Dell Inc. Comprehensive Welfare Benefits Plan Summary Plan Description

For U.S. Team Members and Expatriates

January 1, 2022

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Well at Dell

Introduction

As a Dell team member, you're not just part of our success, you are at the center of it. We need you to thrive for the Company to thrive. We are committed to having a workplace where you are inspired, can achieve your goals and be rewarded for your success. We're also committed to supporting your well-being and livelihood outside of work.

To this end, Dell provides a comprehensive health and wellness benefits program, Well at Dell, designed to support you and your family's total well-being. The program includes a wide range of services, tools and resources to help you maintain, manage and improve your physical and emotional health. In addition to the My Well at Dell benefits portal, this document provides you with detailed information about your benefits. We encourage you to learn about Well at Dell offerings and to take advantage of the benefits available to you.

About This Material

This Summary Plan Description (SPD) is provided to describe the many benefit plans available at Dell and how certain life events may affect your participation in these plans. Portions of this SPD, which are incorporated by reference into the Dell Inc. Comprehensive Welfare Benefits 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. You and your dependents should take the time to read this SPD carefully.

The Plan includes the following benefit plans:

- Medical (includes prescription drug and mental health and substance use disorder coverage);
- Employee Assistance Program (EAP);
- Health Rewards;
- Dental;
- Vision;
- Health Care Flexible Spending Account;
- Dependent Care (Day Care) Flexible Spending Account;
- Critical Illness Insurance*;
- Accidental Injury Insurance*;
- Short-Term Disability;
- Long-Term Disability;
- Basic Life and Accidental Death and Dismemberment (AD&D) Insurance;
- Supplemental Life Insurance;
- Business Travel Accident Insurance;
- MetLife Legal Plans*; and
- Identity Theft Protection.*

*Benefit plans that do not apply to Expatriates.

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In addition to the above benefits, this SPD includes information on additional work/life benefits provided by Dell. These benefits are included in the "Work/Life Benefits" section. Benefits described in that section, as well as the Dependent (Day Care) Flexible Spending Account and Identity Theft Protection are not subject to the Employee Retirement Income Security Act of 1974 (ERISA), the law governing employee benefits, and therefore are not subject to all of the provisions described.

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 team member 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 your classification (for example, U.S. Expatriate) and where you live (for example, California; Hawaii; Massachusetts; Texas; etc.).

Enrolling, Making Changes and Getting Information

If you have questions or need information about any of the programs in the Dell Inc. Comprehensive Welfare Benefits 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, learn about all your options (health, well-being, retirement and more) and make changes to coverage when life events occur. Visit My Well at Dell. To see personalized content, log on via the **single sign-on** link. Then click **Your health and insurance coverage** to view current elections. If you are logged on to the Dell network, you may also choose the My Well at Dell link on MyHR. General information is available without a user ID and password. The My Well at Dell benefits portal provides you with the tools you need to:

- Enroll in coverage;
- 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.

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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 benefits, physically, emotionally and financially;
- 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** tile on the home page to connect with your Benefit Pro.

Nurse Ally
Nurse Ally is a pilot 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

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.

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. A password and benefits user ID are not required if you are logged in to the Dell network and you access through the **View or change your benefits** tile on MyHR.

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.

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Additional Contact Information

