rate. The Plan will cover up to the private room rate if it is needed due to an infectious illness or a weak or compromised immune system;
- Use of special treatment rooms;
- Radiological services and lab work;
- Physical, occupational or speech therapy;
- Oxygen and other gas therapy;
- Other medical services and general nursing services usually given by a skilled nursing facility (this does not include charges made for private or special nursing, or physician's services); and
- Medical supplies.

Benefits are available only if:

- The initial confinement in a skilled nursing facility or inpatient rehabilitation facility was or will be a cost-effective alternative to an inpatient stay in a hospital; and
- You will receive skilled care services (as defined in the "Glossary" section) that are not primarily custodial care.

Pre-certification is required for all in- and out-of-network admissions. Once services are pre-certified, benefits for an inpatient stay in a skilled nursing facility or inpatient rehabilitation facility are provided for:

- Services and supplies received during the inpatient stay; and
- Room and board in semi-private accommodations.

Limitations

Unless specified above, not covered under this benefit are charges for the treatment of:

- Drug addiction;
- Alcoholism;
- Senility;
- Intellectual disabilities; or
- Any other mental illness; and
- Daily room and board charges over the semi-private rate.

Spinal Treatment, Chiropractic and Osteopathic Manipulative Therapy

Benefits for spinal treatment include chiropractic and osteopathic manipulative therapy. Benefits include diagnosis and related services.

However, this maximum does not apply to expenses incurred:

- During your hospital stay; or
- For surgery (this includes pre- and post-surgical care provided or ordered by the operating physician).

The Plan excludes any type of therapy for the treatment of a condition when the therapy is administered solely to maintain the current state of health and no additional health benefit is expected. For example, if, during a course of chiropractic treatment, the provider determines that further progress cannot be expected, additional therapy sessions beyond that point would not be covered. You must notify the Medical Claims Administrator to receive out-of-network benefits for spinal treatment.

Temporomandibular Joint Dysfunction (TMJ)

Diagnostic and surgical treatment for TMJ is covered when medically necessary. The Plan covers charges made by a physician, hospital or surgery center for the diagnosis and surgical treatment of jaw joint disorder. A jaw joint disorder is defined as a painful condition:

- Of the jaw joint itself, such as TMJ syndrome; or
- Involving the relationship between the jaw joint and related muscles and nerves such as myofacial pain dysfunction (MPD).

TMJ appliances, including splints, are covered up to a $1,000 maximum benefit per calendar year. This maximum does not apply to diagnostic or surgical treatment.

Transgender Services

Transgender criteria and services are covered at the level of coinsurance aligning with your health plan.

The Plan pays benefits for the treatment of gender dysphoria as follows:

- Continuous hormone replacement (hormones of the desired gender).
- Diagnosis of gender dysphoria by a psychological professional and psychotherapy for gender dysphoria and associated co-morbid psychiatric diagnoses. **Note:** Services provided by psychiatrists, psychologists, PhDs and master's-level therapists will be treated as mental health benefits.
- Laboratory testing to monitor the safety of continuous hormone therapy.

- Surgery to change the genitalia and specified secondary sex characteristics, including:
  - Breast Augmentation
  - Breast removal/mastectomy
  - Electrolysis
  - Facial Feminization/Masculinization Surgery
  - Follicular Unit Extraction (FUE) / Follicular Unit Transplantation (FUT)
  - Speech Therapy/Tracheal Repair
  - Thyroid Chondroplasty
  - Vocal Folds Shortening and Retrodisplacement of Anterior Commissure (VFSRAC)

Transgender services require pre-certification and health plan approval. Transgender benefits are subject to other exclusions and limitations that apply under the Plan.

Surgical Benefit

Transgender surgical procedures as published in the Standards of Care of the World Professional Association for Transgender Health (WPATH) may be provided if:

- The surgery is performed by a qualified provider at a facility with a history of treating individuals with gender dysphoria;
- You are at least age 18 and have been diagnosed with gender dysphoria; or
- The treatment plan conforms to the WPATH standards.

In addition, the following criteria must be met:

- For breast surgery, at least one letter of recommendation from a mental health professional is required.
- For genital surgery, you must:
  - Have received at least two letters of recommendation from a mental health professional; one of these must include an extensive report; and
  - Be an active participant in a recognized gender dysphoria program and must have completed 12 months of successful continuous full-time real-life experience in the desired gender.

Reversal of previously performed gender reassignment surgery is not covered.

Prescription drugs and mental health treatment associated with gender reassignment surgery are considered under the Plan's mental health and prescription drug provisions, subject to applicable limitations and exclusions.

Hormone Replacement Benefit

In addition to the Plan's overall eligibility requirements, to be eligible for hormone replacement, you must:

- Have been diagnosed with gender dysphoria and treatment is consistent with the recommendation of WPATH;
- Have one referral from the individual's qualified mental health professional competent in the assessment and treatment of gender dysphoria;
- Have demonstrable knowledge of what hormones medically can and cannot do and their social benefits and risks; and

- Obtain documentation of real-life experience for at least three months before the administration of hormones; or
- Go through a period of psychotherapy of a duration specified by the mental health professional after the initial evaluation (usually a minimum of three months).

Exclusions

Transgender benefits do not include coverage for:

- Reversal of previous transgender genital surgery or reversal of previous secondary sex characteristic surgery including facial surgery.

Transplants

Certain organ and tissue transplants are covered when ordered by a physician. Pre-certification is required for all transplant services and services must be provided by or through a designated facility. Transplants must meet the definition of a covered health service and may not be experimental or investigational. Examples of transplants for which benefits are available include, but are not limited to:

- Heart transplants;
- Heart/lung transplants;
- Lung transplants;
- Kidney transplants;
- Kidney/pancreas transplants;
- Liver transplants;
- Liver/kidney transplants;
- Liver/intestinal transplants;
- Pancreas transplants;
- Intestinal transplants; and
- Bone marrow transplants, either from you or from a compatible donor, and peripheral stem cell transplants, with or without high-dose chemotherapy. Not all bone marrow transplants meet the definition of a covered health service.

Organ or tissue transplants or multiple organ transplants other than those listed above are excluded from coverage.

Donor costs for removal for a transplant may be eligible through the organ recipient's benefits under the Plan.

Cornea transplants when provided by an in-network physician at an in-network hospital (or at an approved facility for the Indemnity Plan) are covered the same as any other illness under the Plan.

There are specific guidelines regarding benefits for transplant services, such as using a designated facility. Contact your Medical Claims Administrator for information about these guidelines.

Transportation and Lodging

Dell offers reimbursement for expenses for travel and lodging where covered services are not available from a network provider within 50 miles of your home. Reimbursement is available for U.S. domestic transportation and lodging for you and one companion if those expenses enable you to receive the covered services from a provider in a location where the services are available and permitted under state and local law. Travel expenses must be reasonable and must be necessary to receive the covered services. The maximum lodging benefit per IRS regulation is $50 per night per person. Certain services may require that you receive pre-authorization for reimbursement from your Medical Claims Administrator in advance. Reimbursement is subject to a $10,000 maximum per incident.

If you participate in the Health Fund, you are eligible for reimbursement only after you have satisfied your deductible.

Urgent Care Center/Walk-In Clinic

Services received at an urgent care center or walk-in clinic are covered.

In Case of an Urgent Condition

Call your physician if you think you need urgent care. Network providers are required to provide urgent care coverage 24 hours a day, including weekends and holidays. You may contact any physician or urgent care provider, in- or out-of-network, for an urgent care condition if you cannot reach your physician.

If it is not feasible to contact your physician, please do so as soon as possible after urgent care is provided. If you need help finding an urgent care provider you may call Member Services at the toll-free number on your One Card or medical ID card.

Follow-Up Care After Treatment of an Urgent Medical Condition

Follow-up care is not considered an urgent condition and is not covered as part of any urgent care visit. Once you have been treated and discharged, you should contact your physician for any necessary follow-up care.

For coverage purposes, follow-up care is treated as any other expense for illness or injury.

You may use an out-of-network provider for your follow-up care. However, you will be subject to the deductible and payment percentage that apply to out-of-network expenses, which may result in higher out-of-pocket costs to you.

PPO, Health Fund and Indemnity Plan Exclusions and Limitations

The following section includes lists of services not covered under the Aetna or BCBSIL Medical Program options.

Not every medical service or supply is covered by the Plan, even if prescribed, recommended or approved by your physician. The Plan covers only those services and supplies that are medically necessary and included in the “PPO, Health Fund and Indemnity Plan Covered Expenses” section and not limited or excluded under the Plan.

Benefits will not be paid for any service, treatment or item described in this section, even if it is recommended or prescribed by a physician and/or it is the only available treatment for your condition.

- All surgical procedures for the treatment of obesity, unless specifically listed as covered under the Medical Program. The following procedures are considered unproven and therefore not covered:
  - Bariatric surgical procedures in a person who has not attained an adult level of physical development and maturation.
  - Gastric electrical stimulation with an Implantable Gastric Stimulator (IGS).
  - Intragastric balloon.
  - Natural orifice transluminal endoscopic surgery (for example, Rose Procedure, StomaphyX) for revision of gastric bypass surgery.
  - The Mini-Gastric Bypass (MGB), also known as Laparoscopic Mini-Gastric Bypass (LMGBP).
- Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.
- Alternative treatments:
  - Acupressure.
  - Aromatherapy.
  - Hypnotism.
  - Massage therapy.
  - Other forms of alternative treatment as defined by the National Center for Complementary and Alternative Medicine (NCCAM) of the National Institute of Health.
  - Rolfing.
- Ambulance transportation charges incurred to transport you:
  - If an ambulance service is not required by your physical condition;
  - If the type of ambulance service provided is not required for your physical condition; or
  - By any form of transportation other than a professional ambulance service.
- Amounts for covered benefits that are in excess of negotiated contracted rates or covered or recommended charges.
- Any non-emergency charges incurred outside of the United States if you traveled to such location to obtain medical services, prescription drugs or supplies, even if otherwise covered under this plan. This also includes prescription drugs or supplies if: such prescription drugs or supplies are unavailable or illegal in the United States; or the purchase of such prescription drugs or supplies outside the United States is considered illegal.
- Any of the following procedures or treatments:
  - Ambulatory blood pressure monitoring.
  - Elective ophthalmologic procedures for correction of visual acuity.
  - Transurethral balloon dilatation of the prostate.
  - Immunotherapy for recurrent abortion.
  - Chemonucleolysis.
  - Bilary lithotripsy.
  - Orthotripsy.
  - Intradiscal electrothermal amuloplasty.
  - Home uterine activity monitoring.
  - Immunotherapy for food allergy.
  - Sensory or auditory integration therapy.
  - Percutaneous lumbar discectomy.
  - Prolotherapy.
- Autopsies and other coroner services and transportation services for a corpse.

- Blood, blood plasma, synthetic blood, blood products or substitutes, including but not limited to, the provision of blood, other than blood derived clotting factors. Any related services including processing, storage or replacement costs, and the services of blood donors, apheresis or plasmapheresis are not covered.
- Care and treatment of complications of non-covered procedures, unless the care and treatment become medically necessary to save the life or limb of a participant.
- Care of inmates: Services and supplies you receive or your enrolled dependent receives while in the custody of any state or federal law enforcement authorities or while in jail or prison.
- Charges submitted for services by an unlicensed hospital, physician or other provider or not within the scope of the provider's license.
- Charges submitted for services that are not rendered or are rendered to a person not eligible for coverage under the Plan.
- Comfort or convenience:
    - Purchase or rental of supplies of common household use such as exercise cycles, air conditioners, humidifiers, personal comfort items, motorized transportation equipment, escalators or elevators, saunas or swimming pools.
    - Services such as television, telephone, barber or beauty service, guest service and similar incidental services and supplies.
- Cosmetic services and plastic surgery: Any treatment, surgery (cosmetic or plastic), service or supply to alter, improve or enhance the shape or appearance of the body whether or not for psychological or emotional reasons including:
    - Face lifts, body lifts, tummy tucks, liposuctions, removal or reduction of non-malignant moles, blemishes, varicose veins, cosmetic eyelid surgery and other surgical procedures;
    - Procedures to remove healthy cartilage or bone from the nose (even if the surgery may enhance breathing) or other part of the body;
    - Repair of piercings and other voluntary body modifications, including removal of injected or implanted substances or devices;
    - Surgery to correct gynecomastia; and
    - Otoplasty.
- Counseling: Services or treatment relating to religious, career, social adjustment, pastoral or financial concerns (see the "Mental Health and Substance Use Disorder Program section for information on services available).
- Court ordered services (if not medically necessary), including those required as a condition of parole or release.
- Custodial care.
- Dental: Services and supplies for dental care, oral surgery or treatment of the teeth or periodontium, except as described under "Dental Services—Accident Only" and "Oral Surgery" in the "PPO, Health Fund and Indemnity Plan Covered Expenses" section.
- Diabetic supplies:
    - Bathtub equipment and supplies.
    - Building or automobile additions or modifications.
    - Communication systems.
    - Environmental control items.
    - Exercise equipment.
    - Items of equipment not primarily used for a medical purpose.
- Diagnosis or treatment of sexual dysfunction/impotence. This exclusion does not apply when an underlying medical condition, such as diabetes, prostate cancer or bodily injury is believed to be the cause of the sexual dysfunction/impotence.
- Diagnostic tests that are:
    - Delivered in other than a physician's office or health care facility; and

- Self-administered home diagnostic tests, including but not limited to HIV and pregnancy tests.

- Educational services:
  - Any services or supplies related to education, training or retraining services or testing, except as specifically listed as covered under the Medical Program. Educational services that are not covered include:
    - Job hardening programs.
    - Job training.
    - Remedial education.
    - Special education.
  - Services, treatment and educational testing and training related to behavioral (conduct) problems, learning disabilities and delays in developing skills, unless coverage is specifically defined in other sections of this SPD.
- Foot care:
  - Arch supports.
  - Hygienic and preventive maintenance foot care, including:
    - Applying skin creams to maintain skin tone.
    - Cleaning and soaking the feet.
    - Other services that are performed when there is not a localized illness, injury or symptom involving the foot.

    This exclusion does not apply to preventive foot care for covered persons who are at risk of neurological or vascular disease arising from diseases such as diabetes.

  - Routine foot care (except when needed for severe systemic disease or preventive foot care for covered persons with diabetes), including:
    - Cutting or removal of corns and calluses.
    - Debriding (removal of dead skin or underlying tissue).
    - Nail trimming or cutting.
  - Shoe inserts.
  - Shoes (standard or custom), lifts and wedges.
  - Treatment of flat feet.
  - Treatment of subluxation of the foot.
- Foreign language and sign language services.
- Home and mobility: Any addition or alteration to a home, workplace or other environment, or vehicle and any related equipment or device, such as:
  - Equipment installed in your home, workplace or other environment, including stair-glides, elevators, wheelchair ramps or equipment to alter air quality, humidity or temperature.
  - Equipment or supplies to aid sleeping or sitting, including non-hospital electric and air beds, water beds, pillows, sheets, blankets, warming or cooling devices, bed tables and reclining chairs.
  - Exercise and training devices, whirlpools, portable whirlpool pumps, sauna baths or massage devices.
  - Other additions or alterations to your home, workplace or other environment, including room additions, changes in cabinets, countertops, doorways, lighting, wiring, furniture, communication aids, wireless alert systems or home monitoring.
  - Purchase or rental of exercise equipment, air purifiers, central or unit air conditioners, water purifiers, waterbeds and swimming pools.

    - Removal from your home, worksite or other environment of carpeting, hypo-allergenic pillows, mattresses, paint, mold, asbestos, fiberglass, dust, pet dander, pests or other potential sources of allergies or illness.
    - Services and supplies furnished mainly to provide a surrounding free from exposure that can worsen your illness or injury.
    - Transportation devices, including stair-climbing wheelchairs, personal transporters, bicycles, automobiles, vans or trucks or alterations to any vehicle or transportation device.
- Home births: Any services and supplies related to births occurring in the home or in a place not licensed to perform deliveries.
- Lactation consultant services (except as described under “Maternity Services” in the “PPO, Health Fund and Indemnity Plan Covered Expenses” section).
- Medical and surgical treatment of snoring, except when provided as a part of treatment for documented obstructive sleep apnea (a sleep disorder in which a person regularly stops breathing for 10 seconds or longer).
- Medical supplies and appliances, such as:
    - Cranial banding.
    - Deodorants, filters, lubricants, tape, appliance cleaners, adhesive, adhesive remover and other items that are not specifically identified under “Ostomy Supplies” in the “PPO, Health Fund and Indemnity Plan Covered Expenses” section.
    - Devices and computers to assist in communication and speech, except for speech aid devices and tracheo-esophageal voice devices.
    - Devices used specifically as safety items or to affect performance in sports-related activities.
    - Oral appliances for snoring.
    - Orthotic appliances and devices that straighten or re-shape a body part, except as described under “Durable Medical Equipment, Prosthetic Devices and Orthotics” in the “PPO, Health Fund and Indemnity Plan Covered Expenses” section.
    - Prescribed or non-prescribed medical supplies. Examples of supplies that are not covered include, but are not limited to:
        - Elastic stockings and ace bandages.
        - Urinary catheters.
          This exclusion does not apply to:
            - Diabetic supplies for which benefits are provided as described under “Diabetes Treatment” in the “PPO, Health Fund and Indemnity Plan Covered Expenses” section;
            - Disposable supplies necessary for the effective use of durable medical equipment; or
            - Ostomy bags and related supplies.
    - The following items, even if prescribed by a physician:
        - Blood pressure cuff/monitor, unless covered under a Livongo program (see the “Manage Diabetes and Chronic Conditions With Advanced Support” section for additional information).
        - Enuresis alarm.
        - Non-wearable external defibrillator.
        - Trusses.
        - Ultrasonic nebulizers.
    - The repair and replacement of durable medical equipment and/or prosthetic devices when damaged due to misuse, malicious breakage or gross neglect.
    - The replacement of lost or stolen durable medical equipment and/or prosthetic devices.

- Tubings, nasal cannulas, connectors and masks, except when used with durable medical equipment.

- Mental health and substance use disorder: Mental health services, including serious mental illness and substance use disorder, except as otherwise listed as covered; see the “Mental Health and Substance Use Disorder Program ” section. This exclusion does not apply to office visits to a member’s family practice, internal medicine or pediatrics physician for these diagnoses.
- Miscellaneous charges for services or supplies including:
  - Cancelled or missed appointment charges, charges to complete claim forms or room or facility reservations or record processing.
  - Charges to have preferred access to a physician’s services such as boutique or concierge physician practices.
  - Charges the recipient has no legal obligation to pay or the charges would not be made if the recipient did not have coverage (to the extent exclusion is permitted by law) including:
    - Any care a public hospital or other facility is required to provide.
    - Any care in a hospital or other facility owned or operated by any federal, state or other governmental entity, except to the extent coverage is required by applicable laws.
    - Care for conditions related to current or previous military service.
    - Care in charitable institutions.
    - Care while in the custody of a governmental authority.
- Multi-disciplinary pain management programs provided on an inpatient basis for acute pain or for exacerbation of chronic pain.
- Naturopaths (with the exception of certain states that recognize licensed Naturopaths in accordance with Affordable Care Act [ACA] guidelines).
- Nutrition:
  - Infant formula, baby food, donor breast milk, nutritional supplements, dietary supplements, electrolyte supplements (unless as part of enteral formula/parenteral nutrition solution), diets for weight control or treatment of obesity (including liquid diets or food), food of any kind (diabetic, low fat, cholesterol), oral vitamins and oral minerals **unless** it is the sole source of nutrition or a certain nutritional formula to treat a specific inborn error of metabolism.
  - Megavitamin and nutrition-based therapy.
- Orthognathic surgery unless considered medically necessary by the Medical Claims Administrator (coverage includes services needed for congenital anomalies).
- Personal care attendant services.
- Physical appearance:
  - Enrollment in a health, athletic or similar club to improve appearance.
  - Plastic or cosmetic surgery, unless specifically listed otherwise as covered under the Medical Program. Examples include:
    - Hair removal or replacement by any means.
    - Liposuction or removal of fat deposits considered undesirable, including fat accumulation under the male breast and nipple.
    - Nutritional procedures or treatments.
    - Pharmacological regimens.
    - Replacement of an existing intact breast implant if the earlier breast implant was performed as a cosmetic procedure.
    - Skin abrasion procedures performed as a treatment for acne.
    - Tattoo or scar removal or revision procedures (such as salabrasion, chemosurgery and other such skin abrasion procedures).
    - Treatment for spider veins.

        - Treatments for hair loss.
        - Treatments for skin wrinkles or any treatment to improve the appearance of the skin.
        - Varicose vein treatment of the lower extremities, when it is considered cosmetic.
- Physical, psychiatric or psychological examinations or testing or vaccinations, immunizations, treatments or testing not otherwise covered under the Plan, when such services are to obtain or maintain employment or insurance, related to judicial or administrative proceedings, conducted for purposes of medical research or conducted to obtain or maintain a license of any type.
- Physiological modalities and procedures that result in similar or redundant therapeutic effects when performed on the same body region during the same visit or office encounter.
- Prescription drugs, except as otherwise listed as covered; see the "Prescription Drug Program" section:
    - Any drug, biological product or device that cannot be lawfully marketed without approval of the U.S. FDA and that lacks such approval at the time of its use or proposed use.
    - Any drug, biological product, device, medical treatment or procedure that is experimental or investigational as defined by the Plan.
    - Drugs labeled "Caution – limited by federal law to investigational use."
    - Drugs or medicines, prescription or non-prescription, unless provided during an authorized hospital or skilled nursing facility admission. Medications approved by the Medical Claims Administrator that are administered in a physician's office or an outpatient hospital setting will also be covered.
    - Drugs or substances used for other than FDA approved indications.
    - Experimental drugs or substances not approved by the Medical Claims Administrator or by the FDA.
    - Experimental or investigational services or unproven services, unless the Plan has agreed to cover them as defined under experimental or investigational in the "Glossary" section.
    - Growth hormone therapy.
    - Self-administered injectable drugs.
- Private duty nursing.
- Procedure or surgery to remove fatty tissue, such as panniculectomy, abdominoplasty, thighplasty, brachioplasty or mastopexy (removal of skin is covered as long as it is considered medically necessary by the Medical Claims Administrator).
- Professional pathology charges, including, but not limited to, blood counts, multi-channel testing and other clinical chemistry tests, when, for example, custodial care or rest cures.
- Prohibited charges by federal anti-kickback or self-referral statutes.
- Provider services:
    - A provider may perform on himself or herself.
    - Ordered by a provider affiliated with a diagnostic facility (hospital or freestanding) when that provider is not actively involved in your medical care before ordering the service or after the service is received. This exclusion does not apply to mammography testing.
    - Ordered or delivered by a Christian Science practitioner.
    - Performed by a provider who is a family member by birth or marriage or domestic partnership, including your spouse, domestic partner, brother, sister, parent or child.
    - Performed by a provider with your same legal residence.
    - Performed by an unlicensed provider or a provider who is operating outside of the scope of his/her license.
    - Provided at a diagnostic facility (hospital or freestanding) without a written order from a provider.
    - That are self-directed to a freestanding or hospital-based diagnostic facility.

- Reproduction:
    - Home ovulation prediction kits.
    - Long-term storage of reproductive materials such as sperm, eggs, embryos (longer than 12 months), ovarian tissue and testicular tissue.
    - Parenting, pre-natal or birthing classes.
    - Services provided by a doula (labor aide).
    - Services and supplies furnished by an out-of-network provider, i.e., not a Progyny provider, or not listed as covered in the Progyny Member Guide.
    - All charges associated with a gestational carrier program for the person acting as the carrier, including, but not limited to, fees for laboratory tests.
    - Surrogate parenting and host uterus.
    - The reversal of voluntary sterilization.
    - Treatments considered experimental by the American Society of Reproductive Medicine.
- Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program of services provided to a terminally ill person by a licensed hospice care agency for which Benefits are described under “Hospice Care” in the “PPO, Health Fund and Indemnity Plan Covered Expenses” section.
- Services, supplies or other treatments that are not medically necessary for the treatment of an illness or injury.
- Services while not participating in the Plan, such as health services provided before the effective date or after the termination date of your coverage under the Plan.
- Services required by federal, state or local authorities:
    - Care for health conditions that are required or directed by federal, state or local authorities to be treated in a public facility.
    - Services received in a federal facility or any items or services provided in any institution operated by any state or community government or agencies when the member has no legal obligation to pay for such items or services.
- Service-related conditions: The treatment of any condition caused by or arising out of service in the armed forces of any country or from an insurrection. This exclusion does not apply to covered individuals who are civilians injured or otherwise affected by war, any act of war or terrorism in a non-war zone.
- Speech therapy to treat stuttering, stammering or other articulation disorders.
- Therapies and tests: Any of the following treatments or procedures:
    - Biofeedback and bioenergetic therapy;
    - Chelation therapy (except for heavy metal poisoning);
    - Educational therapy;
    - Hair analysis;
    - Hypnosis and hypnotherapy, except when performed by a physician as a form of anesthesia in connection with a covered surgery;
    - Primal therapy;
    - Psychodrama;
    - Purging;
    - Recreational therapy; and
    - Sleep therapy.
- Thermograms and thermography.
- Third-party liability: Services and supplies for treatment of illness or injury for which a third party is responsible to the extent of any recovery received from or on behalf of the third party.

- Except as specifically covered under this Plan, TMJ diagnosis and treatment services: surface electromyography, Doppler analysis, vibration analysis, computerized mandibular scan or jaw tracking, craniosacral therapy, orthodontics, occlusal adjustment and dental restorations.
- Transplants:
    - Any and all services related to organ or artificial organ transplants or organ donations, except as specifically covered under the Plan.
    - Any solid organ transplant that is performed as a treatment for cancer.
    - Health services connected with the removal of an organ or tissue from you for a transplant to another person. (Donor costs for removal are payable for a transplant through the organ recipient's benefits under the Plan).
    - Health services for transplants involving mechanical or animal organs.
- Treatment and testing for learning disabilities or educational purposes.
- Vision and hearing:
    - Eye exercise or vision therapy.
    - Hearing aids, eyeglasses or contact lenses and the fitting thereof, unless specifically listed as covered under the Medical Program.
    - Purchase and associated fitting and testing charges for hearing aids, bone anchor hearing aids (BAHAs) and all other hearing assistive devices.
    - Surgery and other related treatment that is intended to correct nearsightedness, farsightedness, presbyopia and astigmatism including, but not limited to, procedures such as laser and other refractive eye surgery and radial keratotomy.
- Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).
- Work-related conditions: Services and supplies for treatment of illness or injury arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense for the service or supply is paid under workers' compensation. The only exception would be if you or your enrolled dependent is exempt from state or federal workers' compensation laws.

Mental Health and Substance Use Disorder Program

If you're enrolled in the Retiree Medical Plan, your plan includes coverage for mental health and substance use disorder services. Services received from in-network mental health providers (Aetna or Blue Cross and Blue Shield of Illinois, depending on your state) lower your out-of-pocket expenses. Out-of-network providers are also covered at a level that may create higher out-of-pocket expenses.

If you have any questions about coverage, or if pre-certification/notification is required, contact your Medical Claims Administrator.

Mental Health and Substance Use Disorder Benefit Summary

Regardless of which option you are covered under, if you elect coverage under the Retiree Medical Plan, outpatient and inpatient mental health and substance use disorder treatment is provided as described in the following chart. The Plan will only cover mental health and substance use disorder treatment that is medically necessary, as defined in the “Glossary” section. All out-of-network provider charges are paid based on the covered charge, which is defined as the recognized charge or eligible expense, depending on your Medical Claims Administrator, as defined in the “Glossary” section.

	PPO		**Health Fund**		
Plan Feature	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**	**Indemnity Plan**
Outpatient Treatment	Office visits: $20 copay per visit, no deductible Other outpatient services: 90% after deductible	60% of covered charge, after deductible	85% after deductible	60% of covered charge, after deductible	90% of covered charge, no deductible
Inpatient Treatment	90% after deductible	$200 copay per confinement, then 60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible	90% of covered charge after deductible

Mental Health and Substance Use Disorder Covered Services

Mental health services include those received on an inpatient or outpatient basis in a hospital or an alternate facility or in a provider’s office. All services must be provided or under the direction of a properly qualified health provider.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential treatment.
- Partial hospitalization/day treatment.
- Intensive outpatient treatment.
- Outpatient treatment.

Inpatient treatment and residential treatment includes room and board in a semi-private room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.

- Provider-based case management services.
- Crisis intervention.

The Plan pays benefits for behavioral services for Autism Spectrum Disorder including intensive behavioral therapies such as Applied Behavior Analysis (ABA) that are the following:

- Focused on the treatment of core deficits of Autism Spectrum Disorder.
- Provided by a Board Certified Applied Behavior Analyst (BCBA) or other qualified provider under the appropriate supervision.
- Focused on treating maladaptive/stereotypic behaviors that are posing danger to self, others and property and impairment in daily functioning.
- Assessment and diagnosis completed by a medical physician, psychiatrist or someone with an MD licensure.

ABA services must be pre-authorized and will be processed according to the outpatient treatment benefit. ABA copays for the PPO Plan are limited to $80 per month.

These benefits describe only the behavioral component of treatment for Autism Spectrum Disorder. Medical treatment of Autism Spectrum Disorder is a covered health service for which benefits are available as described under the applicable medical covered health services categories as described in this section.

Benefits include the following levels of care:

- Inpatient treatment.
- Residential treatment.
- Partial hospitalization/day treatment.
- Intensive outpatient treatment.
- Outpatient treatment.

Inpatient treatment and residential treatment includes room and board in a semi-private room (a room with two or more beds).

Services include the following:

- Diagnostic evaluations, assessment and treatment planning.
- Treatment and/or procedures.
- Medication management and other associated treatments.
- Individual, family and group therapy.
- Provider-based case management services.
- Crisis intervention.

All care must be medically necessary, as determined by the Medical Claims Administrator, and may periodically be reviewed for medical necessity. Contact your Medical Claims Administrator for more information on medical necessity criteria and notification/authorization requirements.

Mental Health and Substance Use Disorder Pre-Certification and Notification

See the “Medical Programs’ Compliance” section for additional information relating to emergency services and pre-certification.

Pre-certification no later than 48 hours of admission are required for certain covered services, which include, but are not limited to:

- Admission to any facility or program for mental health care, including:
  - Acute inpatient psychiatric and/or substance use disorder treatment;
  - Partial hospitalization and intensive outpatient hospitalization and structured outpatient programs;
  - Residential treatment center care; or
  - Substance use disorder detoxification.
- Non-routine outpatient, including:
  - Psychological/neuropsychological testing on a small number of cases (provider will be notified if pre-certification is required);
  - Outpatient Electro-Convulsive Therapy (ECT) (does not apply to Aetna members);
  - Repetitive Transcranial Magnetic Stimulation (rTMS); or
  - ABA for the treatment of autism.

All mental health care must be medically necessary, as determined by the Medical Claims Administrator. Contact the Medical Claims Administrator to determine when and how medical necessity information must be provided to receive pre-certification.

You or your provider must contact the Medical Claims Administrator before you receive any services that require pre-certification. Notification for an admission must be given no later than 48 hours of the admission to any facility for mental health care. In general, it is your in-network provider’s or in-network facility’s responsibility to contact the Medical Claims Administrator. However, if you are using an out-of-network provider or facility, it is your responsibility to notify the Medical Claims Administrator, request authorization and ensure that the provider or facility supplies information to demonstrate that services meet medical necessity. If you do not do so, this will result in denial or reduction of your benefit.

PPO, Health Fund and Indemnity Plan Non-Notification Penalty

When you are covered under the PPO, Health Fund or Indemnity Plan, you have to pay a $500 non-notification penalty or your claim may be denied in its entirety, even if services are medically necessary, if you use an out-of-network provider and do not notify the Medical Claims Administrator when required. The non-notification penalty does not apply to the Indemnity Plan.

Contacting the Medical Claims Administrator

Contact the Medical Claims Administrator:

- If you have any questions about coverage;
- For notification of a facility admission within 48-hours of the admission;
- To find a provider;
- To request any other required pre-certification; or
- To verify when pre-certification or notification is required and how to request it.

Mental Health and Substance Use Disorder Claims and Appeals

The criteria used for making decisions about mental health and substance use disorder benefits are available upon request from the Plan Administrator. If you are denied benefits for treatment of mental health or a substance use disorder, the reasons for denial are also available upon request and will be included with the written denial that you receive.

For more information about claims and appeals, see the “Claims and Appeals Procedures” section.

Your mental health claims apply toward your medical deductible and out-of-pocket limits.

For information about filing claims, see the “Filing a Medical Claim” section.

Mental Health, Neurobiological/Autism Spectrum and Substance Use Disorders

The exclusions listed below apply to services under Mental Health, Neurobiological/Autism Spectrum and Substance Use Disorder Services:

- Services performed in connection with conditions not classified in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*.
- Outside of an initial assessment, services as treatments for a primary diagnosis of conditions and problems that may be a focus of clinical attention, but are specifically noted not to be mental disorders within the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
- Services that are solely educational in nature or otherwise paid under state or federal law for purely educational purposes.
- Tuition or services that are school-based for children and adolescents required to be provided by, or paid for by, the school under the *Individuals with Disabilities Education Act*.
- Outside of initial assessment, unspecified disorders for which the provider is not obligated to provide clinical rationale as defined in the current edition of the *Diagnostic and Statistical Manual of the American Psychiatric Association.*
- Transitional living services.

Mental Health Resources

Here are some additional mental health resources that are no cost to you that can help you get support in a way that works for you. You can learn more about these tools at **MyWellatDell.com > Health & Insurance menu > Mental Health coverage details**.

Service	Description	Where to Find It
Talk to a wellness coach.	A **wellness coach** can offer lifestyle guidance for your day-to-day living to help you with things like stress management, work/life balance, sleep and insomnia, anxiety and depression.	DellWellnessHub.com > Health > Coaching
Build resilience with an app.	**meQuilibrium** is an online resilience-building and stress management program that can help you focus, feel more energized and boost your self-confidence so you can keep cool under pressure.	DellWellnessHub.com > Programs > View All > Click any meQuilibrium tile
Learn mindfulness with an app.	The **RethinkCare** app can help you build skills like mindfulness, emotional intelligence and even basic yoga.	DellWellnessHub.com > Programs > View All > Click any RethinkCare tile

Medical Programs' Compliance

The Dell Medical Programs comply with the following:

- **Newborns' and Mothers' Health Protection Act of 1996.** The Medical Programs will not restrict a mother's or newborn's benefits for a hospital length of stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a delivery by cesarean section. The attending provider (who may be a physician or nurse midwife) may decide, after consulting with the mother, to discharge the mother or newborn child earlier. The Medical Programs will not, under federal law, require that a provider obtain authorization from the Plan or the Medical Claims Administrator for prescribing a length of stay of 48 hours or less for vaginal delivery (or 96 hours for cesarean section).
- **Women's Health and Cancer Rights Act of 1998.** The Medical Programs will provide coverage for mastectomies to provide mastectomy-related benefits to Plan participants. If you are a covered individual who receives benefits for a mastectomy and decide to have breast reconstructive surgery, the Plan will provide coverage in a manner determined in consultation with the attending physician and you for:
    - Reconstruction of the breast on which the mastectomy was performed;
    - Surgery and reconstruction of the other breast to produce symmetrical appearances;
    - Prostheses; and
    - Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These procedures will be covered the same as any other medical/surgical benefit under your Plan. Certain general coverage limitations may apply, including, but not limited to, deductibles, coinsurance, copays and covered charges. If you would like more information on mastectomy-related benefits, contact the Medical Claims Administrator.

- **Mental Health Parity and Addiction Equity Act of 2008.** The Medical Programs will provide coverage for mental health and substance use disorder treatment on the same basis as other medical and surgical benefits. The Medical Programs will not require different cost sharing provisions, treatment limitations (such as annual and/or lifetime limits) or coverage decision requirements for these benefits.
- **Patient Protection and Affordable Care Act (PPACA).**
  - ***Pre-Existing Condition Limitations:*** Group health plans are prohibited from imposing pre-existing condition exclusions. A pre-existing condition is an illness or condition you had before you become covered under a plan. With a pre-existing condition exclusion, limits are imposed on coverage for that condition.
  - ***Annual and Lifetime Limits:*** There are no annual or lifetime dollar limits on the amount the Plan will pay for essential benefits during the entire period you are enrolled in a Dell Medical Program. Benefits considered to be essential benefits under the PPACA include ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management and pediatric services, including oral and vision care.
  - ***Primary Care Physicians:*** You have the right to designate any primary care provider who participates in the Medical Claims Administrator's network and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact your Medical Claims Administrator. **Note:** If your Aetna plan or health insurance coverage designates a primary care physician automatically, you will have the plan-designated primary care physician until you designate your own primary care physician.
  - ***Children Primary Care Physicians:*** You may designate a pediatrician as the primary care provider for your child(ren).
  - ***OB-GYN Services:*** You do not need pre-certification to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology in the Medical Claims Administrator's network. However, the health care professional may be required to comply with certain procedures, including requesting pre-certification for certain services, following a pre-approved treatment plan or procedures for making referrals. For a list of participating obstetrical or gynecological health care professionals, contact your Medical Claims Administrator.
  - ***Preventive Care:*** The Plan provides preventive care at 100%, with no deductible required when you use in-network providers. Preventive care provided at 100% is subject to age and/or gender guidelines of the USPSTF, Advisory Committee on Immunization Practices of the CDC and the HRSA. In addition to preventive procedures, some medications are included as preventive services; however, these medications do require a prescription even if they are available over-the-counter. With respect to women, the Plan covers additional preventive care and screenings as provided for in comprehensive guidelines supported by the HRSA including, but not limited to, contraceptives (approved by the FDA), domestic violence screenings for interpersonal and domestic violence, HIV screenings, breast-feeding counseling and equipment (including breast pumps), screening for gestational diabetes in pregnant women, and DNA tests for HPV as part of cervical cancer screening.

- ***Emergency Services:*** The Plan does not require pre-certification for emergency care or require higher copays or coinsurance for out-of-network emergency services.
- ***Rescission of Coverage:*** Once an individual is covered under a group health plan, a retroactive termination (that is, a rescission of coverage) is prohibited unless the individual performs an act, practice or omission that constitutes fraud or if the individual makes an intentional misrepresentation of material fact, as prohibited by the terms of the Plan. In this case, the Plan must provide at least 30 days advance written notice to each participant who would be affected before coverage may be rescinded. If it is determined (for example, through a dependent eligibility audit) that an individual has enrolled an ineligible dependent in Dell's Plan, that would constitute an intentional misrepresentation of a material fact and could result in a retroactive termination of that ineligible dependent's coverage. A retroactive termination is not considered a rescission to the extent it is attributable to a failure to timely pay required premiums or contributions for the cost of coverage, or to the extent otherwise permitted under applicable law.
- ***Health Insurance Consumer Information:*** The Act requires that each state designate an independent office for health insurance consumer assistance (or an ombudsman). This office will be available to work directly or in coordination with insurance regulators and consumer assistance organizations in your state to respond to complaints and inquiries regarding federal insurance requirements and state law. The office of consumer health insurance assistance of ombudsman established by your state will:
  - Help you with filing appeals or complaints.
  - Collection, track and quantify consumer problems and inquiries.
  - Educate and inform you about your rights and responsibilities relating to group health plans and or health insurance coverage.
  - Assist you in enrolling in group health plan or health insurance coverage through referrals, information and assistance.
  - Assist and provide problem resolution for you in acquiring premium tax credits under section 36B of the Internal Revenue Code of 1986.

If you receive an adverse determination on a claim or appeal, the determination notice will include contact information for an office of consumer assistance or ombudsman (if any) that might be available to assist you with the claims and appeals processes.

No Surprises Act

Continuity of Care

If you are under the care of a participating provider as defined in the SPD who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to continue coverage for that provider's covered charge at the participating provider in-network level if one of the following conditions is met:

- You are undergoing a course of treatment for a serious and complex condition;
- You are undergoing institutional or inpatient care;
- You are scheduled to undergo non-elective surgery from the provider (including receipt of post-operative care from such provider with respect to such surgery);
- You are pregnant or undergoing a course of treatment for your pregnancy; or
- You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving chemotherapy, radiation therapy or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan notifies you of the provider's termination, or any longer period provided by state law. If you are in the second or third trimester of pregnancy when the provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for coverage under this provision, as explained in this SPD.

Federal No Surprises Act

Definitions
The definitions below apply only to this "Federal No Surprises Act" section of this SPD.

"Air Ambulance Services" means medical transport by helicopter or airplane for patients.

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in a condition: (i) placing the health of the individual — or, with respect to a pregnant woman, her unborn child — in serious jeopardy; (ii) constituting a serious impairment to bodily functions; or (iii) constituting a serious dysfunction of any bodily organ or part.

"Emergency Services" means:

- A medical screening examination performed in the emergency department of a hospital or a freestanding emergency department;
- Further medical examination or treatment you receive at a hospital, regardless of the department of the hospital, or a freestanding emergency department to evaluate and treat an emergency medical condition until your condition is stabilized; and
- Covered charges you receive from a non-participating provider during the same visit after your emergency medical condition has stabilized, unless:
    - Your non-participating provider determines you can travel by non-medical or non-emergency transport;
    - Your non-participating provider has provided you with a notice-to-consent form for balance billing of services; and
    - You have provided informed consent.

"Non-Participating Provider" means, with respect to a covered item or service, a physician or other health care provider who is not designated as a participating provider in a network covered under a Dell Plan to provide services to members.

"Non-Participating Emergency Facility" means, with respect to a covered item or service, an emergency department of a hospital or an independent freestanding emergency department that is not designated as a participating provider in a network covered under a Dell Plan to provide services to members.

"Participating Provider" means, with respect to a covered service, a physician or other health care provider is designated as a participating provider in a network covered under a Dell Plan to provide services to members.

"Participating Facility" means, with respect to covered charges, a hospital or ambulatory surgical center is designated as a participating provider in a network covered under a Dell Plan to provide services to members.

"Qualifying Payment Amount" means a median of contracted rates calculated pursuant to federal or state law, regulation and/or guidance.

"Recognized Amount" means an amount determined pursuant to a state law that provides a method for determining the total amount payable for the item or service (if applicable); or, if there is no state law that provides a method for determining the total amount payable for the item or service, the lesser of the Qualifying Payment Amount or billed charges.

Federal No Surprises Act Surprise Billing Protections

The federal No Surprises Act contains various protections relating to surprise medical bills on services performed by non-participating providers and non-participating emergency facilities. The items and services included in these protections ("Included Services") are listed below.

- Emergency services obtained from a non-participating provider or non-participating emergency facility.
- Covered non-emergency services performed by a non-participating provider at a participating facility (unless you give written consent and give up balance billing protections).
- Air ambulance services received from a non-participating provider, if the services would be covered if received from a participating provider.

Claim Payments
For covered charges, the Plan will send an initial payment or notice of denial of payment directly to the provider.

Cost Sharing
For non-emergency services performed by non-participating providers at a participating facility, and for emergency services provided by a non-participating provider or non-participating emergency facility, the recognized amount is used to calculate your cost share requirements, including deductibles, copayments and coinsurance.

For air ambulance services received from a non-participating provider, if the services would be covered if received from a participating provider, the amount used to calculate your cost share requirements, including deductibles, copayments and coinsurance, will be the lesser of the qualifying payment amount or billed charges.

For covered charges, these cost share requirements will be counted toward your participating provider deductible and/or out-of-pocket expense limit, if any.

Prohibition of Balance Billing

You are protected from balance billing on covered charges as set forth below.

If you receive emergency services from a non-participating provider or non-participating emergency facility, the most the non-participating provider or non-participating emergency facility may bill you is your in-network cost share. You cannot be balance billed for these emergency services unless you give written consent and give up your protections not to be balanced billed for services you receive after you are in a stable condition.

When you receive covered non-emergency services from a non-participating provider at a participating facility, the most those non-participating providers may bill you is your Plan's in-network cost share requirements. When you receive emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist or intensivist services at a participating facility, non-participating providers can't balance bill you and may not ask you to give up your protections not to be balance billed. If you get other services at participating facilities, non-participating providers can't balance bill you unless you give written consent and give up your protections.