Benefit	Contact	Contact Information
Adoption Assistance Program	Dell Intranet	My Well at Dell
Benefit Pros	Dell Benefits Center	1-888-335-5663
Bicycle Voucher Program	Alight Smart-Choice Accounts	1-888-335-5663 My Well at Dell
Business Travel Accident (BTA) Program	Chubb	U.S.: 1-800-336-0627 Outside U.S.: 1-302-476-6194 Business Travel policy number: ADDN04252263 (have this number available when you call)
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
Commuter Benefits Program	Alight Smart-Choice Accounts	1-888-335-5663 My Well at Dell
Dental Programs (U.S. Team Members)	Delta Dental	1-800-693-2659 deltadentalins.com/Dell
U.S. Expatriate Dental Plan	Aetna International	1-800-231-7729 aetnainternational.com
Disability Programs (Short-Term and Long-Term)	Dell Leave and Disability Center	1-855-857-0325 mySedgwick.com/Dell
Employee Assistance Program (EAP)	Lyra Health	1-877-222-4258 dell.lyrahealth.com
Family Planning, Pregnancy, and Parenting Program	Ovia Health	support@oviahealth.com Download Ovia in the App Store or Google Play
Fertility Program (U.S. Team Members)	Progyny	1-833-278-1676
Consumer Accounts:		
Dependent Care (Day Care) FSA	Alight Smart-Choice Accounts	1-888-335-5663 My Well at Dell
Health Care Flexible Spending Account	Alight Smart-Choice Accounts	1-888-335-5663 My Well at Dell

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Benefit	Contact	Contact Information
Health Savings Account (U.S. Team Members)	Alight Smart-Choice Accounts	1-888-335-5663 My Well at Dell
International SOS	International SOS Assistance Center	1-215-942-8226 internationalsos.com/locations to get the complete Assistance Center directory
Leave of Absence	Dell Leave and Disability Center	1-855-857-0325 mySedgwick.com/Dell
Life Insurance Programs:		
Accidental Death & Dismemberment Program	Dell Benefits Center	1-888-335-5663
Basic Life Insurance Program	Dell Benefits Center	1-888-335-5663
Supplemental Life Insurance Program	Dell Benefits Center	1-888-335-5663
Evidence of Insurability/Statement of Health Submission Status	MetLife	1-800-638-6420 (prompt #1)
Status of Life Insurance Claim Submission	MetLife	1-800-638-6420 (prompt #2)
Porting Coverage	MetLife	1-888-252-3607
Converting Coverage	MetLife	1-877-275-6387
Medical Programs (includes mental health and substance use disorder):		
Aetna PPO, Health Fund and Indemnity (U.S. Team Members)	Aetna	1-800-522-6710 aetna.com or aetnaresource.com/n/dell-microsite
Blue Cross Blue Shield of Illinois PPO and Health Fund (U.S. Team Members)	Blue Cross Blue Shield of Illinois (BCBSIL)	1-888-907-7925 bcbsil.com/dell
Kaiser Permanente California DHMO (U.S. Team Members, excluding Hawaii)	Kaiser Permanente – California	1-800-464-4000 my.kp.org/Dell
Kaiser Permanente POS (Hawaii Team Members)	Kaiser Permanente	1-800-966-5955 my.kp.org/Dell

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Benefit	Contact	Contact Information
U.S. Expatriate Medical Plan	Aetna International	1-800-231-7729 aetnainternational.com
Medicare	Centers for Medicare and Medicaid Services (CMS)	1-800-MEDICARE (633-4227) CMS: cms.gov Medicare: medicare.gov
Medical Benefits Abroad	Cigna Global	1-800-243-1348 001-302-797-3535 (outside the U.S.) cignaenvoy.com
Expert Medical Opinion	Teladoc Medical Experts	1-800-TELADOC (835-2362) Teladoc.com/Dell
Telemedicine/Virtual Visits	Teladoc	1-800-TELADOC (835-2362) Teladoc.com/Dell
Cancer Support Line	AccessHope	1-833-983-DELL (3355) dell.myaccesshope.org
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 (U.S. Team Members)	CVS Caremark	1-855-248-3445 caremark.com
Kaiser Permanente California DHMO (U.S. Team Members, excluding Hawaii)	Kaiser Permanente – California	1-800-464-4000 my.kp.org/Dell
Kaiser Permanente POS (Hawaii Team Members)	Kaiser Permanente	1-800-966-5955 my.kp.org/Dell
U.S. Expatriate Medical Plan	Aetna International	1-800-231-7729 aetnainternational.com
Vision Program (U.S. Team Members)	Vision Service Plan (VSP)	1-800-877-7195 vsp.com