If your Plan includes air ambulance services as a covered service, and such services are provided by a non-participating provider, the most the non-participating provider may bill you is your in-network cost share. You cannot be balance billed for these air ambulance services.

Filing a Medical Claim

Your claim must be filed no later than 12 months from the date of service. In some instances, providers will have contracts with the Medical Claims Administrator, and they will file claims for you. But in general, you must file claims if you use an out-of-network provider.

It is always your responsibility to ensure that your claim is filed with the Medical Claims Administrator no later than 12 months from the date of service, even if your physician or hospital files your claim for you. If your claim is not filed with the Medical Claims Administrator within 12 months from the date of service, your claim may be automatically denied, unless you were unable to timely file due to legal incapacity, and you would be financially responsible for the entire claim.

The claim should contain an itemized bill from your provider and include the following information:

- Provider's name, address and tax ID number;
- Full name of the patient (no nicknames), age and relationship to the retiree;
- Retiree's name and mailing address;
- The name of the Company (Dell Inc.) and the contract number as stated on your One Card or medical ID card;
- Date and place of service;
- An itemized bill from the provider that includes:
    - Current Procedural Terminology (CPT) codes;
    - Date the illness or injury began;
    - Description of, and the charge for, each service; and
    - Statement indicating either that you are, or you are not, enrolled for coverage under any other health insurance plan or program. If you are enrolled for other coverage you must include the name and address of the other carrier(s); and
- Identification number from your One Card or medical ID card.

Obtain the appropriate claim form from the Medical Claims Administrator. You may use a claim form approved by the Medical Claims Administrator or a HCFA-1500 claim form.

When you complete and submit a claim:

- Make sure to provide all requested information.
- Use a separate claim form for each person for whom you are filing a claim.
- Review the form to ensure accuracy. Incomplete forms will be returned to you and may cause a delay in processing the claim.
- Make a copy of the claim for your records; originals cannot be returned to you.
- Be sure to sign and date the form.
- Be sure to enclose the original bill or statement with the form; cash register receipts, cancelled checks and money order stubs are not acceptable.
- If you or your dependent has coverage under another plan (including Medicare), be sure to include information on the other coverage, including any Explanation of Benefits (EOB) if the other plan paid first.

For more information on filing a claim or appeal, see the “Claims and Appeals Procedures” section.

Submit the form to your Medical Claims Administrator at one of the addresses listed below:

Provider	**Address**
Aetna PPO, Health Fund and Indemnity Plan Claims Filing Address	Aetna P.O. Box 981106 El Paso, TX 79998-1106
BCBSIL PPO and Health Fund	Blue Cross Blue Shield of Illinois P.O. Box 805107 Chicago, IL 60680

If you believe that all or part of your claim was denied in error, you have the right to appeal. See the “Claims and Appeals Procedures” section for more information.

Prescription Drug Program

Introduction

If you are a participant in the Dell Inc. Retiree Medical Plan, you have prescription drug coverage. Prescription drug benefits described in this section, included as part of the Medical Program PPO, Health Fund and Indemnity Plan options, are administered by CVS Caremark.

Prescription Drug Program Terms to Know

- A **formulary** is a list of drugs covered by your Dell health plan prescription drug benefit. It contains generic medications and carefully selected brand-name drugs divided into three tiers, each with a different copay. The drugs on the formulary have been selected based on clinically sound, evidence-based medicine. Formulary medications will fall into one of the following categories:
    - **Tier 1 (generic drugs):** Approved by the U.S. FDA, generic drugs (Tier 1) contain the same active ingredients as corresponding brand-name drugs, are just as safe and effective, and usually cost less. Dell encourages the dispensing of generic drugs whenever possible. Generic drugs have the lowest member copay.
    - **Tier 2 (formulary brand-name drugs):** Formulary brand-name drugs (Tier 2) are marketed under the trademarked brand name, usually by one manufacturer, and do not have generic equivalents. Formulary brand-name drugs are selected based on a review of the relative safety, effectiveness and cost of the many FDA-approved drugs on the market. Your copay for formulary preferred brand-name drugs is higher than for generic drugs in Tier 1.
    - **Tier 3 (non-formulary brand-name drugs):** Non-formulary brand-name drugs (Tier 3) are medications not listed on the formulary. When you opt to use a drug that is not listed as a Tier 1 generic or Tier 2 preferred brand-name drug on the formulary, you will be responsible for the higher copays than for Tier 1 or Tier 2 drugs.
- **Non-formulary, non-covered drugs** are medications that are not covered without a prior authorization for medical necessity. There are covered generic and/or preferred brand-name drug options in the categories of these non-covered drugs. When you opt to use a non-covered drug without prior approval of medical necessity, you will be responsible for the full cost of the medication.
- **Legend** drugs, medications or vitamins are those that require a prescription.
- **Non-legend** drugs, medications or vitamins are those that do not require a prescription.
- A **therapeutic class** is a way of classifying similar medications that are used to treat the same medical conditions. Examples of therapeutic classes are ACE inhibitors to treat conditions such as high blood pressure or statin medications used to treat high cholesterol.

Pharmacy Benefit Overview

There are three ways to obtain your covered medications through the prescription drug benefits:

- **Retail Pharmacy Benefits** for a short-term (up to a 34-day) supply of medications.
- **Home Delivery and Maintenance Choice**® for a long-term (up to a 90-day) supply of maintenance medications.
- **Specialty Drug Pharmacy Benefits**, for specialty drugs dispensed by CVS Specialty (CVS Caremark's specialty pharmacy) as described in the "Specialty Drugs" section.

How to See Prescription Costs, Pharmacies, What's Covered and More
Download the CVS Caremark app or visit **caremark.com** to explore for yourself.

Or you can have your Benefit Pro do it for you. Your Benefit Pro can estimate your prescription costs, find in-network pharmacies, help you understand your prescription benefits and more.

Log on to My Well at Dell **> Contact your Benefit Pro**.

State Requirements

In certain states, new laws require your physician to hand-write "brand necessary" or "brand medically necessary" on prescriptions when your physician feels that generic substitution is not appropriate. Whether you or your doctor requires the brand when a generic substitution is available, you will pay the generic copay plus the cost difference between the brand and the generic. The cost difference will not apply to the prescription drug deductible (if applicable) or prescription drug out-of-pocket maximum.

Using a Retail Pharmacy

CVS Caremark has a national network of participating pharmacies. To experience the lowest out-of-pocket costs, it is important that you use a participating pharmacy. Prescriptions for up to 34-day maintenance medications may be filled up to two times at a participating in-network retail pharmacy. If you choose, you may continue to get your maintenance medication from your local non-CVS retail pharmacy, but **a penalty applies on the third and subsequent fill of the same maintenance medication**. The penalty does not apply toward your prescription drug deductible (if applicable) or prescription drug out-of-pocket maximum, and you are required to pay it even if you meet the calendar year out-of-pocket maximum. The penalty is waived when you use the Maintenance Choice program (described below). To locate a CVS Caremark participating pharmacy in your area, call CVS Caremark at 1-855-248-3445, or go online to caremark.com. You can also use the CVS Caremark mobile app available from the App Store or Google Play.

When filling a prescription you must:

- Obtain a prescription from your physician;
- Bring your prescription to a participating pharmacy;
- You may need to show your CVS Caremark ID card to the pharmacist;
- Verify that the pharmacist has the correct information about you;
- Pay the copay or coinsurance; and
- Sign for receipt of your prescription.

If you lose your ID card, you can find a digital version of the card when logged on to MyWellatDell.com > **Access your digital One Card**.

Using a Non-Participating Retail Pharmacy

If you use a non-participating pharmacy, you must pay 100% of the prescription price when you have it filled and then submit your prescription receipts for covered medications with a completed claim form to CVS Caremark. See the “Filing a Prescription Claim” section for more information on the amount reimbursed.

90-Day Maintenance Medications—Maintenance Choice

Your Prescription Drug Program includes a CVS Caremark Pharmacy Services program called **Maintenance Choice** that provides savings and convenience for members who are regularly taking long-term, maintenance medications for chronic conditions or long-term therapy such as high blood pressure, asthma, diabetes, high cholesterol and depression. It may also result in better adherence to medication you need to take regularly and lower your annual prescription drug costs.

With Maintenance Choice you have the choice and convenience of filling your 90-day supply of maintenance medications at CVS Pharmacy locations (including those inside Target stores) or through CVS Caremark Mail Service Pharmacy at the same 90-day cost.

Prescriptions for 30-day maintenance medications may be filled up to two times at a retail pharmacy. If you choose, you may continue to get your maintenance medication from your local non-CVS retail pharmacy, but a **penalty applies** on the third and subsequent fill of the same maintenance medication. The penalty does not apply toward your prescription drug deductible (if applicable) or prescription drug out-of-pocket maximum, and you are required to pay it even if you meet the calendar year out-of-pocket maximum. To avoid the penalty, use the Maintenance Choice program.

Specialty Drugs

Specialty drugs are high-cost oral, injectable and infused medications that are used to manage complex illnesses such as multiple sclerosis, hepatitis, rheumatoid arthritis, and inflammatory conditions.

The Prescription Drug Program includes an exclusive home delivery service for specialty medications through CVS Specialty. You also have the option to pick up your specialty medication at a CVS retail pharmacy. Certain specialty medications that are required to be administered immediately (that is, within hours) are not subject to the specialty drug requirements included in this section.

For your specialty medication to be covered, you must have your prescription filled through CVS Specialty. If you need to obtain these medications for use in your physician’s office, CVS Specialty can ship the medication directly to your physician’s office or to your home.

CVS Specialty will dispense specialty medications up to a 34-day supply. Before each medication is shipped, you will be contacted to schedule the next fill and confirm delivery information. You may have a specialty medication shipped to your doctor’s office, to your home or to a local CVS Pharmacy location for pickup there.

To find out if a drug you need is classified as a specialty drug, contact CVS Specialty at 1-800-237-2767.

Note: The CVS Caremark Home Delivery program does not carry and therefore is not able to dispense any specialty medications through the Home Delivery program. To expedite delivery, please be sure to work directly with CVS Specialty when obtaining specialty medications. Any prescriptions sent to CVS Caremark for specialty medications will be forwarded to CVS Specialty.

CVS PrudentRx Program

If you are a participant in the PPO or Indemnity medical plan, and you fill certain specialty medications through CVS Specialty pharmacy, you'll have access to new discounts that could bring your out-of-pocket cost for those medications down to $0. If you opt out and fill an eligible prescription, you pay 30% coinsurance.

The CVS PrudentRx program leverages manufacturer discounts. Once you sign up, discounts are automatically applied at the time of purchase if your prescription is eligible.

The types of specialty medications eligible include, for example, certain drugs that treat autoimmune diseases, multiple sclerosis and hemophilia. To find out if your prescription is eligible for the discount and to enroll, contact CVS Specialty pharmacy at 1-800-237-2767.

PrudentRx is not available to members of the Health Fund Plan. Due to IRS rules, HSA-qualified high-deductible health plans like the Health Fund require members to meet a deductible prior to receiving coverage of a non-preventive medication (or service). The PrudentRx program waives the out-of-pocket responsibility ($0 copays) for eligible specialty medications dispensed by CVS Specialty pharmacy, making Health Fund members ineligible.

Specialty Copay Card Program

Some specialty medications may qualify for third-party copayment assistance programs which could lower your out-of-pocket costs for those products. For any such specialty medication where third-party copayment assistance is used, you will not receive credit toward your out-of-pocket maximum or deductible for any copayment or coinsurance amounts that are applied to a manufacturer coupon or rebate.

Prescription Drug Program Copays and Coinsurance

PPO and Indemnity Plans

In the PPO and Indemnity plans, you pay a copay (a flat fee) for Tier 1 (generic) drugs and coinsurance (a percentage of the total cost) for Tier 2 (formulary brand-name) and Tier 3 (non-formulary brand-name) drugs. Minimum and maximum payments apply to brand-name medication coinsurance amounts. Certain non-formulary drugs are not covered by the Dell plan except in instances where a medical necessity prior authorization has been granted.

Plan Feature	Coverage
Prescription Drug Benefits	
Out-of-Pocket Maximum	$1,500 per person/$4,500 per family Includes copays and coinsurance paid for retail, Home Delivery and CVS Specialty claims; excludes ancillary fees and out-of-pocket costs paid for non-covered medications, such as non-sedating antihistamines and proton pump inhibitors.

Plan Feature	Coverage
Deductible	No deductible
Fertility Medications	Medications are bundled within the Smart Cycle benefit for members participating in the Progyny fertility program. There are two smart cycles per lifetime per family. For further information, see the “Progyny Fertility Program” section, where you’ll find contact information for Progyny’s PCAs.
*Retail Pharmacy**	
Maximum Supply Per Prescription	
Tier 1: Generic Medication	$8 copay up to 34-day supply
Tier 2: Formulary Brand-Name Medication	You pay 25% of cost; $30 minimum/$70 maximum copay per 34-day supply
Tier 3: Non-Formulary Brand-Name Medication	You pay 45% of cost; $50 minimum/$125 maximum copay per 34-day supply
*You can get two 30-day fills of long-term maintenance medications at any pharmacy in the network. But, if you continue to get 30-day fills of a maintenance medication at a non-CVS pharmacy after that, you’ll pay a higher copay (2x regular retail copay) unless you switch to a 90-day supply using home delivery through CVS Caremark or at a CVS pharmacy, including those inside Target stores.	
Home Delivery/Mail Order Pharmacy (or CVS Pharmacy)	
Maximum Supply Per Prescription	
Tier 1: Generic Medication	$16 copay up to 90-day supply
Tier 2: Formulary Brand-Name Medication	You pay 25% of cost; $75 minimum/$175 maximum copay per up to 90-day supply
Tier 3: Non-Formulary Brand-Name Medication	You pay 45% of cost; $125 minimum/$300 maximum copay per 90-day supply
CVS Specialty	
Tier 1: Generic Medication	$8 copay up to 34-day supply
Tier 2: Formulary Brand-Name Medication	You pay 25% of cost; $30 minimum/$70 maximum copay per 34-day supply
Tier 3: Non-Formulary Brand-Name Medication	You pay 45% of cost; $50 minimum/$125 maximum copay per 34-day supply
Preventive Drugs	Certain preventive medications (examples include but are not limited to aspirin, fluoride, folic acid supplements and breast cancer prevention drugs) will be covered at no cost to you. These medications require a prescription and are subject to certain requirements (for example, folic acid supplements will be covered at no cost for women between the ages of 18 and 45). For more information go to healthcare.gov/what-are-my-preventive-care-benefits.

Health Fund Plan

In the Health Fund Plan, once you meet your combined medical and prescription drug deductible, you pay a copay (a flat fee) for Tier 1 (generic) drugs and coinsurance (a percentage of the total cost) for Tier 2 (formulary brand-name) and Tier 3 (non-formulary brand-name) drugs. Minimum and maximum payments apply to brand-name medication coinsurance amounts. Certain non-formulary drugs are not covered by the Dell plan except in instances where a medical necessity prior authorization has been granted.

Plan Feature	**Coverage**
Prescription Drug Benefits	
Out-of-Pocket Maximum	Combined with medical, $3,500 per person/$7,000 per family. Includes copays and coinsurance paid for retail, Home Delivery and CVS Specialty claims; excludes ancillary fees and out-of-pocket costs paid for non-covered medications, such as non-sedating antihistamines and proton pump inhibitors.
Deductible	Combined with medical, $1,500 per person/$3,000 per family.
Fertility Medications	Medications are bundled within the Smart Cycle benefit for members participating in the Progyny fertility program. There are two smart cycles per lifetime per family. For further information, see the “Progyny Fertility Program” section, where you’ll find contact information for Progyny’s PCAs.
*Retail Pharmacy**	
Maximum Supply Per Prescription	
Tier 1: Generic Medication	After deductible, $8 copay up to 34-day supply
Tier 2: Formulary Brand-Name Medication	After deductible, you pay 25% of cost; $30 minimum/$70 maximum copay per 34-day supply
Tier 3: Non-Formulary Brand-Name Medication	After deductible, you pay 45% of cost; $50 minimum/$125 maximum copay per 34-day supply
* You can get two 30-day fills of long-term maintenance medications at any pharmacy in the network. But, if you continue to get 30-day fills of maintenance medications at a non-CVS pharmacy after that, you’ll pay a higher copay (2x regular retail copay) unless you switch to a 90-day supply using home delivery through CVS Caremark or at a CVS pharmacy, including those inside Target stores.	
Home Delivery/Mail Order Pharmacy (or CVS Pharmacy)	
Maximum Supply Per Prescription	
Tier 1: Generic Medication	After deductible, $16 copay up to 90-day supply
Tier 2: Formulary Brand-Name Medication	After deductible, you pay 25% of cost; $75 minimum/$175 maximum copay up to 90-day supply
Tier 3: Non-Formulary Brand-Name Medication	You pay 45% of cost; $125 minimum/$300 maximum copay up to 90-day supply

Plan Feature	Coverage
CVS Specialty	
Tier 1: Generic Medication	After deductible, $8 copay up to 34-day supply
Tier 2: Formulary Brand-Name Medication	After deductible, you pay 25% of cost; $30 minimum/$70 maximum copay per 34-day supply
Tier 3: Non-Formulary Brand-Name Medication	After deductible, you pay 45% of cost; $50 minimum/$125 maximum copay per 34-day supply
Preventive Drugs	Under the Health Fund, there is no requirement to meet your overall deductible when purchasing drugs on CVS Caremark's Preventive Drug list. You will pay the appropriate cost share. Certain preventive medications (examples include, but are not limited to aspirin, fluoride, folic acid supplements and breast cancer prevention drugs) will be covered at no cost to you. These medications require a prescription and are subject to certain requirements (for example, folic acid supplements will be covered at no cost for women between the ages of 18 and 45). For more information go to healthcare.gov/what-are-my-preventive-care-benefits.

You save the most out of pocket when you purchase generic drugs. Talk with your doctor to see if a generic or formulary brand-name medication on the formulary would be an option for your condition. In most cases, your doctor will find a drug on the formulary that meets your needs. However, you and your doctor may decide that a non-formulary drug is the most appropriate medication for you. If so, you will pay the higher non-formulary brand-name drug coinsurance.

You can compare the cost of different medications:

- If you are not currently enrolled in the CVS Caremark plan, you can go to the "*Prescription drug tools"* section on My Well at Dell (no registration necessary) and follow the steps to estimate your out-of-pocket expenses and see a list of commonly used formulary medications. (Click **Health and Insurance** at the top of the Home page, click the **Prescription Drug Coverage** tile and then click the **Prescription Drug Tools** tile.)
- You can order refills, view claims information, obtain a copy of your prescription drug ID card and more on Caremark.com or on the CVS Caremark app.

Prescription Drug Program Covered Expenses

Following is a short list of some common drugs that are covered. It is not intended to be a complete list of covered medications and supplies. If you have questions about coverage for a specific medication, you should contact CVS Caremark directly at 1-855-248-3445. CVS Caremark Patient Care Advocates are available to take your calls 24 hours a day, seven days a week, 365 days a year.

- Prescription (legend) drugs (for exceptions, see the "Prescription Drug Exclusions and Limitations" section).
- Medications are bundled within the Smart Cycle benefit for members participating in the Progyny fertility program. For further information, please call your PCA at 1-833-278-1676.

- One replacement prescription per year if due to loss, theft or destroyed medication.
- Diabetic supplies, including syringes, needles, devices and pump supplies.
- Respiratory therapy supplies.
- Non-insulin syringes.
- Drugs, biological prescriptions or any other medical substance that federal law requires be dispensed by a qualified pharmacist as prescribed by a physician unless otherwise excluded.
- Insulin and disposable hypodermic needles and syringes necessary to administer insulin.
- Blood glucose testing strips and lancets.
- Fluoride supplements.
- Topical tretinoins.
- HIV medicines.
- Growth hormones.
- Injectables, except as otherwise noted.
- Progesterone suppositories.
- Schedule V controlled substances.
- Hematopoietic agents.
- Legend multivitamins.
- Prescription contraceptives and non-prescription contraceptives when prescribed. (Generic and formulary contraceptives are covered at 100%.)
- Generic legend products (products requiring a written prescription; over-the-counter products are not covered, except prescribed over-the-counter preventive care drugs), subject to the age/gender requirements, at $0 copay, including:
    - Oral fluoride supplement for children from birth through age 5; and
    - Folic acid supplementation for women of childbearing age (age 18 to 45).
- Immunizations. Vaccines are covered under the Medical Program, except that immunizations considered as Preventive under the Affordable Care Act (ACA) are covered through the Medical Program or this Prescription Drug Program. The copay for these preventive immunizations is $0 through the Prescription Drug Program (or through the Well at Dell clinic, if applicable).

CHILDREN (birth through age 18):	**ADULTS (doses, recommended ages and recommended populations vary):**
COVID-19*	COVID-19*
Diphtheria, Tetanus, Pertussis	Hepatitis A
Haemophilus influenzae type B	Hepatitis B
Hepatitis A	Herpes Zoster
Hepatitis B	Human Papillomavirus
Human Papillomavirus	Influenza
Inactivated Poliovirus	Measles, Mumps, Rubella
Influenza	Meningococcal
Measles, Mumps, Rubella	Pneumococcal
Meningococcal	Tetanus, Diphtheria, Pertussis
Pneumococcal	Varicella
Rotavirus	
Varicella	
*Covered for populations recommended by the Centers for Disease Control and Prevention (CDC) at the time of administration. Subject to state allocation guidelines and availability.	

- Diabetic formulary medications and supplies are available at reduced or no cost if you are compliant with the Livongo diabetes management program.

- The copay is waived for diabetic supplies and test strips when purchased with insulin or an oral agent or injectable diabetic medications (e.g., Byetta, Symlin, Victoza, Bydrueron, Trulicity, Tanzeum) when the medication is dispensed first on the same day (you pay this copay).
- Tobacco cessation drugs at no cost, including:
    - Over-the-counter (OTC) products (Nicorette gum, Commit Lozenge, Nicoderm patch).
    - Chantix Starting Pak—retail $0/home delivery $0.
    - Chantix Continuous Pak—retail $0 (1 month)/home delivery $0 (2 months).
    - Zyban generic—retail $0/home delivery $0.
- Formulary medications at the Tier 1 and Tier 2 cost share (as applicable), as well as Tier 3 non-formulary medications cost share (as applicable).

Prescription Drug Program Formulary Exceptions

In some cases, non-formulary drugs may be covered due to medical necessity prior authorization. If there is a medical reason you need the non-formulary medication, ask your doctor to contact CVS Caremark at 1-800-294-5979 and provide documentation that supports your need for a non-formulary drug. Generally, you must have previously tried at least two alternatives (for example, a generic and a lower-cost formulary brand-name drug) before a non-formulary drug will be approved.

Generics Preferred

Generic drugs will always be dispensed if available. Generic drugs are regulated by the federal government to be chemically and therapeutically equivalent to their brand-name drug counterparts. Generic drugs are made available after the patent expires on the brand-name drug.

Under the generics preferred program, members will be charged the brand-name drug coinsurance plus the difference in cost between the brand-name and generic drug, if you receive the brand-name drug when a generic drug is available.

When you bring a prescription to a participating pharmacy, the pharmacist informs you if a generic equivalent is available. You, or your doctor who prescribed the medication, can choose the brand-name medication or its generic equivalent.

If a brand-name drug is necessary, your physician should write “dispense as written” on the prescription. In addition to any copay and coinsurance, you pay the cost difference between the generic and the brand-name medication (which may be up to 100% of the cost of the brand-name medication). This additional amount does not apply toward your prescription drug out-of-pocket maximum, and you are required to pay this difference even if you meet the calendar year out-of-pocket maximum.

Prescription Drug Program Prior Authorization

Some drugs require prior authorization. This means that CVS Caremark will need to make sure these prescriptions meet the Plan’s conditions for coverage. If a drug you take requires prior authorization, your physician will need to contact CVS Caremark for a clinical review. If your prescription is authorized, you will pay your copay or coinsurance amount. If the prescription is not approved for coverage, and you and your physician decide that you should still take the prescribed drug that was not authorized, you will pay the full cost of the medication.

To determine if your medication requires prior authorization, **your physician** (not you) should call CVS Caremark's prior authorization line at 1-800-294-5979. The best way to avoid inconvenience is to have your physician call the prior authorization line before you go to the pharmacy or send for your prescription by mail. The prior authorization line is not for patient use. You cannot obtain prior authorization by calling this line yourself.

Step Therapy

With a step therapy program, medications are grouped in categories, based on cost-effectiveness:

- Front-line medications, the first step, are generic drugs proven safe, effective and affordable. These medications should be tried first because they can provide the same health benefit as more expensive medications, at a lower cost.
- Back-up medications, the second and third steps, are brand-name drugs. These are lower-cost brand-name medications (Step 2) and higher-cost brand-name medications (Step 3).

Step therapy means that certain prescriptions require the use (and treatment failure) of front-line medications before coverage may be allowed for a prescription of a back-up medications.

To find out if your prescriptions are part of the step therapy program, go to caremark.com or call CVS Caremark at 1-855-248-3445.

When a prescription is submitted that is not for a front-line medication, your pharmacist will let you know, and your cost will be higher if you want to get that medication. If you prefer not to pay the full price for the drug prescribed, you should contact your physician. Only your physician can approve and change your prescription to a front-line medication. Call CVS Caremark to get examples of effective front-line medications in the Plan to discuss with your physician. If your physician decides you need a different medication for medical reasons, he or she must call 1-800-294-5979 to request a prior authorization. A CVS Caremark representative will check the Plan's guidelines to see if a Step 2 medication can be covered. If it can, you may pay a higher copay than for a front-line medication. If it cannot be covered, you may need to pay the full price for the medications.

If you do not either try the front-line (or Step 2 back-up) medication or get prior authorization for the drug within 72 hours, a letter will be mailed to your home address explaining the step therapy program and your prescription options.

Drug Quantity Management Program

To help make the use of prescription drugs safer and more affordable, the Plan includes a **Drug Quantity Management** program. For certain medications, you can receive an amount to last you a certain number of days. This gives you the right amount to take the daily dose considered safe and effective, according to the recommendations of the U.S. FDA.

Here is how the program works at the pharmacy:

- When your pharmacist attempts to fill your prescription, the pharmacist will get a message about any applicable quantity limitations for the quantity prescribed. This could mean:
    - You are getting your refill too soon; that is, you should still have medicine left from your last supply. In this case, ask your pharmacist when it will be time to get a refill; or
    - Your physician wrote you a prescription for a quantity larger than the Plan covers.
- If the quantity on your prescription is more than allowed on the benefit, you can:
    - Have your pharmacist fill your prescription as written, for the amount the Plan covers, and pay the appropriate copay or coinsurance amount. If you would like the additional quantity prescribed, you have the option to pay the full price.
    - Ask your pharmacist to call your physician. They can discuss changing your prescription to a higher strength, if one is available.
    - Ask your pharmacist to contact your physician about getting a "prior authorization." That is, your physician can call CVS Caremark to request that you receive the original quantity and strength he/she prescribed. CVS Caremark's prior authorization is available to your physician at 1-800-294-5979, 24 hours a day, seven days a week, so a determination can be made right away.

For home delivery, the CVS Caremark Mail Pharmacy will try to contact your physician to suggest either changing your prescription to a higher strength or a prior authorization review process. If the CVS Caremark Mail Pharmacy does not hear back from your physician within two days, they will fill your prescription for the quantity covered by the Plan. If a higher strength is not available, or the plan does not provide a prior authorization for a higher quantity, the Home Delivery Pharmacy can fill your prescription for the quantity that the Plan covers. For more information about quantity limits under the Plan, visit caremark.com or call CVS Caremark at 1-855-248-3445.

Drug Utilization Review

Drug utilization review electronically alerts your pharmacist to important information that has been previously provided to the pharmacy, such as other medications that you are currently taking. If the potential for drug-related illnesses exists, an alert message is also sent to your pharmacist.

The pharmacist can then inform you of the alert, check with your physician or make a professional judgment whether or not to dispense your prescription. If you notify or your pharmacist notifies your physician of the alert, your physician may authorize the dispensing of a different medication.

Drug utilization review is designed to catch potentially harmful drug interactions in advance, but may not catch all potential problems. You are responsible for reviewing all of your prescription drugs with your physician.

Prescription Drug Exclusions and Limitations

The following is a list of items **not covered** by the Dell Prescription Drug Program. It is not intended to be all-inclusive. If you have questions about a particular medication or supply, you should contact CVS Caremark directly at 1-855-248-3445.

- Prescribed non-sedating antihistamines (prescription non-sedating antihistamines can be obtained by using the CVS Caremark card, however, the cost will be 100% of the discounted price).
- Prescribed Proton Pump Inhibitors. Prescription Proton Pump Inhibitors can be obtained by using the CVS Caremark card; however, the cost will be 100% of the discounted price. Members with specific medical conditions that require treatment with a prescription Proton Pump Inhibitor medication, such as Barrett's esophagus or Zollinger-Ellison syndrome, or if you cannot swallow oral solids (as in the case of very young children and those with feeding tubes), will qualify for an exception. In the event of an exception, the appropriate copay will apply.
- Non-prescription (non-legend) drugs other than insulin and prescribed non-prescription preventive care drugs.
- Most compound medications (drugs that require a licensed pharmacist to combine, mix or alter the ingredients of a medication when filling a prescription).
- Ephedrine, pseudoephedrine and phenylpropanolamine in the state of Oregon.
- Medical devices.
- Nutritional supplements, including infant formulas.
- Anti-wrinkle agents.
- Cosmetic hair removal products.
- Charges for the administration or injection of any drug other than covered immunizations.
- Therapeutic devices or appliances, including support garments and other non-medicinal substances, regardless of intended use.
- Prescriptions that an eligible person is entitled to receive without charge from any workers' compensation laws, or any municipal, state or federal program.
- Drugs labeled "Caution – limited by federal law to investigational use" or experimental drugs.
- Any prescription refilled in excess of the number specified by the physician or any refill dispensed after one year from the physician's original order.
- Medications packaged in individual unit dose packages, unless this is the only packaging available for the medication.
- Medications indicated only for cosmetic use.
- Depigmentation products used for skin conditions requiring a bleaching agent.
- Yohimbine.
- Serums, toxoids and vaccines, unless otherwise stated.
- Ostomy supplies.
- Legend homeopathic drugs.
- Supplemental agents (usually have over-the-counter counterparts).
- Injectable allergy serums.
- Arestin.
- Medications that have over-the-counter equivalents or are available over the counter, except prescribed non-prescription preventive care drugs.
- Any retail cost of drugs above the negotiated fee.

Filing a Prescription Claim

If you need to purchase a covered medication and do not have your member ID card, or if you purchase a covered medication from a non-participating pharmacy, your pharmacist will charge you the full price and you must submit a claim for eligible reimbursement.

Claim forms are available from CVS Caremark Member Services at 1-855-248-3445 or at caremark.com. Read the claim form carefully, fill it out completely and sign it. Incomplete forms will be returned, causing a delay in payment. Send the completed claim form with the original prescription receipts from the pharmacy to:

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

Pharmacy claims must be submitted within 365 days of the date of service to be eligible for reimbursement. Paper pharmacy claims for a covered medication are reimbursed at the contracted rate that CVS Caremark has for that pharmacy, less your applicable copay or coinsurance.

Prescription Drug Claim Determinations

Paper Claims That Do Not Require Prior Authorization

If you or your authorized representative submits a paper claim relating to medications or supplies that do not require prior authorization, a determination will be made within 30 days after the Prescription Drug Claims Administrator receives the paper claim. You or your authorized representative will be notified by the Prescription Drug Claims Administrator of a decision within this 30-day period. See the “Health Care Benefit Claims and Appeals” section for information regarding when this 30-day period for making a determination may be extended.

Submission of a prescription at a pharmacy is not considered the submission of a claim for benefits under the Plan. Except in the context of a prior authorization request, as described below, you or your authorized representative must submit a paper claim to the Prescription Drug Claims Administrator for these claims procedures to apply.

Prescription Drugs That Require Prior Authorization

Prior authorization requests submitted to CVS Caremark will be treated as benefit claims. A decision regarding your prior authorization request will be made within 15 days after receipt of the request by CVS Caremark. The Prescription Drug Claims Administrator will notify your physician within this 15-day period if the prior authorization request is approved. If the prior authorization request is denied, the Prescription Drug Claims Administrator will notify you or your authorized representative in writing within this 15-day period. See the “Health Care Benefit Claims and Appeals” section for information regarding when this 15-day period for making a prior authorization determination may be extended.

If a Claim or Prior Authorization Request Is Denied

If you are dissatisfied with a denial of a paper claim or prior authorization request, you may contact the Prescription Drug Claims Administrator and/or appeal the decision. You must appeal the decision and exhaust the appeals process before you can bring any legal action regarding the claim.

Contact the Prescription Drug Claims Administrator

As an alternative to, or in addition to, an appeal, you may contact the Prescription Drug Claims Administrator at 1-855-248-3445 to clarify any questions you or your authorized representative may have regarding why your claim for coverage was denied. You are not required to contact the Prescription Drug Claims Administrator before appealing.

If you or your authorized representative submitted a paper claim to the Prescription Drug Claims Administrator and it was denied, but you or your authorized representative believes the Prescription Drug Claims Administrator should have considered additional information in processing the paper claim, or you or your authorized representative believes the Prescription Drug Claims Administrator relied on erroneous information, you or your authorized representative may submit additional information to the Prescription Drug Claims Administrator at:

CVS Caremark
P.O. Box 52136
Phoenix, AZ 85072-2136

The Prescription Drug Claims Administrator will treat this submission as the request for a second claim for benefits, rather than as an appeal of the initially denied claim, and, if based on the additional information, you are entitled to reimbursement, the Prescription Drug Claims Administrator will reimburse you in accordance with Plan terms. This is a process that allows you to have your claim reviewed before filing an appeal. However, if the Prescription Drug Claims Administrator decides denial is appropriate based on the additional information, you will be notified according to Plan terms.

For a denied prior authorization request, your physician may choose to initiate different drug therapy to meet both your clinical needs and the Plan's coverage criteria, or your physician may send a follow-up coverage request to CVS Caremark. If you, your authorized representative or your physician believes additional information should have been considered in connection with your prior authorization request, your physician may submit additional information to CVS Caremark by calling 1-800-294-5979. If coverage is justified based on the follow-up coverage request or additional information submitted by your physician, the Prescription Drug Claims Administrator will reimburse you as required under Plan terms.

Prescription Drug Appeal Process—PPO, Health Fund, Indemnity Plan

Coverage Review Description

You have the right to request that a medication be covered or be covered at a higher benefit (e.g., lower copay, higher quantity, etc.). The first request for coverage is called an initial coverage review. CVS Caremark reviews both clinical and administrative coverage review requests.

Clinical coverage review request: A request for coverage of a medication that is based on clinical conditions of coverage that are set by the Plan. For example, medications that require a prior authorization.

Administrative coverage review request: A request for coverage of a medication that is based on the Plan's benefit design.

How to Request an Initial Coverage Review

The preferred method to request an initial clinical coverage review is for the prescriber or dispensing pharmacist to call CVS Caremark at 1-800-294-5979. Alternatively, the prescriber may submit a completed coverage review form to 1-888-836-0730. Forms may be obtained online at caremark.com.

If your situation meets the definition of urgent under the law, an urgent review may be requested and will be conducted as soon as possible, but no later than 72 hours from receipt of request. In general, an urgent situation is one which, in the opinion of the attending provider, your health may be in serious jeopardy or you may experience pain that cannot be adequately controlled while you wait for a decision on the review. If you or your provider believes your situation is urgent, an expedited review may be requested.

How a Coverage Review Is Processed

In order to make an initial determination for a clinical coverage review request, the prescriber must submit specific information to CVS Caremark for review. For an administrative coverage review request, you must submit information to CVS Caremark to support your request. The initial determination and notification to you and your prescriber will be made within the specified time frames as follows:

Type of Claim	**Decision Time Frame** Decisions are completed as soon as possible from receipt of request but no later than:	**Notification of Decision**	
		Approval	**Denial**
Standard Pre-Service*	15 days (retail) 5 days (home delivery)	Patient: Automated call (letter if call not successful) Prescriber: Fax (letter if fax not successful)	Patient: Letter Prescriber: Fax (letter if fax not successful)
Standard Post-Service*	30 days		
Urgent	72 hours	Patient: Automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: Live call and letter Prescriber: Fax (letter if fax not successful)

*If the necessary information needed to make a determination is not received from the prescriber within the decision time frame, a letter will be sent to you and your prescriber informing them that the information must be received within 45 days or the claim will be denied. The deadline for making a determination is tolled while the Plan is waiting for information from you. CVS Caremark may extend the deadline for making a determination for up to 15 days in special circumstances–see the “Health Care Benefit Claims and Appeals” section for more information.

How to Request a Level 1 Appeal or Urgent Appeal After an Initial Coverage Review, Paper Claim or Prior Authorization Has Been Denied

If an initial coverage review, paper claim or prior authorization has been denied (adverse benefit determination) and you disagree with that denial, a request for appeal must be submitted by your or your authorized representative within 180 days from receipt of notice of the initial adverse benefit determination. To initiate an appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient.
- Member ID.
- Phone number.
- The drug name for which benefit coverage has been denied.
- Brief description of why the claimant disagrees with the initial adverse benefit determination.
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents.

CVS Caremark
Attn: Prescription Claim Appeals MC 109
P.O. Box 52084
Phoenix, AZ 85072
Fax: 1-866-443-1172

An urgent appeal may be submitted if in the opinion of the attending provider, the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function or would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

How a Level 1 Appeal or Urgent Appeal Is Processed

CVS Caremark completes appeals per business policies that are aligned with state and federal regulations. Depending on the type of appeal, appeal decisions are made by a CVS Caremark pharmacist, physician, panel of clinicians, trained prior authorization staff member or independent third-party utilization management company. See the "Health Care Benefit Claims and Appeals" section for additional information regarding level 1 appeals.

Appeal decisions and notifications are made as follows:

Type of Appeal	Decision Time Frame Decisions are completed as soon as possible from receipt of request but no later than:	Notification of Decision	
		Approval	**Denial**
Standard Pre-Service	15 days	Patient: automated call (letter if call not successful) Prescriber: Fax (letter if fax not successful)	Patient: letter Prescriber: Fax (letter if fax not successful)
Standard Post-Service	30 days		
Urgent*	72 hours	Patient: automated call and letter Prescriber: Fax (letter if fax not successful)	Patient: live call and letter Prescriber: Fax (letter if fax not successful)

*If new information is received and considered or relied upon in the review of the appeal, such information will be provided to you and your prescriber together with an opportunity to respond prior to issuance of any final adverse benefit determination.

The decision made on an urgent appeal is final and binding. In the urgent care situation, there is only one level of appeal prior to an external review.

How to Request a Level 2 Appeal After a Level 1 Appeal Has Been Denied

If a level 1 appeal has been denied (adverse benefit determination) and you disagree with that denial, a request for a level 2 appeal must be submitted by you or your authorized representative within 90 days from receipt of notice of the level 1 appeal adverse benefit determination. To initiate a level 2 appeal, the following information must be submitted by mail or fax to the appropriate department for clinical or administrative review requests:

- Name of patient.
- Member ID.
- Phone number.
- The drug name for which benefit coverage has been denied.
- Brief description of why the claimant disagrees with the adverse benefit determination.
- Any additional information that may be relevant to the appeal, including prescriber statements/letters, bills or any other documents.

Clinical review requests:

CVS Caremark
Attn: Prescription Claim Appeals MC 109
P.O. Box 52084
Phoenix, AZ 85072
Fax 1-866-443-1172

How a Level 2 Appeal Is Processed

CVS Caremark completes appeals per business policies that are aligned with state and federal regulations. Appeal decisions are made by a CVS Caremark pharmacist, physician, panel of clinicians or independent third-party utilization management company.

See the “Health Care Benefit Claims and Appeals” section for additional information regarding level 2 appeals.

Appeal decisions and notifications are made as follows:

Type of Appeal	**Decision Time Frame** Decisions are completed as soon as possible from receipt of request but no later than:	**Notification of Decision**	
		Approval	**Denial**
Standard Pre-Service	15 days	Patient: automated call (letter if call not successful) Prescriber: Fax (letter if fax not successful)	Patient: letter Prescriber: Fax (letter if fax not successful)
Standard Post-Service	30 days		

When and How to Request an External Review

The right to request an independent external review may be available for an adverse benefit determination involving medical judgment, rescission or a decision based on medical information, including determinations involving treatment that is considered experimental or investigational. Generally, all internal appeal rights must be exhausted prior to requesting an external review. The external review will be conducted by an independent review organization with medical experts that were not involved in the prior determination of the claim.

To submit an external review, the request must be mailed or faxed to:

Prescription Claim Appeals MC109
CVS Caremark
P.O. Box 52084
Phoenix, AZ 85072-2084

The request must be received within four months of the date of the final Internal adverse benefit determination. If the date that is four months from that date is a Saturday, Sunday or holiday, the deadline will be the next business day.

How an External Review Is Processed

Standard External Review: CVS Caremark will review the external review request within five business days to determine if it is eligible to be forwarded to an Independent Review Organization (IRO) and you will be notified within one business day of the decision.

If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO within five business days of assigning the IRO. The IRO will notify the claimant in writing that it has received the request for an external review and if the IRO has determined that the claim involves medical judgment or rescission, the letter will describe the claimant's right to submit additional information within 10 business days for consideration to the IRO. Any additional information the claimant submits to the IRO will also be sent back to the Claims Administrator for reconsideration. The IRO will review the claim within 45 calendar days from receipt of the request and will send the claimant, the Plan and CVS Caremark written notice of its decision. If the IRO has determined that the claim does not involve medical judgment or rescission, the IRO will notify the claimant in writing that the claim is ineligible for a full external review.

Urgent External Review: Once an urgent external review request is submitted, the claim will immediately be reviewed to determine if it is eligible for an urgent external review. An urgent external review is available if in the opinion of the attending provider, the application of the time periods for completion of (1) an expedited internal appeal (and you have filed an expedited internal appeal) or (2) a standard external review could seriously jeopardize your life or health or the ability for you to regain maximum function or if your final internal adverse benefit determination concerns a health care service for which you received emergency services, but you have not been discharged from a facility.

If the claim is eligible for urgent processing, the claim will immediately be reviewed to determine if the request is eligible to be forwarded to an IRO, and the claimant will be notified of the decision. If the request is eligible to be forwarded to an IRO, the request will randomly be assigned to an IRO and the appeal information will be compiled and sent to the IRO. The IRO will review the claim within 72 hours from receipt of the request and will send the claimant written notice of its decision.

Other Benefits

An Alternative to Physical Therapy

If you're dealing with back, joint or muscle pain, Sword Health is a free virtual platform that offers a convenient, at-home alternative to physical therapy. Sword Health's innovative approach combines guidance from a dedicated physical therapist with easy-to-use technology, giving you the power to heal from home safely and effectively.

Whether you're suffering from a recent injury or struggling with chronic aches and pains, Sword Health can help — with the average member seeing a reduction in pain of up to 70% after just eight weeks.

How It Works

- Your physical therapist will create a custom program just for you, whether you need care for prevention or for addressing acute conditions, chronic pain or post-surgical recovery.
- Sword Health will ship you a tablet and motion sensors to guide you and provide real-time feedback during your exercises.
- Complete your exercise sessions wherever and whenever it is convenient for you.
- Your physical therapist is there to support you virtually and is available to chat.

Please note: You and your dependents (age 18 and over) must be enrolled in the Retiree Medical Plan to access Sword Health. This service is offered in addition to traditional physical therapy coverage through your plan.

Life Events

Overview

During your retirement, you may experience life events such as birth of a child, marriage, divorce, a child losing dependent status, or death. While these types of events may be demanding times in your life, they are also times when you need to consider how your benefits are affected. Most events require that you make changes within 31 days of the event, unless noted otherwise. This section summarizes the effect of the following events on your benefits and the changes that you are allowed to make at that time (you may also want to review the information in the "Changing Your Election" section):

To make changes to your benefit elections go to My Well at Dell and click the **View or change your benefits** tile to see personalized content. Read the instructions carefully and make your elections. When you finish making your changes, you must submit your elections and receive confirmation. If you do not submit your elections, none of the benefit elections will be saved by the system and any changes will not be processed.