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Benefit	Contact	Contact Information
Voluntary Benefit Programs (U.S. Team Members)		
Critical Illness Insurance	Cigna Group Insurance	1-800-351-9214
Accidental Injury Insurance	Cigna Group Insurance	1-800-351-9214
Legal Plan	MetLife Legal Plans	1-800-821-6400 legalplans.com (access code: 9901433)
Identity Theft Protection	Allstate Identity Protection	1-800-789-2720 myaip.com
Premise Health Virtual Fitness (U.S. Team Members)	Premise Health	WellatDellFitness.com VirtualFitness@Dell.com
Health Rewards and well-being resources	Virgin Pulse	Virgin Pulse Member Services 1-888-317-1268 DellWellnessHub.com

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Plan Participation

Eligibility

Eligible Team Members

You are eligible to participate in the Dell Inc. Comprehensive Welfare Benefits Plan if you are a team member regularly scheduled to work at least 20 hours per week.

U.S. Interns

Interns regularly scheduled to work at least 20 hours per week:

- Are eligible for the Dell Wellness Hub. Interns have access to the Hub and can use all of the programs at no cost. Interns are not eligible for the Health Rewards program on the Dell Wellness Hub.
- Will automatically be enrolled in the Employee Assistance Program (EAP); and are eligible for medical coverage as follows:
  - U.S. Expatriate interns – Aetna International.
  - Hawaii interns – Kaiser Permanente POS Program.
  - All other U.S. interns – Health Fund medical plan (no HSA contribution from Dell). If the Health Fund medical plan is not available in your area (based on your home ZIP code), you will be offered the Indemnity medical plan.

  Enrollment in the medical plan includes access to prescription drug and mental health/substance use disorder coverage, telemedicine, expert medical services and Cancer Support Line.

Not Eligible

The following groups are not eligible for coverage:

- Members of a collective bargaining unit that have no agreement for coverage under the Plan;
- Leased or contracted individuals (a person who is not paid by Dell, but who instead is paid by another employer under a leasing or staffing arrangement);
- Non-resident aliens with no earned income from Dell that is considered income from sources within the United States;
- Interns, as classified by Dell (except as noted in the "Eligible Team Members" section above); and
- Individuals who are designated as classified or treated by Dell as non-common law employees, including independent contractors.

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Dependent Eligibility

You may enroll your eligible dependents for coverage in the programs that provide dependent coverage. 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).

  Children are not eligible for the Health Rewards program.

Notes:

- All eligible children under age 26 are eligible for coverage under their Medical Program regardless of the child's status as a dependent for income tax purposes or the child's residency, student, employment or marital status.
- Dependent eligibility may vary for regional medical plans and other fully insured benefits, such as Supplemental Life Insurance. Please refer to the certificate of coverage for the applicable benefit for dependent eligibility provisions.

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.

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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.

Note: For the Aetna International Program, grandchildren are only covered when legally adopted, court ordered or if another custody arrangement is in place by the covered employee. For life insurance under MetLife, foster children are not eligible for coverage.

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.

Note that the value of coverage for your domestic partner and your domestic partner's children, if they are not your children by birth or adoption, is considered taxable income to you unless they can be claimed as dependents on your federal taxes. See the "Cost of Benefit Coverage" section for more information. You and your domestic partner should consult with your own tax and legal advisors regarding these and other potential consequences.

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. If you report this change after the 31-day window, the domestic partner status will not be changed retroactively, and any imputed income cannot be corrected.

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.

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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 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 Dell 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 coverage in the Medical, Dental and Vision Programs. This means that neither you nor they may be enrolled as both a team member and a dependent for medical, dental and vision coverage. Similarly, if your spouse or domestic partner is employed by Dell, you may not elect supplemental life insurance coverage for your spouse or domestic partner. And if your child is employed by Dell, you may not elect supplemental life insurance coverage for that child.

Likewise, if both parents work at Dell, their dependent children may only be covered under the Medical, Dental and Vision Programs of one parent.