The chart below shows qualified status changes, considerations and any changes you may be required or permitted to make due to the change.

If you are making your benefit changes due to the loss of CHIP or Medicaid coverage or because you became eligible for contribution subsidies from Medicaid or CHIP, or if you are adding a newborn to coverage due to birth of a child, you must make changes within **60 days** of the event through the Dell Benefits Center. Newborns will automatically receive medical coverage under the Plan for the first 31 days if you or your spouse is enrolled in a Dell Medical or Retiree Medical Program. **You must report the birth of the child to the Dell Benefits Center at 1-888-335-5663 and add the child to coverage within 60 days to extend coverage beyond day 31.** If you do not add the child within 60 days, he or she cannot be enrolled for coverage under the Plan until the next annual enrollment, unless you experience another qualified status change that is reported within 31 days.

All other changes must be made within **31 days** of your status change or event. If you add or drop coverage for a dependent and the change affects your coverage tier, your coverage tier will automatically be adjusted based on your enrolled dependents.

Qualified Status Change	Required or Allowed Changes
Birth, Adoption, Placement for Adoption, Foster Child, Marriage or Domestic Partnership	▪ You may add coverage for your newly eligible dependent.
Child Loses Plan Eligibility	▪ You must drop coverage for the affected child. (Coverage for children turning age 26 will continue through the end of the month in which they turn 26.)
COBRA Continuation Coverage From Another Plan Ends	▪ You may change your Medical Program option.

Qualified Status Change	Required or Allowed Changes
Death of a Dependent Child	▪ You must drop coverage for the child who has died. ▪ Your coverage tier may be adjusted due to the number of your covered dependents.
Death of a Spouse or Domestic Partner	▪ You must drop your spouse's or domestic partner's coverage. ▪ You must drop coverage for your spouse's or domestic partner's children if they lose eligibility. ▪ You may change your Medical Program option, for example from PPO to Health Fund.
Divorce or Termination of Domestic Partnership	▪ You must drop coverage for your ex-spouse or domestic partner. ▪ You must drop coverage for your ex-spouse's or domestic partner's children if they lose eligibility. ▪ You may drop coverage for your dependent children if they become covered under your ex-spouse's or domestic partner's plan. ▪ You may change your Medical Program option; for example, from PPO to Health Fund.
Family Member Gets New Coverage	▪ You may drop your coverage. ▪ You may drop coverage for your spouse or domestic partner. ▪ You may drop coverage for your affected children.
Family Member Makes New Annual Enrollment Election	▪ You may drop coverage for yourself if you become covered under your spouse's or domestic partner's plan. ▪ You may drop coverage for your spouse or domestic partner and your eligible children if they become covered under the other plan.
Family Member's Coverage Costs Change Significantly	▪ You may drop coverage for yourself and your dependents. ▪ You may drop coverage for your spouse or domestic partner. ▪ You may drop coverage for the affected children.

Qualified Status Change	Required or Allowed Changes
Gain Eligibility in Another Plan	▪ You may drop coverage for yourself, your spouse or domestic partner or any affected children. ▪ You may change your Medical Program option.
Lose Subsidy from Another Employer (for example, if you received subsidized coverage from a prior employer in a severance package and your severance package expires)	▪ You may change your Medical Program option.
Medicare or Medicaid Eligibility	▪ You may drop coverage for the person who became Medicare- or Medicaid-eligible.
Move	▪ You may change your Medical Program option.

Dependents who lose coverage because they are no longer eligible may continue coverage under COBRA. For more information about COBRA, see the “COBRA Continuation Coverage” section.

Death of a Retiree

If you die while covered under the Dell Inc. Retiree Medical Plan, all benefits for you and your dependents will stop at the end of the day that you die. Your covered dependents are eligible for continuation coverage under COBRA. See the “COBRA Continuation Coverage” section for more information.

Claims and Appeals Procedures

Overview

Note: The Claims Administrators have been delegated the exclusive rights to interpret and administer Plan provisions when making decisions on claims and appeals. In most cases, the Claims Administrators have the sole and complete discretionary authority to grant or deny benefits under the Plan and to interpret the terms of the Plan. The Claims Administrators' decisions are final, conclusive and binding. Where the Claims Administrators do not have sole and complete discretionary authority, the Plan Administrator or its delegee has complete discretionary authority to interpret Plan terms. For additional information on claims and appeals procedures, refer to the sections describing each benefit plan.

If you decide to bring any lawsuit, your lawsuit must be filed within one year from notification of a final decision. If you do not do so within this time, you waive any right you may have had to bring a lawsuit.

Types of Claims

There are different types of claims, as follows:

- **Eligibility Claims.** Eligibility claims are related to participation in a program or option or the change of an election to participate during the year.
- **Health Care Benefit Claims.** Health care claims include medical, mental health and substance use disorder, and prescription drug claims.

Eligibility Claims and Appeals Procedures

Eligibility claims and appeals are related to participation in a program or option or the change of an election to participate during the year.

The following information explains the claims and appeals process for eligibility claims:

- **Filing an Eligibility Claim:** Claims should be submitted as soon as possible, but no later than 120 days after the occurrence of the event or expense that is the basis of the claim. To file an eligibility claim, request a Claim Initiation Form from the Dell Benefits Center by calling 1-888-335-5663. You must complete this form and include:
    - A description of the eligibility benefits for which you are applying;
    - The reason(s) for the request; and
    - Relevant documentation.

  Return the form to:

  Dell Claims and Appeals Management
  P.O. Box 1407
  Lincolnshire, IL 60069-1407
  Fax to Dell Claims and Appeals Management: 1-847-554-1826

- **Notification of Claim Decision:** In most cases, a determination letter will be mailed stating approval or denial of your claim within 30 days of receipt by the Dell Claims and Appeals Management team. If additional time is required for completion, you may receive notice within 30 days of a one-time 30-day extension. If your claim is denied, the letter will include:
    - The specific reason or reasons for the denial;
    - Specific references to pertinent Plan provisions on which the denial is based;
    - Information on any new or additional evidence considered, relied on or generated by the review process; and
    - Right to appeal.

  The following information explains the claims and appeals process for eligibility appeals:

- **Filing an Eligibility Appeal:** Appeals should be submitted as soon as possible, but no later than 180 days following the date on the claim determination letter. To file an eligibility appeal, you must include:
    - A description of the eligibility benefits for which you are applying;
    - The reason(s) for the request; and
    - Relevant documentation.

  Return the form to:

  Benefits Administration Committee
  Dell Inc. Retiree Medical Plan
  c/o Global Benefits Director
  One Dell Way
  RR 1 Box 42
  Round Rock, TX 78682

- **Notification of Appeal Decision:** You will receive a certified letter stating approval or denial of your appeal within 30 days of receipt. If additional time is required for completion, you may receive notice within 30 days of a one-time 30-day extension. If your appeal is denied, the letter will include:
    - The specific reason or reasons for the denial;
    - Specific references to pertinent Plan provisions on which the denial is based; and
    - Information on any new or additional evidence considered, relied on or generated by the review process.

Eligibility claim decisions of the Benefits Administration Committee are final. A denial, reduction, rescission (that is, certain retroactive terminations) or termination of benefits based on a determination that a retiree or dependent does not meet the Plan's eligibility requirements is not subject to any outside review.

You may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures. If you decide to bring any lawsuit, your lawsuit must be filed within one year from notification of a final decision. If you do not do so within this time, you waive any right you may have had to bring a lawsuit.

Health Care Benefit Claims and Appeals

Health care benefit claims include medical, mental health and substance use disorder, and prescription drug claims.

For health care benefit claims, many providers will file claims for you; be sure to show your One Card or medical ID card to your provider so they will know where to submit the claim. If your provider does not file the claim, it is your responsibility to do so. If a claim is denied, in whole or in part, and you disagree with the denial, there is a process you must follow to appeal your claim.

The following information provides an overview of the claims and appeals process for health care benefit claims, which include medical, mental health and substance use disorder, and prescription drug claims. Health care claims are divided into:

- ***Urgent Claims***, which are requests for verification or approval of medical care where if the request were not handled quickly, the delay could jeopardize the individual's life, health or ability to regain maximum function or, in the opinion of a physician with knowledge of the condition, the individual would suffer severe pain that cannot be adequately managed without the care or treatment requested.
- ***Pre-Service Claims***, which are claims for benefits where pre-certification is required before you receive care.
- ***Concurrent Claims***, which are claims relating to termination (rescission), reduction or extension of ongoing care.
- ***Post-Service Claims***, which are claims for benefits that have already been provided.

Note: This section provides information on the claims and appeals process for health care benefit claims. However, each Program may vary slightly, as described in the various sections of this SPD that describes the Program. Be sure to refer to these sections for additional information. For example, specific information on filing certain prescription drug claims is described in the "Prescription Drug Program" section.

Filing a Health Care Benefit Claim

To file a health care benefit claim under any of the Programs in this SPD, you should follow each Program's specific claim filing procedures. Claims for health care benefits should be filed directly by the provider or with the Claims Administrator for that Program. Claims will be processed in accordance with the claim procedures under the specific Program.

Claims can be filed by you, your dependent, your beneficiary or someone properly authorized to act on your or their behalf. Claims should be submitted as soon as possible. Unless specified otherwise by your Claims Administrator, your claim may be denied if it is not submitted before the earlier of 12 months after an eligible expense is incurred or by the end of the plan year in which the eligible expense was incurred. This period may be shortened if your coverage under the Plan ends; contact your Claims Administrator for more information.

Health Care Benefit Claim Determination Period

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested and which are submitted to the health plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within five days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral, unless you request written notification.

Ongoing Course of Treatment (for Aetna members only): If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to your health plan and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

You or your dependent will receive a determination notice as soon as possible. If the claim is denied you will receive the written explanation within:

- 72 hours for an urgent claim;
- 15 days for a pre-service claim (one 15-day extension is allowed for special circumstances); or
- 30 days for a post-service claim (one 15-day extension is allowed for special circumstances).

If there is not sufficient information to decide your urgent care claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

The Claims Administrator may extend the deadline for making a determination on a pre-service or post-service claim for up to 15 days if the Claims Administrator determines that such extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the original period to decide the claim, of the circumstances requiring the extension and the date by which the Plan expects to render a decision. If there is an extension, the Claims Administrator will make a decision no later than the last day of this extended determination period. If a decision is not made within this period, your claim is deemed to have been denied. If an extension is requested because additional information is needed from you to determine your claim, you will have 45 days to provide such information and the time period for making the determination will be tolled until you submit the information or the deadline for you to provide the information has passed.

Notification of Health Care Benefit Claim Decision

If your claim is approved, you will receive an Explanation of Benefits or Health Statement. If your claim is not approved, you will receive a written notice with information about the denial or limitation of benefits, including:

- The specific reason or reasons for the denial;
- Specific references to pertinent Plan provisions on which the denial is based;
- A description of any additional materials or information necessary for you to perfect the claim and an explanation of why the material or information is necessary;
- An explanation of the steps you should take if you want to request a review of your claim denial, including any time limits that apply and any applicable voluntary external review procedures; and
- A statement of your right to bring a civil action under ERISA Section 502(a).

In addition, the notice may include:

- A copy, or a statement that a copy is available upon request, of any internal rule, guideline, protocol or other similar criterion that was relied on in making the determination;
- An explanation, or a statement that the explanation is available upon request, of any scientific or clinical judgment that was used in making the determination if it was based on medical necessity, experimental treatment or a similar exclusion or limit; and
- A description of the expedited review process for an urgent claim.

If You Disagree With a Health Care Benefit Claim Decision

If a benefit is denied, rescinded or limited, you or your representative may review pertinent documents and submit written issues and comments to the appropriate Claims Administrator (for an urgent claim, you may appeal orally). If an appeal is filed by a party other than the member (for example, provider, parent for dependents over age 18, spouse) the member must submit an authorization for that person to appeal on their behalf. To request this authorization form, please contact the appropriate Claims Administrator.

If you disagree with the denial, you or your representative, with proper consent, must make a written request for a full and fair review of the claim and denial. **The Claims Administrator must receive the written request within 180 calendar days after receipt of claim denial or limitation notice.** The 180-day requirement may be waived by the Claims Administrator in appropriate cases. Your request for an appeal should be sent to the appropriate Claims Administrator, as shown in the following table:

Type of Appeal	**Send Written Appeals to:**
Medical Program	Depending on your medical option enrollment: Aetna Customer Resolution Team P.O. Box 14463 Lexington, KY 40512 BCBSIL Claim Review Section P.O. Box 2401 Chicago, IL 60690-1364
Fertility Benefit Services	Progyny 1359 Broadway New York, New York 10018
Mental Health and Substance Use Disorder	Depending on your medical option enrollment: Aetna Customer Resolution Team P.O. Box 14463 Lexington, KY 40512 BCBSIL Claim Review Section P.O. Box 2401 Chicago, IL 60690-1364

Type of Appeal	Send Written Appeals to:
Prescription Drug Program. See the "Prescription Drug Program" section for information on handling claims and how to appeal any prescription drug denial.	Depending on your medical option enrollment: Aetna or BCBSIL Option: Clinical review requests: CVS Caremark Attn: Prescription Claim Appeals MC 109 P.O. Box 52084 Phoenix, AZ 85072 Fax: 1-866-443-1172 Administrative Review Requests: CVS Caremark Attn: Prescription Claim Appeals MC 109 P.O. Box 52084 Phoenix, AZ 85072 Fax: 1-866-443-1172

Health Care Benefit Claim Appeal Determination

The review of your claim on appeal will be conducted by an impartial and independent party from the initial claim review. For certain Claims Administrators, including Aetna and BCBSIL, two independent internal levels of appeal must be exhausted for all health care claims. Each level of appeal will review relevant information submitted, including any new information submitted. If a claim involves a medical judgment, the Claims Administrator will consult with a health care professional who was not involved in any previous reviews during the appeal process that has expertise in the specific area involved in the medical judgment.

After your initial request for review is received, you or your beneficiary will receive a written notice of the decision on your initial appeal from the Claims Administrator. You or your beneficiary will receive the written notice within:

Aetna and BCBSIL	Other
72 hours for an urgent claim appeal (this is the final decision). **For Aetna members only:** Aetna has two levels of appeals for urgent care claims, each appeal will be completed within 36 hours; 15 days for a pre-service claim; or 30 days for a post-service claim.	72 hours for an urgent claim appeal; 30 days for a pre-service claim; or 60 days for a post-service claim.

You will be notified, in writing, by the Claims Administrator. If your appeal is **denied**, in whole or in part, the written notice will include:

- The specific reason or reasons for the denial;
- Specific references to pertinent Plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits;
- A description of any voluntary appeal procedures; and
- A statement of your right to bring a civil action under ERISA Section 502(a) and the time frame within which you must bring such action.

In addition, the notice may include a copy, or a statement that a copy is available upon request, of any internal rule, guideline, protocol or other similar criterion that was relied on in making the determination.

An explanation, or a statement that the explanation is available upon request, of any scientific or clinical judgment that was used in making the determination if it was based on medical necessity, experimental treatment or a similar exclusion or limit. In addition, for claims under the Medical Programs, the notice will include:

- Information sufficient to identify the claim involved (including the date of service, the health care provider, and the claim amount [if applicable]);
- The reason or reasons for the denial, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim and a discussion of the decision;
- A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
- The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the internal claims and appeals and external review processes; and
- A statement describing availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

If You Disagree With a First Level Health Care Benefit Claim Appeal Determination

If your first appeal on a non-urgent health care benefit claim is denied, you or your authorized representative must make a written request for a second review of the appeal. Note, where Aetna is the Claims Administrator, a second level appeal must be filed for urgent health care claims. The Claims Administrator must receive the written request for a second appeal within 180 calendar days (within 60 days for Aetna members) after your receipt of the first appeal denial or limitation notice.

After your request for a second review is received, you or your beneficiary will receive a written notice of the decision on your second, and final, appeal from the Claims Administrator within:

- 36 hours for an urgent claim (Aetna only);
- 15 days for a pre-service claim; or
- 30 days for a post-service claim.

A second appeal of your claim is independent of the first appeal, as required by law. This means that the decision on the first appeal will not be considered when reviewing the claim again, and the person who made that decision (or a subordinate of that person) will not be responsible for the second appeal.

Unless otherwise determined by an outside review or a validly filed lawsuit (pursuant to ERISA), the appeals determination of the Claims Administrator, Plan Administrator or their designee is final and binding.

Health Care Benefit Claims and Appeals Special Review Rules

In addition to the procedures described elsewhere in this section:

You have the right to review your claim file and to present evidence and testimony regarding the claim.

You will be provided, free of charge, with any new or additional evidence that the Plan considered or generated in connection with the claim as soon as possible to give you the opportunity to respond before the date a decision is required on your appeal.

Your appeal will not be denied based on a new or additional rationale until you have been provided the rationale, free of charge as soon as possible to give you the opportunity to respond before the date the decision is required on your appeal.

The Plan will continue to provide coverage until your appeal has been decided, to the extent required by law.

If your appeal involves an urgent claim, an expedited appeal may be initiated. You may appeal a denial involving an urgent claim either orally or in writing. All necessary information, including the appeal decision, will be communicated by telephone, facsimile or similar method. In certain circumstances, you may be eligible for an expedited review of an urgent claim denial under the Plan's Health Care Benefit Voluntary External Review, as described in the following section.

Health Care Benefit Voluntary External Review

If, after exhausting the two levels of appeal, you are not satisfied with the final determination, you may request to participate in the voluntary external review program. This program only applies if the claim denial is based on:

- Clinical reasons;
- The exclusions for experimental, investigational or unproven services; or
- Rescission of care.

The voluntary external review program is not available if the claim denial is based on explicit benefit exclusions or defined benefit limits. Contact your Claims Administrator for more information.

A request for an external review must be made within four months of the day you receive an appeal denial or the claim is deemed to be denied on appeal. If the filing deadline falls on a Saturday, Sunday or federal holiday, the deadline is extended to the next business day.

Preliminary Eligibility Determination

To determine the eligibility of your request for external review, the Claims Administrator will determine within five business days of receipt of your request if:

- You had Plan coverage at the time relating to the claim;
- The denial is not related to ineligibility under the Plan;
- You completed the Plan's internal appeal process to the extent completion is required; and
- You provided all information and forms required to process an external review.

Your request for an external review is not eligible if the Claims Administrator determines that you have not met all of the above four requirements.

Within one business day after making a determination, the Claims Administrator will provide you with a written notice of the determination. If your request is:

- Complete but does not meet the requirements for an external review, the notice will include the reasons the request is not eligible as well as contact information for the Employee Benefits Security Administration.
- Not complete, the notice will describe the information or materials needed to complete the request.

Your deadline to complete the request is the end of the four-month period described above or, if later, 48 hours after you receive the notice that the request was not complete.

Voluntary External Review Program

If your request qualifies for external review, it will be assigned to one of the qualified Independent Reviewer Organizations (IRO)—also referred to as External Review Organization (ERO) by Aetna or BCBSIL—with which the Claims Administrator has a contract. Within five business days after assigning the request to the IRO/ERO, the Claims Administrator will provide the documents and information that were considered in making the denial to the IRO/ERO.

The IRO/ERO will give you written notice of the request's acceptance for external review. The notice will include a statement that you have 10 business days to submit additional written information. The IRO/ERO will consider this information in its review. The IRO/ERO also may agree to consider additional information submitted after 10 business days. Within one business day after receiving additional information from you, the IRO/ERO will forward the information to the Claims Administrator. The Claims Administrator may reconsider the denial on appeal based on this additional information. If the Claims Administrator decides to reverse the denial on appeal and provide coverage or payment, written notice will be provided to you and to the IRO/ERO within one business day of the decision. The IRO's/ERO's external review will end when this notice is received.

If the Claims Administrator does not reverse the decision, the IRO/ERO will review all of the information and documents submitted by the deadline. The IRO/ERO will make its own independent decision and will not be bound by any decisions or conclusions reached during the Claims Administrator's internal claims and appeals process.

In addition to the documents and information provided by you and the Claims Administrator, the IRO/ERO will consider the following information or documents if they are available and the IRO/ERO considers them appropriate:

- Your medical records;
- Your attending health care professional's recommendation;
- Reports from appropriate health care professionals and other documents submitted by the Claims Administrator, you or your treating provider;
- Plan terms, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, which include applicable evidence-based standards;
- Any applicable clinical review criteria developed and used by the Claims Administrator, unless the criteria are inconsistent with Plan terms or applicable law; and
- The opinion of the IRO's/ERO's clinical reviewer(s) after considering the information described above to the extent the information or documents are available and the clinical reviewer(s) consider appropriate.

The IRO/ERO will provide written notice of the decision to you and the Claims Administrator within 45 days after the IRO/ERO receives your request. This notice will contain:

- A general description of the reason for the request and information that identifies the claim, including the date(s) of service, health care provider, claim amount (if applicable), diagnosis code and its meaning, treatment code and its meaning and the reason for the previous denial;
- The date the IRO/ERO received the request and the date of the decision;
- References to the evidence or documents (including the specific coverage provisions and evidence-based standards) considered in reaching the decision;
- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards that were relied on in making the decision;
- A statement that the determination is binding except to the extent that other remedies may be available under state or federal law to you or the Claims Administrator;
- A statement that review by a judge may be available to you; and
- Current contact information, including phone number, for any office of health insurance consumer assistance or ombudsman.

If the Claims Administrator receives notice from the IRO/ERO that reverses a denial, the Claims Administrator will immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

The IRO/ERO will maintain records of all claims and notices associated with the outside review process for six years and make these records available for examination by you, the Claims Administrator, or a state or federal oversight agency upon request (except where disclosure would violate state or federal privacy laws).

Expedited External Review

You may file a request for an expedited external review in certain circumstances involving emergency services or where a longer review period could put you in jeopardy (Aetna members may also apply for an expedited internal appeal and an expedited external review at the same time). Specifically, you may file this type of request with respect to a denial involving a medical condition for which the time allowed for completion of:

- An expedited appeal under the Plan's internal appeal process would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function if you file a request for an expedited internal appeal with the Plan; or
- A standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function.
- You may also request an expedited external review if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or a health care item or service for a condition for which you received emergency services if you have not been discharged from the facility.

The processing of your request will be substantially the same as described above for other external review requests, except:

- The decision and notice of eligibility on the preliminary review will be made immediately upon the Claims Administrator's receipt of your request;
- If the request is eligible for external review, the Claims Administrator will transmit required information and documents to the IRO/ERO electronically, by telephone or facsimile, or any other fast, available method; and
- The IRO/ERO will provide you and the Claims Administrator with notice of its decision as quickly as your medical condition or circumstances require, but in no event more than 72 hours after the IRO/ERO receives the request for an expedited external review. If the IRO's/ERO's notice is not provided in writing, within 48 hours after the date of providing that notice, the IRO/ERO will provide written confirmation of the decision to you and the Claims Administrator.

Assignment of Benefits

Except as otherwise expressly provided under the terms of a written agreement with a provider of health care services or supplies to which the Plan or other delegate of the Plan is a named party (a "**Plan Agreement**"), no rights and benefits under the Plan can be assigned or transferred to any person or entity, including, but not limited to, an out-of-network health care provider (or any representative or agent with respect to such provider), either before or after health care services or supplies are provided to or on behalf of a covered person. In the absence of a Plan Agreement which specifically provides for assignment of benefits and/or rights under the Plan (i.e., is not merely an agreement between the covered person and the provider or its representative or agent), the Plan reserves the unilateral right and discretion to elect to make any benefit payment under the Plan directly to the provider, the covered person, or to another designated person or entity, with each such payment being made on behalf of the covered person, and not to such payment recipient in its, his or her own right. Moreover, if the Plan elects to make any such direct payment, it shall not constitute a waiver by the Plan of these anti-assignment provisions. In addition, any payment made under the Plan to any such person or entity discharges the Plan's responsibility to the covered person for benefits under the Plan to the full extent of such payment.

Disclosures of information about the covered person can only be made to the covered person or a covered person's authorized representative and in accordance with applicable law and the terms of the Plan.

Action for Recovery

No action at law or in equity may be brought for recovery under the Plan before exhaustion of the claims and appeals procedures described in this SPD.

Under no circumstances may a claim for recovery under this Plan be made more than one year from a final internal adverse benefit determination.

Participant's Responsibilities

Each participant is responsible for providing the Plan Administrator and/or the Company with your, your dependents' (in the event of a QMSCO) current U.S. mailing address and/or electronic address. Any notices required or permitted to be given by this Plan will be deemed provided if sent by U.S. mail or by electronic means (as specified in ERISA Section 2420.104b-1(c)) to the address you provide. The Plan Administrator, the Company and the Employer have no obligation or duty to locate a participant, dependent or beneficiary. If a participant, dependent or beneficiary becomes entitled to a payment under this Plan and the payment is delayed or cannot be made:

- Because the current address according to the Company's records is incorrect;
- Because the participant, dependent or beneficiary does not respond to the notice sent to the current address according to the Company's records;
- Because of conflicting claims for the payments; or
- For any other reason;

the amount of the payment, if and when made, will be determined under the provisions of the Plan without payment of any interest or earnings.

Unclaimed Benefits

If, within 12 months after any amount becomes payable by this Plan to a participant, dependent or beneficiary, and the amount is not claimed or any check issued under the Plan remains not cashed, provided reasonable care has been exercised in attempting to make the payment, the amount of the payment will be forfeited and will no longer be a liability of the Plan.

Aetna members: Aetna will attempt to contact members if any check issued remains uncashed after 12 months of the date the amount first becomes payable. If the amount has not been claimed within 15 months after it becomes payable, the amount of payment will be forfeited and will no longer be a liability of the Plan.

About the Overall Claims and Appeals Process

For all eligibility and benefit claims, the appropriate Claims Administrator has the exclusive right to interpret and administer Plan provisions, subject to any external voluntary review process, where applicable. The Claims Administrator's decisions are conclusive and binding. Please note that for health care benefit claims, the Claims Administrator's decision is based only on whether benefits are available under the Plan for the proposed treatment or procedure. The determination as to whether a health service is necessary or appropriate is between you and your provider.

In evaluating any claim, the Claims Administrator has the right to require that you (or any other claimant) provide any and all records, documentation and other evidence necessary or helpful to make a determination. Any failure to provide required information may result in a reduction or forfeiture of your rights to benefits if it is determined that due to the omission, you have failed to establish your entitlement to have your claim granted.

The Claims Administrator has no power to add to, subtract from or modify any of the terms of the Plan or to change or add to any benefits provided by the Plan. Any failure by the Claims Administrator to follow the terms of the Plan will not result in a waiver or equitably stop the Plan from relying upon the terms of the Plan.

Note: If you do not comply with the Plan's claims and appeals procedures (which vary by program as noted in this SPD), or do not do so in a timely manner, you will not have exhausted your administrative remedies and may not begin any legal or equitable action in court claiming Plan benefits. However, if you follow the Plan's claims and appeals procedures, you may be able to initiate or pursue an external or judicial review.

Once a final decision has been made, you have a right to bring a civil action under Section 502(a) of ERISA. You must exhaust all levels of appeal under the applicable program of this Plan, including a second appeal, before you have the right to bring a civil action under ERISA.

If you decide to bring any lawsuit, your lawsuit must be filed within one year from notification of a final decision. If you do not do so within this time, you waive any right you may have had to bring a lawsuit.

Benefits Administration Committee Contact Information

All correspondence addressed to the Plan Administrator must be sent to the Administration Committee's office:

Benefits Administration Committee
Dell Inc. Retiree Medical Plan
c/o Global Benefits Director
One Dell Way
RR 1 Box 42
Round Rock, TX 78682

Authorized Representatives

When appealing a claim, you may authorize a representative to act on your behalf. However, you must provide written notification authorizing this representative and comply with each program's claims and appeals procedures. Written notification must be received before a determination is made. The Plan will not address any representative unless it is absolutely sure that he or she is your representative. You or your authorized representative may review the pertinent records and Plan Documents. However, the Plan recognizes court orders giving a person authority to submit claims filed on your behalf. For health care urgent claims, a health care professional with knowledge of your condition may act as your authorized representative without a court order.

You may have, at your own expense, legal representation at any stage of the review process. If any Plan provision is determined to be unlawful or illegal, the illegality will apply only to the provision in question and will not apply to any other Plan provisions.

Release of Information

As a participant in the Plan, you authorize providers to provide the Plan, upon request, with information relating to benefits that you are or may be entitled to under the Plan. This authorization allows the Plan to examine records with respect to those benefits and to obtain information requested.

We strive to protect your health information to the extent required under the law. Under federal law, we may be required to allow the Secretary of Health and Human Services access to your health information for investigations regarding our compliance with the federal privacy requirements for health information.

Coordination of Benefits

If you or any of your covered eligible dependents are covered under any employer group health plan other than this Plan offered by Dell or are eligible for Medicare, the Plan determines how to coordinate benefits paid or payable under this Plan and the benefits paid or payable under the other plan or Medicare. The process by which the Plan makes this determination is called “coordination of benefits.”

Note: Coordination of benefits is not allowed for prescription drug claims. Dell only provides primary coverage for prescription drug coverage.

Once you or a dependent becomes eligible for Medicare based on age, you or the dependent will no longer be eligible for coverage under the Plan. However, an eligible dependent who becomes eligible for Medicare based on a disability may continue to be covered under the Plan concurrently.

Your Responsibility

You must inform the Plan Administrator if you have or any covered eligible dependent has other health coverage or if you are or any covered eligible dependent is eligible for Medicare. You must also consent to the release of any necessary information related to the other coverage. However, to the extent permitted by state and federal law, for determining the applicability of and implementing the terms of these coordination of benefits provisions, the Plan may, without your consent or the consent of any other person, release to or obtain from any other individual or entity any information with respect to any person that the Plan deems to be necessary or advisable for this purpose.

How Benefits Are Coordinated

If this Plan is the primary plan (as defined below), a benefit will be paid by this Plan without regard to any amount paid or payable under any other plan or Medicare. If there is an additional payor, then the allowed amount should be the lower of the two payors.

If the Plan is the secondary plan (as defined below), the amount paid by this Plan will be the difference between:

- The amount the Plan would be required to pay if it were the primary plan; and
- The amount paid or payable by the primary plan.

It is not intended that a plan provide duplicative benefits. Based on the rules contained in this section, this Plan will pay either its benefits in full or a reduced amount that, when added to the benefits payable by other plans, does not exceed 100% of the Plan's normal benefit per processed claim transaction. In no event will amounts paid by this Plan and any other plans exceed 100% of the total amount of the covered expense incurred.

Whenever a benefit has been paid by the Plan that should have been paid by another plan or Medicare (according to the coordination of benefits provisions), the Plan has the right, exercisable alone and in its sole discretion, to recover the payment in any manner the Plan deems appropriate or necessary to obtain recovery.

Whenever payment of a benefit has been made by another plan or Medicare that should have been made by this Plan (according to these coordination of benefits provisions), the Plan has the right to make such payment in any amount it deems necessary to comply with these coordination of benefits provisions, and any payment will be deemed to be full benefits paid under the Plan and will fully discharge the Plan from liability.

Primary Plan

- This Plan will always be secondary to medical payment coverage or personal injury protection coverage under any auto liability or no-fault insurance policy.
- If the other plan is not Medicare and does not have a coordination of benefits provision, the other plan is always primary.
- If the other plan is not Medicare and has a coordination of benefits provision, whether the other plan or this Plan is primary is determined under the following rules:
    - This Plan is primary for a covered expense incurred by a participant (other than a participant who is covered under the other plan as an eligible retiree and has been so covered for a period longer than his or her period of coverage under the Plan).
    - The other plan is primary for a covered expense incurred by a covered eligible dependent or a participant who is covered under the other plan as an eligible retiree and who has been so covered for a period longer than the period of coverage under this Plan, if the covered eligible dependent or participant is an active participant (either as an employee, former employee, retiree, director or former director) in the plan of an employer other than Dell.
    - This Plan is primary for a covered expense incurred by a covered eligible dependent who is covered under the COBRA continuation coverage provisions under the other plan.
    - For a covered expense incurred by a dependent child whose parents are not separated or divorced and who is a covered eligible dependent under a plan of an employer of both parents, the plan covering the parent whose birthday falls earlier in the calendar year is primary. If the birthdays of both parents fall on the same day of the same month, the plan of the parent who has been an active participant in the plan for the longer period is primary.
    - For a covered expense incurred by a dependent child whose parents are not married or who divorced or separated (whether or not they were ever married) and who is a covered eligible dependent under a plan of an employer of both parents:
        - The plan of the parent who by divorce decree, separation agreement, other legal document or state law is designated primarily responsible for the health care expenses for the eligible child is primary; or

        - In the absence of a designation by divorce decree, separation agreement, other legal document or state law, the plan of the parent who has the primary right to possession of the eligible child is primary. If this parent does not have a plan, this parent's spouse's/domestic partner's plan, if any, is primary. If this spouse/domestic partner does not have a plan, then the plan of the parent who does not have primary right to possession of the eligible child is primary.
    - The other plan is primary for a covered expense incurred by a qualified beneficiary covered under this Plan's COBRA and under another plan either as an employee, former employee, retiree, director or former director.
    - The other plan is primary for a covered expense incurred by a qualified beneficiary covered under this Plan's COBRA and under another plan as an eligible dependent.
    - Where none of the above rules determine the order of benefit payments, the plan that has covered the claimant for the longer period will pay benefits first.

Secondary Plan

With respect to a covered expense, if you or a covered eligible dependent is either covered under a plan of an employer other than Dell or is eligible for Medicare, this Plan, the other plan or Medicare will always be the secondary plan whenever it is not determined to be the primary plan under the above rules.

Medicare

Dell's programs comply with the rules of the Social Security Act of 1965, as amended. To the extent permitted by law, this Plan will pay benefits second to Medicare when you become "eligible for Medicare," even if you do not elect it. A person is "eligible for Medicare" if he or she is:

- Covered under it;
- Not covered under it because of having:
    - Refused it;
    - Dropped it; or
    - Failed to make the proper request for it.

There are, however, Medicare-eligible individuals for whom the Plan pays benefits first and Medicare pays benefits second:

- Employees with active current employment status age 65 or older and their spouse is age 65 or older (however, domestic partners are excluded as provided by Medicare);
- Individuals with end-stage renal disease, for a limited period of time; and
- Disabled individuals under age 65 with current employment status and their dependent is under age 65.

This means that if Medicare rules determine Medicare is the secondary plan, this Plan is primary. In all other cases, Medicare is primary and pays first. For more information on coordination of benefits with Medicare, refer to the CMS website at cms.gov.

Filing Claims

You should file your claim first with the primary plan. When the claim is paid by the primary plan, send a copy of the charges and a copy of the explanation of benefits from the primary plan to the secondary plan.

Subrogation and Right of Reimbursement

This section applies to all current or former Plan participants and also to the parents, guardian or other representative of a dependent child who incurs claims and is or has been covered by the Plan. The Plan's right to recover by subrogation or reimbursement applies to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" in this section includes anyone on whose behalf the Plan pays benefits. No adult covered hereunder may assign any rights to, recover medical expenses from any tortfeasor, or other person or entity, to any minor child or children of said adult without the prior express written consent of the Plan.

If the Plan pays benefits for an accident, illness or other condition, the Plan is subrogated to your legal rights and is entitled to be reimbursed by you for any other benefits paid on account of that harm. The Plan's right of subrogation or reimbursement extends to all insurance coverage available to you due to an injury, illness or condition for which the Plan has paid medical claims (including, but not limited to, liability coverage, uninsured or underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers' compensation coverage, no-fault automobile coverage or any first-party insurance coverage). The Plan is always secondary to no-fault coverage, personal injury protection coverage or medical payments coverage.

- **Subrogation:** Subrogation is a doctrine that attempts to place ultimate liability for debt on the party who is responsible for the harm. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to all of your rights of recovery with respect to any claim or potential claim against any party, due to an injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The right of subrogation allows the Plan to "step into your shoes" and bring any legal action against the wrongdoer that you are entitled to bring in an effort to be reimbursed for benefits already paid to you. Claims Administrators may act on behalf of the Plan to seek recovery under the doctrine of subrogation. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name. The right of subrogation will not limit any additional rights of subrogation that the Plan may have to seek repayment of such benefit.
- **Right of Reimbursement:** The right of reimbursement and subrogation are related concepts. If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the Plan first from such payment for all amounts the Plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery. You cannot obtain a double recovery for the same harm at the expense of the Plan. Claims Administrators may act on behalf of the Plan to pursue the Plan's right of reimbursement.
- **Constructive Trust:** By accepting benefits, you agree that if you receive any payment (whether payment is made to you or made on your behalf to any provider) as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds.
- **Lien Rights:** The Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery related to treatment of such harm for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds relating to benefits paid by the Plan including you, your representative or agent, or any other source possessing such funds.
- **First-Priority Claim:** By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

- **Information:** The Plan may in its discretion, without consent of or notice to you, your covered eligible dependent or other person, release to or obtain from any other individual or entity any information with respect to any person that the Plan deems necessary or advisable for the enforcement of the provisions of this section. You acknowledge that the Plan has notified you that it has the right pursuant to HIPAA to share your personal health information in exercising its subrogation and reimbursement rights.

Amount Plan Is Entitled to Recover

The Plan or its designee is subrogated to your or your covered eligible dependents' rights to recover any and all benefits that have been paid or are payable or that are likely (in the opinion of the Plan) to become payable under the Plan and that are related to any condition for which a third party, including another group plan, is or may be liable, without regard to the characterization by a third party, you, your covered eligible dependent, court, jury or any other person or entity, of the payment of such amount as being recovery for pain and suffering, mental anguish, punitive damages or any other basis of recovery other than for payment of medical or other welfare benefits provided by the Plan. In addition, the Plan or its designee may recover its reasonable costs, including attorneys' fees.

The amount the Plan or its designee is subrogated will not be limited or reduced pro rata or otherwise because the third party is liable only in part, because the third party's resources or insurance is limited, because you or your covered eligible dependent has not been fully compensated or because of any other reason or law. The Plan's right to recovery will not be reduced due to your own negligence.

Maximum Amount Plan May Recover

The Plan's right of subrogation will not exceed the:

- Sum of the amount of benefits paid, payable or likely (in the opinion of the Plan) to become payable under the Plan, plus the Plan's reasonable costs, including, but not limited to, attorneys' fees; or
- Total amount of the recovery received from third parties.

Enforcing Plan's Right to Subrogation and Reimbursement

The Plan, in its discretion, may take any and all actions necessary or convenient to enforce any or all of the provisions of this section, including, but not limited to:

- Bringing an action in the name of the Plan, you or your covered eligible dependent against a third party, the third party's liability carrier or, in the case of uninsured or underinsured motorist coverage, your or your covered eligible dependent's automobile insurance carrier;
- Joining in any action by you or your covered eligible dependent against a third party, the third party's liability carrier or, in the case of uninsured or underinsured motorist coverage, your or your covered eligible dependent's automobile insurance carrier;
- Offsetting future benefits by amounts that you or your covered eligible dependent has obtained (or could have obtained with reasonable diligence) from a third party, the third party's liability carrier or, in the case of uninsured or underinsured motorist coverage, your or your covered eligible dependent's automobile insurance carrier; or
- Bringing an action to set aside any settlement agreement entered into without the consent of the Plan.

Participants' and Covered Dependents' Obligations

It is your duty to notify the Plan within 30 days of the date when any notice is given to any party of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition.

You or your covered eligible dependent must inform any attorney, third party and insurance carrier, as well as any other individual or entity connected with the condition or involved in the collection of any amount connected with the condition, of the Plan's right of subrogation.

You or your covered eligible dependent must:

- Execute and deliver to the Plan any assignment, reimbursement or other documents requested by the Plan for enforcing the Plan's rights under this section;
- Provide all information requested by the Plan, the Claims Administrator or its representative;
- Not take any action that might prejudice the Plan's right of subrogation; and
- Not release any third party (even if the release purports to be a partial release or a release for the excess liability over Plan benefits) without the advance written consent of the Plan.

The Plan's rights will not be affected by a release of any third party entered into without such consent.

If you or your covered eligible dependent initiates a liability claim against any third party or the third party's liability carrier, or if reimbursement is sought from you or your covered eligible dependent's automobile insurance carrier under the uninsured or underinsured motorist endorsement, the amounts recoverable must be described and included in the claim.

If you or your covered eligible dependent receives money from or on behalf of any third party, you or your covered eligible dependent must hold the money in trust for the Plan to the extent of the Plan's rights under this section.

If you have a claim for damages or a right to recover damages from a third party or parties for any illness or injury for which benefits are payable under this Plan, the Plan Administrator is subrogated to the claim or right of recovery. The right of subrogation will be to the extent of any benefits paid or payable under this Plan and will include any compromise settlements.

You may be required to make assignments in our favor or do whatever else is reasonably necessary to assist us in enforcing this right. If you refuse to comply with any reasonable request, the Plan Administrator may suspend payments of Plan benefits to you until you comply with the request.

Failure to comply in all respects with this section may cause a denial of benefits for the condition or a termination of your or your covered eligible dependents' coverage under the Plan.

Modification or Waiver of Rules

The Plan may waive or modify any or all of the provisions of this section whenever, under the facts and circumstances of a particular case, it deems the waiver or modification necessary to prevent inequity with respect to any participant or covered eligible dependent.

Notice of Privacy Practices for Protected Health Information

This Notice describes how health care information about you may be used and disclosed by the Dell Inc. Retiree Medical Plan (referred to in this section as the Dell Health Plan) and how you can get access to this information.

Understanding Your Health Information

Each time you visit a hospital, physician or other health care provider, information is documented about you and your symptoms, examination and test results, diagnoses, treatment and plan for future care or treatment. This information is also used by the Dell Health Plan that helps pay for care and services provided to you. For example, the health information may be used as:

- A legal document describing the care you received;
- A means to verify that services billed were actually provided;
- An information tool for underwriting, premium rating and other activities related to creating a contract for health care payment;
- A source of information for determining eligibility and/or coverage under a Dell Health Plan;
- A data resource for utilization review, such as pre-certification and pre-authorization for services; and
- A source of information for establishing or maintaining a service offered under the Dell Health Plan through a business associate.

Understanding what is in your medical record and how your health information is used helps you to:

- Ensure the accuracy of your record;
- Better understand who, what, when, where and why others may access your health information; and
- Make more informed decisions when authorizing disclosure to others.

Your Rights Regarding Your Health Information

Although the Dell Health Plan may use health information about you in carrying out its payment and administrative functions, that information belongs to you. You have the following rights regarding your health information:

- **Right to Request Restrictions.** You have the right to request a restriction on how we use and disclose the health information we receive about you to carry out our payment and health care operations activities and how we disclose health information to persons involved in paying for your care, such as relatives or close friends. You may request a restriction by writing to the Dell Privacy Office at US_Benefits_HIPAA@Dell.com. Your request will be complied with **only** if the:
    - Disclosure is to a health plan for purposes of payment or health care operations (not for purposes of carrying out treatment); and
    - Health information pertains solely to a health care item or service for which the health care provider has been paid out of pocket in full.

- **Right to Request Confidential Communications.** You can request that we communicate with you about your health information only in the way that you ask us to. You may request that we provide your health information by alternative means (for example, only by mail) or at alternative locations (for example, only at work). We follow your request, if it is reasonable and you clearly state that the disclosure of all or part of your health information could endanger you. Requests must be made in writing to the Dell Privacy Office at **US_Benefits_HIPAA@Dell.com**.
- **Right to Access, Inspect and Copy Your Health Information.** You have the right to inspect and/or obtain a copy of the health information that we have about you, except for information that we are allowed to withhold by law. You may also request a summary or an explanation of your health information. Requests for access or a summary or explanation of your health information must be made in writing to the Dell Privacy Office at US_Benefits_HIPAA@Dell.com. The request should indicate the form or format in which you would like to see your health information. We may charge you a fee to copy and mail the information to you or to prepare a summary or explanation. In certain situations, we may deny your request to see your health information. You may be entitled to have a licensed health care professional review that denial.

  If the Plan uses or maintains an electronic health record with respect to your health information, you may obtain a copy of this health information in an electronic format, and, if you choose, direct the health plan to transmit a copy of the electronic health record directly to a third party you designate clearly and specifically. The fee charged for an electronic copy will be limited to labor costs in responding to your request for a copy.
- **Right to Amend Your Health Information.** You have the right to request changes to the health information we have about you. Requests for changes must be made in writing to the Dell Privacy Office at US_Benefits_HIPAA@Dell.com and must explain why you think the change is needed. We may decide that the change you request does not need to be made, for example, if the health information is already correct and complete.
- **Right to Receive an Accounting of Disclosures.** You have the right to receive a listing of how we disclosed your health information to other people or organizations. There are certain disclosures that are not included in the listing, for example, disclosures we make to you about your own health information or disclosures that you give us permission to make. Disclosures that are made for payment and health care operations purposes listed below also are not included. A request for a listing of disclosures must be made in writing to the Dell Privacy Office at US_Benefits_HIPAA@Dell.com. The request must include the dates for the disclosures you want. The first list is free of charge, but there may be a charge for more listings you request within the same 12 months.

  Effective January 1, 2014 insofar as the Plan acquired an Electronic Health Record as of January 1, 2009, or the later of January 1, 2011 or the date the Plan obtained an Electronic Health Record insofar as the Plan acquires an Electronic Health Record after January 1, 2009, disclosures of Protected Health Information made by the Plans from an Electronic Health Record for Treatment, Payment and Health Care Operations during the three years before an individual's request are also subject to a request for an accounting. In that case, we will provide you an accounting of disclosures of health information made by the Plan, and either an accounting of disclosures of health information by all business associates acting on its behalf or a list of business associates acting on its behalf, including contact information, from whom you may request an accounting of disclosures they have made.
- **Right to Receive a Paper Copy of this Notice.** You have the right to request and receive a paper copy of this Notice of Privacy Practices, even if you agreed to receive this Notice electronically. You may obtain a copy of this Notice on the internet by logging on to My Well at Dell. Or you may obtain a paper copy of this Notice by contacting the Dell Privacy Office at US_Benefits_HIPAA@Dell.com.

A Note About Personal Representatives

You may exercise your rights through a personal representative. Your personal representative will be required to produce evidence of his or her authority to act on your behalf before that person will be given access to your health information or allowed to take any action for you. Proof of such authority may take one of the following forms:

- A power of attorney for health care purposes, notarized by a notary public;
- A court order of appointment of the person as the conservator or guardian of the individual; or
- Proof that you are the parent of a minor child.

The Dell Health Plan retains discretion to deny access to your Personal Health Information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

Our Responsibilities With Respect to Your Health Information

We are required by law to keep your health information confidential and to provide you with this Notice of our legal duties and privacy practices with respect to your health information. We will abide by the terms of the Notice as it is currently in effect. We are required to notify you of any "breach" of your unsecured health information.

We reserve the right to change the practices described in this Notice and to apply the new provisions to all the health information we maintain, regardless of when created or received. If we revise our privacy practices, we will send you a copy of the revised notice. You may also request a copy of the revised notice on or after the date that it takes effect.

Routine Uses and Disclosures of Health Information

Except for the situations described below, we will not use or disclose your private health information without your authorization or permission. If you give us permission to disclose your private health information to someone, you have the right to revoke that permission so that we will not disclose the information to that person or organization in the future. The revocation will not affect any uses or disclosures that we made with your permission before it was revoked. Also, if you gave us permission to disclose your information to obtain insurance coverage, you may not revoke it if other law allows the insurer to contest a claim under the policy or the policy itself.

Following are situations where the law allows us to make a use or disclosure of your health information without obtaining your permission:

- **Uses and Disclosures for Payment and Health Care Operations.** We will use or disclose your health information for payment purposes. For example, a bill may be sent to us to pay for your health care. The bill may contain or be accompanied by information that identifies you, your health condition and the treatment you received. We may use your health information to be sure that the bills we pay for your health care are correct. We may also allow certain other health care organizations to see your health information so that they also can arrange payment for care that was provided to you. We will use or disclose your health information for health care operations. For example, we may use your health information for underwriting or to help us determine the premium rates for the Dell Health Plan. We may also allow another health care organization to see your health information for their health care operations. But we will do so only if that other organization has a relationship with you and is required by law to protect the privacy of your information. Also, the information we give to that other organization can only be for specific purposes, such as quality assessment and improvement, evaluation and review of health care professionals, case management, care coordination and health plan performance.
- **Uses and Disclosures to Business Associates**. In some instances, we may contract with business associates for the payment and health care operations services we provide including any third-party tools offered by the Dell Health Plan. For example, we may use an outside company to administer and manage the Dell Health Plan or assist us in evaluating and selecting a service provider to provide or implement certain health technology tools under the Dell Health Plan. We may disclose your health information to our business associates so that they can perform the work that we ask them to. However, to protect your health information, we contractually require that our business associates protect the privacy of your information. Business Associates may include health care organizations, benefits consultants and health technology service providers, as well as other third-party service providers that offer health care related services. We may disclose your health information to a business associate regardless of whether you have used or intend to use a particular service offered by or provided in relation to the contract with such business associate.
- **Uses or Disclosures Required or Permitted by Law.** We may use or disclose health information if the law requires us to use or disclose it for certain reasons. We may also disclose health information if a state law requires us to for auditing or monitoring situations and for licensing or certifying health care facilities or professionals.
- **Disclosure for Public Health Authorities.** We may disclose your health information to public health authorities who need the information to prevent or control disease, injury or disability or handle situations where children are abused or neglected.
- **Disclosures to the FDA.** We may disclose health information when there are problems with a product that is regulated by the FDA. For instance, when the product has harmed someone, is defective or needs to be recalled, we may disclose certain information.
- **Communicable Diseases.** We may disclose health information to a person who has been exposed to a communicable disease or may be at risk of spreading or contracting a disease or condition.
- **Employment-Related Situations.** We may disclose health information to an employer when the employer is allowed by law to have that information for work-related reasons. We may also disclose health information for workers' compensation or similar programs established by law that provide benefits for work-related injuries or illnesses without regard to fault.
- **Disclosures about Victims of Abuse, Neglect or Domestic Violence.** We may disclose health information to appropriate authorities if we have reason to believe that a person has been a victim of abuse, neglect or domestic violence.

- **Disclosures for Health Care Oversight.** We may disclose health information so that government agencies can monitor or oversee the health care system and government benefit programs and be sure that certain health care entities are following regulatory programs or civil rights laws like they should.
- **Disclosures for Judicial or Administrative Proceedings.** We may disclose health information in a court or other type of legal proceeding if it is requested through a legal process, such as a court order or a subpoena.
- **Disclosures for Law Enforcement Purposes.** We may disclose health information to law enforcement if:
    - It is required by law;
    - It is needed to help identify or locate a suspect, fugitive, material witness or missing person;
    - It is about an individual who is or is suspected to be the victim of a crime;
    - We think that a death may have resulted from criminal conduct; or
    - We think the information is evidence that criminal conduct occurred on our premises.
- **Uses or Disclosures in Situations Involving Decedents.** We may use or disclose health information to coroners, medical examiners or funeral directors so that they can carry out their responsibilities.
- **Uses or Disclosures Relating to Organ Donation.** We may use or disclose health information to organizations involved in organ donation or organ transplants.
- **Uses or Disclosures Relating to Research.** We may use or disclose health information for research purposes if the privacy of the information will be protected in the research.
- **Uses or Disclosures to Avert Serious Threat to Health or Safety.** We may use or disclose your health information to appropriate persons or authorities if we have reason to believe it is needed to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
- **Uses or Disclosures Related to Specialized Government Functions.** We may use or disclose health information to the federal government for military purposes and activities, national security and intelligence or so it can provide protective services to the U.S. President or other official persons.
- **Uses or Disclosures for Law Enforcement Custodial Situations.** We may disclose health information about a person in a prison or other law enforcement custody situation for health, safety and security reasons.
- **Uses or Disclosures to Those Involved in Paying for Your Care.** We may disclose health information to a family member, other relative, close personal friend or any other individual you identify if that information is relevant to their involvement in paying for your health care. If possible, we will inform you in advance and allow you to prohibit or limit the disclosure of information to such persons.
- **Disclosures to Plan Sponsor.** We may disclose health information to Dell Inc. as the Plan Sponsor of the Dell Health Plan. Dell Inc., as Plan Sponsor of the Dell Health Plan, has certified that health information will not be used for any other benefits, employee benefit plan or employment-related activities.
- **Marketing.** Communications of health information for the purpose of “marketing” generally require your authorization. Health care operations are not considered “marketing” so do not require your authorization. A communication about a product or service that encourages the recipients of the communication to purchase or use the product or services is not a health care operation, unless the communication relates to a health-related product or service provided by the Dell Health Plan, treatment of the individual or case management or coordination for the individual. Even if the communication is under one of these exceptions, in most but not all circumstances it will still be considered marketing if the communication is made in exchange for direct or indirect payment.

For More Information or to Report a Problem

If you have questions regarding anything contained in this Notice and would like additional information or would like to exercise any of your rights listed above, you may contact the Dell Privacy Officer at US_Benefits_HIPAA@Dell.com.

If you feel that your privacy rights with respect to your health information have been violated, you may file a complaint with us by contacting the Dell Privacy Office. You may also file a complaint with the Secretary of Health and Human Services. There will be no retaliation against you for filing a complaint.

Statement of Compliance

We strive to protect your health information to the extent required under the law. Under federal law, we may be required to allow the Secretary of Health and Human Services access to your health information for investigations regarding our compliance with the federal privacy requirements for health information.

Plan Administration Information

Overview

This SPD is as accurate and up-to-date as possible. Portions of this SPD, which are incorporated by reference into the Dell Inc. Retiree Medical Plan (the Plan) document, together with the Plan document and other documents incorporated by reference into the Plan, constitute and contain the terms of the Plan.

If there is a difference between the Plan Document and the SPD, the Plan Document will govern.

In the case of any uncertainty regarding the meaning or intent of any section in the Plan Document or SPD, the interpretation of the Plan Administrator or the Plan Administrator's designee will be final.

Your participation in the Plan does not provide you with any benefits other than those described in this SPD.

While it is the intent of Dell to continue the Plan indefinitely, Dell reserves the right to terminate or modify the Plan and any benefits hereunder even if the benefits are negotiated, including eligibility for the Plan at any time. This SPD is not a contract for employment.

Certain employers affiliated with Dell participate in the Plan for providing benefits for eligible retirees and eligible dependents. A complete list of employers participating in the Plan and their addresses may be obtained by sending your written request to the Benefits Administration Committee. The address for the Benefits Administration Committee is located in this section.

Plan Basics

- **Company Name and Address:**
  Dell Inc.
  One Dell Way
  Round Rock, TX 78682
- **Plan Name:** Dell Inc. Retiree Medical Plan
- **Employer Identification Number:** 74-2487834
- **Plan Number:** 501
- **Plan Funding:** The Plan is self-funded, which means Dell pays benefits from retiree contributions and Dell's general assets.
- **Type of Administration:** Dell Inc. through its Benefits Administration Committee
- **Plan Year:** January 1 – December 31
- **Plan Administrator and Plan Sponsor:**
  Dell Inc.
  One Dell Way
  Round Rock, TX 78682
- **Agent for Service of Legal Process:**
  Dell Inc.
  Benefits Administration Committee
  One Dell Way
  Round Rock, TX 78682
- **Summary Plan Description Effective Date:** January 1, 2023

- **Benefits:** The Plan is a welfare plan providing medical, mental health and substance use disorder, and prescription drug benefits.

Benefits Administration Committee

The Plan is administered by the Benefits Administration Committee (Committee) appointed by the Leadership Development and Compensation Committee of Dell's Board of Directors. The Committee is responsible for general Plan administration and has all of the powers necessary to administer the Plan, including the sole discretion to:

- Interpret all Plan provisions;
- Decide all matters of fact in granting or denying claims under the Plan;
- Determine Plan eligibility; and
- Determine the amount of and authorize Plan payments.

The Committee may from time to time delegate to Dell retirees or to other persons or entities any of its powers, duties or responsibilities. For example, the Committee may delegate to a Claims Administrator, utilization review organization or insurer certain powers, duties and responsibilities relating to any of the programs offered under the Plan. Also, where benefits provided by the Plan are fully insured the insurance company that provides the benefits may reserve decision-making authority regarding participant claims.

Committee members are:

- Senior Vice President Global Compensation and Benefits;
- Vice President – Corporate Legal; and
- Vice President and Treasurer.

Your ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants are entitled to the rights described below.

Receive Information About Plan and Benefits

You have the right to:

- Examine, without charge, at our office and at other specified locations, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (EBSA).
- Obtain, upon written request, copies of documents governing the operation of the Plan including insurance contracts and copies of the latest annual report (Form 5500 series) and updated SPD. A reasonable charge may be required for the copies.
- Receive a summary of the Plans' annual financial report (summary annual report), which is required by law to be provided to each participant.

Continue Group Health Plan Coverage

Under certain circumstances, you also have the right to:

- Continue health care coverage for yourself, your spouse/domestic partner or your dependents (if eligible) if there is a loss of coverage as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
- Reduce or eliminate exclusionary periods of coverage for pre-existing conditions under your group health plan if you have creditable coverage from another plan.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision (without charge) and to appeal any denial, all within certain time schedules. However, you may not begin any legal action, including proceedings before administrative agencies, until you have followed and exhausted the Plan's claims and appeals procedures.

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

If you have a claim that is denied or ignored, in whole or in part, and you have exhausted the Plan's claims and appeals procedures, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in a federal court. If you believe that Plan fiduciaries have misused the Plan's money or if you believe that you have been discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim is frivolous.

Assistance With Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the EBSA, U.S. Department of Labor, listed in your telephone directory, or the national office at:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210
1-866-444-3272

For more information or to obtain publications about your rights and responsibilities under ERISA or for a list of EBSA offices, contact the EBSA by visiting their website at dol.gov/ebsa or call the publications hotline of the EBSA.

Glossary

Disclaimer

The terms below are commonly used terms but are not intended to be specific to every benefit described in this SPD only.

Terms

Alternate Facility means a health care facility that is not a hospital and that provides, as permitted by law, one or more of the following on an outpatient basis:

- Surgical services;
- Emergency health services; or
- Rehabilitative, laboratory, diagnostic or therapeutic services.

An alternate facility may also provide mental health and/or substance use disorder services.

Approved Health Care Facility or **Approved Health Care Program** means a facility or program that is licensed, certified or otherwise authorized to provide health care pursuant to the laws of the state in which it operates. It must be approved by the Claims Administrator or have entered into an agreement with the Claims Administrator to provide the care described in the contract. These terms include, but are not limited to, hospital, skilled nursing facilities, home health care agencies and hospice care programs.

Autism Spectrum Disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association.

Benefit Claim or Appeal means any claim, which is not a claim for eligibility, for any benefit provided under the Plan. An appeal may relate to the termination, rescission, denial or reduction of any benefit.

Body Mass Index or **BMI** means a calculation used in obesity risk assessment that uses a person's weight and height to approximate body fat.

Breast Reconstruction means the reconstruction of a breast on which a medically necessary mastectomy has been performed and the reconstruction of the non-diseased breast to achieve symmetry. The term also includes prostheses required for reconstruction and treatment of physical complications of all stages of mastectomy including lymphedemas, in a manner determined in consultation with the attending physician and the member. Modification relating to achieving symmetry after the initial reconstruction must be medically necessary.

Calendar Year means a period of one year beginning on January 1 and ending on December 31.

Claims Administrator means the entity that has been engaged by the Benefits Administration Committee to process Plan claims and appeals. Please refer to the "Claims and Appeals Procedures" section for contact information.

- **Eligibility Claims Administrator:** Dell Benefits Administration Committee.
- **Fertility & Family Building Administrator:** Progyny, Inc.
- **Medical Claims Administrators:** Aetna or BCBSIL, depending on enrollment.
- **Prescription Drug Claims Administrator:** CVS Caremark for claims and their Independent Review Organization (IRO) for appeals for Aetna or BCBSIL, depending on enrollment.

Clinical Trial means a scientific study designed to identify new health services that improve health outcomes. In a clinical trial, two or more treatments are compared to each other and the patient is not allowed to choose which treatment will be received.

Coinsurance means the percentage of eligible expenses you are responsible for paying after you meet any applicable deductible.

Concurrent Care means a decision:

- By the Plan to reduce or terminate benefits otherwise payable for a course of treatment that has been approved by the Plan (other than by Plan amendment or termination); or
- With respect to a request by a claimant to extend a course of treatment beyond the period of time or number of treatments that the Plan approved.

Confinement means that a member is a registered bed patient in an approved health care facility or approved health care program due to a physician's recommendation. This does not include detainment for observation.

Congenital Anomaly means a physical developmental defect present at birth.

Copayment or Copay means a set dollar amount of covered expenses that must be paid by or on behalf of a member incurring the expenses.

Cosmetic Procedures means procedures or services that change or improve appearance without significantly improving physiological function, as determined by the Claims Administrator.

Cost-Effective means the least expensive equipment that performs the necessary function. This term applies to durable medical equipment and prosthetic devices.

Covered Charge means either the recognized charge, when Aetna is the Medical Claims Administrator, or the eligible expense, when BCBSIL is the Medical Claims Administrator.

Craniofacial Abnormality means abnormal structure caused by congenital defects, development deformities, trauma, tumors, infections or disease.

Custodial Care means services that are not likely to improve your condition. These services may include, but are not limited to, assistance with dressing, bathing, preparation and feeding of special diets, walking, supervision of medication that is ordinarily self-administered, getting in and out of bed and maintaining continence.

The Claims Administrator determines if care is custodial care.

Deductible means a fixed-dollar amount that you pay each year before the Plan begins to pay for most benefits.

Copays do not count toward your deductible. The paid amount of the deductible does count toward the annual out-of-pocket maximum.

Designated Facility means a facility that has entered into an agreement with the Claims Administrator or with an organization contracting on behalf of the Plan, to provide covered health services for the treatment of specified diseases or conditions. A designated facility may or may not be located within your geographic area.

To be considered a designated facility, the facility must meet certain standards of excellence and have a proven track record of treating specified conditions. Check with your Medical Claims Administrator for specific information about designated facilities included in their network.

Detoxification Treatment means medically necessary services that are required to withdraw, stabilize and evaluate a member who has a physical abstinence syndrome that has created significant impairment in judgment and motor functions.

Inpatient treatment may be required for treatment that:

- Cannot be safely managed on an ambulatory basis; and
- Requires 24 hours observation.

Diabetes Equipment means:

- Blood glucose monitors, including monitors designed to be used by blind individuals;
- Insulin pumps and associated appurtenances;
- Insulin infusion devices; and
- Podiatric appliances for the prevention of complications associated with diabetes.

Diabetes Supplies includes test strips for blood glucose monitors, visual reading and urine test strips, lancets and lancet devices, insulin and insulin analogs, injection aids, syringes, prescriptive and non-prescriptive oral agents for controlling blood sugar levels, glucagon emergency kits and alcohol swabs.

Diabetes Self-Management Training means training provided to a member after the initial diagnosis of diabetes for care and management of the condition, including nutritional counseling and use of diabetes equipment and supplies. It also includes training when changes are required to the self-management regimen and when new techniques and treatments are developed.

Disabled Child means a child who is age 26 or older if he or she meets all of the following:

- Becomes disabled before age 26;
- Has had continuous coverage under a health care plan since he or she became disabled ;
- Lives with you for more than half of the year;
- Does not provide more than half of his or her own support for the year; and
- Provides written proof of disability and dependency satisfactory to the Claims Administrator.

You must request to continue coverage for a disabled child beyond the usual Plan age limits. Requests for continued coverage for your disabled child will be denied if the information is not provided to the Claims Administrator by the submission deadline. (Contact your Claims Administrator for more information.) Coverage can also be requested for a disabled child age 26 or older during a normal enrollment period such as new hire enrollment or due to a qualified status change. Disabled dependent coverage is subject to carrier approval.

Disposable Medical Supplies means supplies ordered by a physician as part of the treatment of an illness or injury such as sterile supplies for the home care of an open wound. This does not include common, over-the-counter, self-care items.

Durable Medical Equipment means equipment that:

- Can stand repeated use;
- Is primarily and customarily used to serve a medical purpose rather than being primarily for comfort or convenience;
- Is usually not useful to a person in the absence of illness or injury;
- Is appropriate for home use;
- Is related to the patient's physical disorder;
- Is not disposable; and
- Is not implantable in the body.

Eligibility Claim or Appeal means a claim or appeal to participate in a plan or option or to change an election to participate during the year.

Eligible Expenses means (a) in the case of a provider, other than a professional provider, which has a written agreement with the Claims Administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time covered services are rendered, such provider's claim charge for covered services and (b) in the case of a provider, other than a professional provider, which does not have a written agreement with the Claims Administrator or another Blue Cross and/or Blue Shield Plan to provide care to you at the time covered services are rendered, will be the lesser of:

- The provider's billed charges, or;
- The Claims Administrator non-contracting eligible charge. Except as otherwise provided in this section, the non-contracting eligible charge is developed from base Medicare reimbursements and represents approximately 240% of the base Medicare reimbursement rate for professional services and 200% of the base Medicare rate for facility charges and will exclude any Medicare adjustment(s) which is/are based on information on the claim.

The base Medicare reimbursement rate described above will exclude any Medicare adjustment(s) which is/are based on information on the claim.

When a Medicare reimbursement rate is not available for a covered service or is unable to be determined on the information submitted on the claim, the eligible charge for non-participating or non-administrator providers will be 60% of the non-participating or non-administrator provider's standard billed charge for such covered service.

The Claims Administrator will utilize the same claim processing rules and/or edits that it utilizes in processing participating provider claims for processing claims submitted by non-participating or non-administrator providers which may also alter the eligible charge for a particular service. In the event the Claims Administrator does not have any claim edits or rules, the Claims Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the claims. The eligible charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

Emergency Care or **Emergency Services** means health services, including mental health and substance use disorder services, provided in a hospital emergency facility or comparable facility to evaluate and stabilize medical conditions of recent onset and severity including, but not limited to, severe pain that would lead a prudent person, possessing an average knowledge of medicine and health, to believe that his or her condition, illness or injury is of a nature that failure to get immediate medical care could result in:

- Placing the patient's health in serious jeopardy;
- Serious impairment of bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- In the case of a pregnant woman, serious jeopardy to the health of the fetus.

Experimental or Investigational (as defined by Aetna) means a drug, device, procedure or treatment that Aetna finds is experimental or investigational because:

- There is not enough outcome data available from controlled clinical trials published in the peer-reviewed literature to validate its safety and effectiveness for the illness or injury involved;
- The needed approval by the U.S. FDA has not been given for marketing;
- A national medical or dental society or regulatory agency has stated, in writing, that it is experimental or investigational, or suitable mainly for research purposes;
- It is the subject of a Phase I, Phase II or the experimental or research arm of a Phase III clinical trial. These terms have the meanings given by regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
- The written protocols or a written consent form used by a facility provider state that it is experimental or investigational.

Experimental or Investigational (as defined by BCBSIL) means medical, surgical, diagnostic, psychiatric, mental health, substance-related and addictive disorders or other health care services, technologies, supplies, treatments, procedures, drug therapies, medications or devices that, at the time the Medical Claims Administrator makes a determination regarding coverage in a particular case, are determined to be any of the following:

- Not approved by the U.S. FDA to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the proposed use;

- Subject to review and approval by any institutional review board for the proposed use (devices that are FDA approved under the Humanitarian Use Device exemption are not considered to be experimental or investigational); or
- The subject of an ongoing clinical trial that meets the definition of a Phase I, II or III Clinical Trial set in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Exceptions:

- Clinical trials for which benefits are available as described in this SPD; and
- If you are not a participant in a qualifying Clinical Trial and have a sickness or condition that is likely to cause death within one year of the request for treatment, the Medical Claims Administrator may, at its discretion, consider an otherwise experimental or investigational service to be a covered health service for that sickness or condition. Before this consideration, the Medical Claims Administrator must determine that, although unproven, the service has significant potential as an effective treatment for that sickness or condition.

Explanation of Benefit or EOB means an itemized statement that shows what action has been taken on a claim; an EOB is provided whenever a medical claim is processed. An EOB is not a bill; it is provided to help you understand how expenses were paid and that the information received by the Plan was correct. An EOB is for your information and files. When you receive an EOB, you should review it to verify that it is accurate and report any inaccuracies.

Fertility Services in regards to Progyny is the premier fertility benefit designed to provide all-inclusive comprehensive coverage for cutting-edge fertility treatments to assist any member wishing to have a child. Progyny's program includes a credentialed provider network and a personalized concierge-style member support team (Patient Care Advocates) that offers education, support and coordinated care.

Progyny’s program does not require a medical diagnosis of infertility in order to access fertility treatment services, which ensures that members of the LGBTQ+ community and single parents by choice receive equitable access to coverage.

Through Progyny's benefit, members have access to a full suite of fertility treatment options, which may include (but may not be limited to): artificial insemination (IUI), cryopreservation of oocytes and sperm, FDA bloodwork and testing, fresh IVF cycle, frozen embryo transfer (FET), frozen oocyte transfer (includes fertilization of previously frozen oocytes and transfer), IVF freeze-all, Patient Care Advocate (PCA) concierge support, pre-authorized fertility medications (via Progyny Rx), PGT-A (PGS, or pre-implantation genetic screening) to assess embryo viability, PGT-M (PGD, or pre-implantation genetic diagnosis), pregnancy gap coverage (pregnancy monitoring coverage until the in-network fertility clinic releases the member into the care of the member's OB-GYN medical provider), tissue transportation (transportation of member’s previously frozen reproductive tissue to in-network facilities) and the purchase of donor tissue (eggs and sperm).

Glucose Level refers to the amount of sugar in your blood. The most common type of test to measure glucose is the fasting blood sugar test (FBS), which measures blood glucose after you have not eaten for at least eight hours. It is often the first test done to check for prediabetes and diabetes.

Health Status-Related Factor means any of the following:

- Health status or medical history;
- Medical condition, either physical or mental;

- Claims experience;
- Receipt of health care;
- Disability; or
- Evidence of Insurability.

Health Services means the health care services or supplies covered under the SPD, except to the extent that such health care services and supplies are limited or excluded.

Home Health Care Agency means a facility or program that is:

- Licensed, certified or otherwise authorized, pursuant to the laws of the jurisdiction where it is located, as a home health agency; and
- Approved by the Medical Claims Administrator to provide covered health services.

Hospice Care or Hospice Care Program means a coordinated, interdisciplinary program designed to meet the special physical, psychological, spiritual and social needs of terminally ill members and their covered dependents, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. The hospice agency or facility must be licensed by the laws of the state in which it operates and must be run as a hospice as defined by those laws. The program must be administered by a hospice facility and it must be for individuals who have been medically diagnosed as having no reasonable prospect of cure for their illness.

Hospice Facility or Agency means a licensed facility or part of a facility that:

- Principally provides hospice care;
- Keeps medical records of each patient;
- Has an ongoing quality assurance program; and
- Has a physician on call at all times.

Hospital means an institution that meets all of the following:

- It provides, for a fee, medical care and treatment of sick or injured patients on an inpatient basis;
- It provides or operates, either on its premises or in facilities available to the hospital on a prearranged basis, medical, diagnostic and major surgical facilities;
- It provides care and treatment by and supervised by physicians;
- It provides nursing services on a 24-hour basis by or supervised by registered nurses;
- It is licensed by the laws of the jurisdiction where it is located and is run as a hospital as defined by those laws; and
- It is not primarily a:
    - Convalescent, rest or nursing home; or
    - Facility providing custodial care or educational services.

The term also includes licensed psychiatric hospitals that are properly accredited to provide psychiatric, diagnostic and therapeutic services for the treatment of patients who have mental illnesses. In addition, if services specifically for the treatment of a physical disability are provided in a licensed hospital, payment of those services will not be denied solely because the hospital is primarily of a rehabilitative nature and lacks major surgical facilities.

Illness means a sickness, disease or pregnancy.

In-Network means covered services provided by network or participating providers.

Individual Treatment Plan means a treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Infertility Services means services or supplies given for the diagnosis or treatment of infertility.

Injury means bodily damage other than illness, including all related conditions and recurrent symptoms.

Inpatient Rehabilitation Facility means a hospital (or a special unit of a hospital) that provides physical therapy, occupational therapy and/or speech therapy on an inpatient basis, as authorized by law.

Inpatient Stay means an uninterrupted confinement, following admission to a hospital, skilled nursing facility or inpatient rehabilitation facility.

Intensive Behavioral Therapy (IBT) means outpatient mental health care services that aim to reinforce adaptive behaviors, reduce maladaptive behaviors and improve the mastery of functional age-appropriate skills in people with Autism Spectrum Disorders. The most common IBT is Applied Behavior Analysis (ABA).

Intensive Outpatient Treatment means a structured outpatient mental health or substance-related and addictive disorders treatment program. The program may be freestanding or hospital-based and provides services for at least three hours per day, two or more days per week.

Intermittent Care means skilled nursing care that is provided or needed either less than seven days each week or less than eight hours each day for 21 days or less.

Life Threatening means an illness or condition for which the likelihood of death is probable unless the course of the illness or condition is interrupted.

Maintenance Medication is any prescription medication that is taken on a long-term basis for chronic conditions. Examples include asthma, diabetes, high cholesterol, high blood pressure or arthritis.

Manipulative Treatment means the therapeutic application of chiropractic and/or manipulative treatment with or without ancillary physiologic treatment and/or rehabilitative methods provided to restore/improve motion, reduce pain and improve function in the management of an identifiable neuromusculoskeletal condition.

Medical Necessity or Medically Necessary means health care services provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, mental illness, substance-related and addictive disorders, condition, disease or its symptoms, that are all of the following as determined by the Medical Claims Administrator or its designee, within the Medical Claims Administrator's sole discretion:

- In accordance with *Generally Accepted Standards of Medical Practice*.
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for your sickness, injury, mental illness, substance-related and addictive disorders disease or its symptoms;
- Not mainly for your convenience or that of your doctor or other health care provider; and
- Not more costly than an alternative drug, service(s) or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of your sickness, injury, disease or symptoms.

Generally Accepted Standards of Medical Practice are standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.

If no credible scientific evidence is available, then standards that are based on physician specialty society recommendations or professional standards of care may be considered. The Medical Claims Administrator reserves the right to consult expert opinion in determining whether health care services are medically necessary. The decision to apply physician specialty society recommendations, the choice of expert and the determination of when to use any such expert opinion, shall be within the Medical Claims Administrator's sole discretion.

The Medical Claims Administrator develops and maintains clinical policies that describe the *Generally Accepted Standards of Medical Practice* scientific evidence, prevailing medical standards and clinical guidelines supporting its determinations regarding specific services. These clinical policies (as developed by the Medical Claims Administrator and revised from time to time), are available to covered persons by calling the number on your One Card or medical ID card, and to physicians and other health care professionals by contacting the Medical Claims Administrator.

Medicare means the insurance program established by Title 18, Social Security Act of 1965, as amended.

- **Medicare Part A** means the Social Security program that provides hospital insurance benefits.
- **Medicare Part B** means the Social Security program that provides medical insurance benefits.
- **Medicare Part C** means the managed care portion of the Social Security program that provides medical benefits.
- **Medicare Part D** means the Social Security program that provides prescription drug benefits.

You are considered to be eligible for Medicare on the earliest date your coverage under Medicare could become effective.

If you are eligible to enroll in Medicare Part B, but you do not enroll, it is assumed that you receive the amount you could have received under Medicare Part B if you had enrolled.

Mental Health and Substance Use Disorder Services means services for mental illness and substance use disorder that are classified in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

Network means a group of providers that offer services to members in a health plan (like a PPO) at a negotiated cost according to a participation agreement with the Claims Administrator.

Nicotine User means anyone who has used any type of tobacco products in the past 12 months or is currently using nicotine in any form (including cigarettes, cigars, pipe, chewing tobacco, e-cigarettes or any other form or tobacco). (Nicotine use includes the patch, gum or any other nicotine product.)

Non-Participating Hospital means a hospital that has not been designated as a participating hospital in a network covered under a Dell Plan.

Non-Participating Physician means a physician who has not been designated as a participating physician in a network covered under a Dell Plan.

Non-Participating Provider means a hospital, physician or any other health services provider who has not been designated as a participating provider in a network covered under a Dell Plan.

One Card means your ID card for medical, mental health and substance use disorder and prescription benefits. Based on your medical plan, you may also receive a medical ID card from your carrier.

Oral Surgery means procedures to correct diseases, injuries and defects of the jaw and mouth structure.

Out-of-Network means covered services provided by providers not participating in the network.

Out-of-Pocket Maximum means the maximum you pay for eligible expenses in a plan year.

Copays count toward out-of-pocket maximums unless otherwise noted. The paid amount of the deductible does count toward the annual out-of-pocket maximum.

Participating Hospital means a hospital that has been designated as a participating hospital in a network covered under a Dell Plan to provide services to members.

Participating Physician means a physician who has been designated as a participating physician in a network covered under a Dell Plan to provide services to members.

Participating Provider means a hospital, physician or any other health services provider who has been designated as a participating provider in a network covered under a Dell Plan to provided services to members.

Partial Hospitalization/Day Treatment means a structured ambulatory program. The program may be freestanding or hospital-based and provides services for at least 20 hours per week.

Physician means anyone licensed to practice medicine, including a Doctor of Medicine or Doctor of Osteopathy.

A podiatrist, dentist, psychologist, chiropractor, optometrist or other provider who acts within the scope of his or her license will be considered on the same basis as a physician. The fact that a provider is described as a physician does not mean that services from that provider are available under the Plan.

Physician Advisor means a physician who has contracted with the Medical Claims Administrator to review cases to determine whether or not services and supplies are medically necessary.

Plan means the Dell Inc. Retiree Medical Plan.

Plan Year means the 365-day period beginning January 1 and ending December 31.

Post-Delivery Care means post-partum health care services provided in accordance with accepted maternal and neonatal assessments. The term includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any necessary and appropriate clinical tests. The timeliness of the care will be determined in accordance with recognized medical standards for that care. The care may be provided at the mother's home if she chooses, or at her participating physician's office or an approved health care facility.

Pre-Certification or Pre-Authorization means a review of medical necessity of a service, supply or treatment before receiving the service supply or treatment to ensure it meets specific medical criteria for coverage.

Preventive Care means:

- Evidence-based services or supplies that have an 'A' or 'B' rating in the current recommendations of the USPSTF;
- Immunizations that are recommended by the Advisory Committee on Immunization Practices of the CDC;
- For infants, children and adolescents, evidence-informed preventive care and screenings per the guidelines of the HRSA or services as recommended in the American Academy of Pediatrics/Bright Futures Guidelines for Children and Adolescents;
- For women, additional preventive care and screenings not described above but included in the comprehensive guidelines of the HRSA for well-woman care; and
- Current recommendations of the USPSTF regarding breast cancer screening, mammography and prevention.

Primary Physician means a physician who has a majority of his or her practice in general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Reasonable and Customary Charge (R&C) means the lowest of:

- The provider's usual charge for furnishing a service or supply; and
- The charge that the Claims Administrator determines to be appropriate or the prevailing charge level made for it in the geographic area where it is furnished.

Reasonable Costs means costs that do not exceed negotiated schedules of payments that are accepted by participating providers within a geographic area specified by the appropriate Claims Administrator as payment in full.

Recognized Charge (applies to Aetna U.S. medical plans) means, as determined by Aetna as the Medical Claims Administrator, the amount of an out-of-network provider's charge that is eligible for coverage. The recognized charge is determined based on the geographic area where you receive the service or supply. Except as otherwise specified below, the recognized charge for each service or supply is the lesser of what the provider bills and the reasonable amount rate. The reasonable amount rate for professional services is the 80th percentile value reported in a database prepared by FAIR Health, a nonprofit company. FAIR Health changes these rates periodically. Aetna updates its systems with these changes within 180 days after receiving them from FAIR Health. If the FAIR Health database becomes unavailable, Aetna reserves the right to substitute an alternative. If the alternative data source does not contain a value for a particular service or supply, Aetna will base the recognized charge on the Medicare allowable rate.

The recognized charge is the negotiated charge for providers with whom Aetna has a direct contract but are not network providers or, if there is no direct contract, with whom we have a contract through any third party that is not an affiliate of Aetna.

The recognized charge is the rate Aetna has negotiated with a National Advantage Program (NAP) provider. A NAP provider is a provider with whom Aetna has a contract through any third party that is not an affiliate of Aetna or through the Coventry National or First Health Networks.

The recognized charge will also be determined based on Aetna's reimbursement policies. Those policies may further reduce the recognized charge. These policies take into account factors such as:

- The duration and complexity of a service;
- When multiple procedures are billed at the same time, whether additional overhead is required;
- Whether an assistant surgeon is necessary for the service;
- If follow up care is included;
- Whether other characteristics modify or make a particular service unique;
- When a charge includes more than one claim line, whether any services described by a claim line are part of or incidental to the primary service provided; and
- The educational level, licensure or length of training of the provider.

Aetna reimbursement policies are based on their review of:

- The CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate;
- Generally accepted standards of medical and dental practice; and
- The views of physicians and dentists practicing in the relevant clinical areas.

Some policies are different for professional services than for facility services.

Reconstructive Surgery means any surgery (and all other associated expenses) that is:

- Incidental to or following surgical removal of all or less than all of a body part (the surgical removal must be done due to injury or illness of the body part);
- Due to an illness or a disorder of a normal bodily function;
- To repair or lessen damage caused by an injury; or
- Performed to correct a congenital defect.

Reconstructive surgery does not include surgery where the primary result is to change or improve physical appearance.

Residential Treatment means treatment in a facility established and operated as required by law, which provides mental health care services or substance-related and addictive disorders services. It must meet all of the following requirements:

- Provides a program of treatment, approved by the mental health/substance-related and addictive disorders designee, and under the active participation and direction of a physician.
- Has or maintains a written, specific and detailed treatment program requiring your full-time residence and participation.
- Provides at least the following basic services in a 24-hours-per-day, structured setting:
    - Room and board.
    - Evaluation and diagnosis.
    - Counseling.
    - Referral and orientation to specialized community resources.

A residential treatment facility that qualifies as a hospital is considered a hospital.

Self-Administered Injectable Drugs means an FDA-approved medication that a person may administer to himself or herself by means of intramuscular, intravenous or subcutaneous injection, not including insulin, and intended for use by the member or the member's family for whom it was prescribed.

Semi-Private Room or **Accommodations** means a room with two or more beds in an approved health care facility or approved health care program. If the participating physician determines it is medically necessary, private accommodations may be covered. The difference in cost between a semi-private room and a private room is a benefit only when a private room is necessary in terms of generally accepted medical practice, or when a semi-private room is not available.

Serious Mental Illness means the following psychiatric illnesses as defined by the American Psychiatric Association in the most recent version of the *Diagnostic and Statistical Manual* (DSM V):

- Schizophrenia;
- Paranoia and other psychotic disorders;
- Bipolar disorders (hypomanic, manic, depressive and mixed);
- Major depressive disorders (single episodes or recurrent);
- Schizo-affective disorders (bipolar or depressive);
- Pervasive development disorders;
- Obsessive-compulsive disorders; and
- Depression in childhood and adolescence.

Service Area means the geographical area where participating provider services are available to members.

Skilled Care means skilled nursing, teaching and rehabilitation services when:

- Delivered or supervised by licensed technical or professional medical personnel to obtain the specified medical outcome and provide for the safety of the patient;
- A physician orders them;
- Not delivered to assist with activities of daily living;
- Require clinical training to be delivered safely and effectively; and
- Not custodial care.

Skilled Nursing Facility means a facility that is:

- Licensed and operated in accordance with state law;
- Approved by the Medical Claims Administrator to provide certain health services; and
- Medicare approved.

Specialist means a physician who has the majority of his or her practice in areas other than general pediatrics, internal medicine, obstetrics/gynecology, family practice or general medicine.

Substance Use Disorder means covered health care services for the diagnosis and treatment of alcoholism and substance-related and addictive disorders that are listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association*. The fact that a disorder is listed in the current edition of the *International Classification of Diseases section on Mental and Behavioral Disorders* or *Diagnostic and Statistical Manual of the American Psychiatric Association* does not mean that treatment of the disorder is a covered health care service.

Surgery means excision or incision of the skin or mucosal tissue or insertion for exploratory purposes into a natural body opening. This includes insertion of instruments into any body opening, natural or otherwise, done for diagnostic or other therapeutic purposes.

Toxic Inhalant means a volatile chemical under Chapter 484, Health and Safety Code, or abusable glue or aerosol paints under Section 485.001, Health and Safety Code.

Transitional Living means mental health care services and substance-related and addictive disorders services provided through facilities, group homes and supervised apartments which provide 24-hour supervision and are either:

- Sober living arrangements such as drug-free housing or alcohol/drug halfway houses. They provide stable and safe housing, an alcohol/drug-free environment and support for recovery. They may be used as an addition to ambulatory treatment when it doesn't offer the intensity and structure needed to help you with recovery.
- Supervised living arrangements which are residences such as facilities, group homes and supervised apartments. They provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. They may be used as an addition to treatment when it doesn't offer the intensity and structure needed to help you with recovery.

Unproven Services means health services, including medications that are determined not to be effective for treatment of the medical condition and/or not to have a beneficial effect on health outcomes due to insufficient and inadequate clinical evidence from well-conducted randomized controlled trials or cohort studies in the prevailing published peer-reviewed medical literature.

- Well-conducted randomized controlled trials are two or more treatments compared to each other, with the patient not being allowed to choose which treatment is received.
- Well-conducted cohort studies are studies in which patients who receive study treatment are compared to a group of patients who receive standard therapy. The comparison group must be nearly identical to the study treatment group.

The Medical Claims Administrator has a process by which it compiles and reviews clinical evidence with respect to certain health services. From time to time, the Medical Claims Administrator issues medical and drug policies that describe the clinical evidence available with respect to specific health care services. These medical and drug policies are subject to change without prior notice.

Note: For Aetna plans, you can review these policies at aetna.com. For BCBSIL plans, you can view these policies at bcbsil.com/dell.

Note:

- If you have a life-threatening illness or condition (one that is likely to cause death within one year of the request for treatment), the Medical Claims Administrator may, at its discretion, consider an otherwise unproven service to be a covered health service for that illness or condition. Before this consideration, the Medical Claims Administrator must first establish that there is sufficient evidence to conclude that, albeit unproven, the service has significant potential as an effective treatment for that illness or condition, and that the service would be provided under standards equivalent to those defined by the National Institutes of Health.

- The Medical Claims Administrator may, in its discretion, consider an otherwise unproven service to be a covered health service for a covered person with an illness or injury that is not life-threatening. For that to occur, all of the following conditions must be met:
    - If the service is one that requires review by the U.S. FDA, it must be FDA-approved.
    - It must be performed by a physician and in a facility with demonstrated experience and expertise.
    - The covered person must consent to the procedure acknowledging that the Medical Claims Administrator does not believe that sufficient clinical evidence has been published in peer-reviewed medical literature to conclude that the service is safe and/or effective.
    - At least two studies must be available in published peer-reviewed medical literature that would allow the Medical Claims Administrator to conclude that the service is promising but unproven.
    - The service must be available from a network physician and/or a network facility.

The decision about whether such a service can be deemed a covered health service is solely at the Medical Claims Administrator's discretion. Other apparently similar promising but unproven services may not qualify.

Urgent Admission means a hospital admission by a physician due to the onset of or change in an illness, the diagnosis of an illness, or an injury.

Urgent Care means treatment of an unexpected illness or Injury that is not life threatening but requires outpatient medical care that cannot be postponed. An urgent situation requires prompt medical attention to avoid complications and unnecessary suffering, such as high fever, a skin rash or an ear infection.

Urgent Care Center means a facility that provides urgent care services as an alternative if you need immediate medical attention, but your physician cannot see you right away where:

- An appointment is not necessary; and
- The center is open outside of normal business hours.

Walk-in Clinics are freestanding health care facilities. They are an alternative to a physician's office visit for treatment of:

- Unscheduled, non-emergency illnesses and injuries;
- The administration of certain immunizations; and
- Individual screening and counseling services.

It is not an alternative for emergency room services or the ongoing care provided by a physician.

Neither an emergency room nor the outpatient department of a hospital shall be considered a Walk-in Clinic.