For example, if both you and your spouse work for Dell, you may be covered as a dependent under your spouse's medical coverage or you could each have your own medical coverage. You cannot have both. In addition, if you and your spouse have children, only one of you may cover your children under the Medical Program, not both of you.

Duplicate coverage is allowed under the Health Care and Dependent Care (Day Care) Flexible Spending Accounts. However, Internal Revenue Service (IRS) regulations limit benefits under the Flexible Spending Accounts. See the "Health Care Flexible Spending Account Program" and "Dependent Care (Day Care) Flexible Spending Account Program" sections for information about these limits.

Enrollment

Some of the programs in the Plan require that you enroll yourself and/or your eligible dependents to participate. Some programs automatically enroll you if you are eligible for coverage. As a new hire, your dependents are never automatically assigned any coverages.

You must enroll within 31 days of initial eligibility to receive the following benefits:

- Medical (includes prescription drug and mental health and substance use disorder coverage);
- Dental;
- Vision;
- Health Care Flexible Spending Account (you must make a new election each year);

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- Dependent Care (Day Care) Flexible Spending Account (you must make a new election each year; your election does not carry over from year to year);
- Critical Illness Insurance*;
- Accidental Injury Insurance*;
- MetLife Legal Plans*;
- Identity Theft Protection*; and
- Supplemental Life Insurance. You may enroll in Supplemental Life Insurance after your initial eligibility period, however, Evidence of Insurability (EOI) will be required.

If you do not enroll within 31 days, you will not be able to participate in the programs requiring enrollment. You will not have another opportunity to enroll until the next annual enrollment, with changes generally becoming effective the following January 1, unless you have a qualified status change or special enrollment event during the year. See the "Changing Your Election" section for more information.

You are automatically enrolled in coverage under the following programs, which means you do not need to enroll:

- Employee Assistance Program (EAP);
- Health Rewards program (registering on the Dell Wellness Hub is required to complete the program);
- Short-Term Disability;
- Long-Term Disability (you have the option to opt out of this coverage during the enrollment period);
- Basic Life Insurance (two times your benefit-eligible earnings — up to $1,500,000); or a flat amount of $50,000;
- Accidental Death and Dismemberment (AD&D) insurance (two times your benefits eligible earnings);
- Travel medical (international travel); and
- Business Travel Accident Insurance (three times your benefit-eligible earnings).

Each year during annual enrollment, you will have the opportunity to enroll for or make changes to your coverage elections, with changes generally becoming effective the following January 1. Additional information will be provided during the annual enrollment period.

Once you enroll in coverage or have been assigned coverage, you will not be able to change your benefit elections until the next annual enrollment, unless you or your dependent qualify for special enrollment, are required to enroll a child under a QMCSO or experience a qualified status change. See the "Changing Your Election" section for more information. **Note for U.S. team members:** HSA funding changes can be made at any time.

If you opt out of the Long-Term Disability (LTD) Program during your 31-day initial enrollment period and wish to later enroll, you may need to submit Evidence of Insurability (EOI).

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.)

*Benefit plans that do not apply to Expatriates.

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Rehires

If you return to Dell within 30 days and within the same calendar year that you left, you will automatically receive the same coverage you had when your employment ended; this includes your annual FSA election(s); however, contributions will be recalculated based on the remaining pay periods. If you return in a different calendar year or more than 30 days from your termination of employment, you must follow the same enrollment guidelines as a new hire.

How to Enroll

To enroll in coverage, go to My Well at Dell. Click on the **New to Dell** tab, where you will find enrollment resources and a link to enroll in your benefits. Read the instructions carefully and make your elections. When you have finished choosing your benefits, you must submit your elections and receive confirmation. If you do not submit your elections, none of the benefit elections you have made will be saved by the system, and will not be effective. If you have difficulties enrolling online, or prefer to enroll by phone, please call the Dell Benefits Center at 1-888-335-5663.

Once your elections have been submitted, a paper Confirmation of Enrollment will be mailed to your home address. When you receive your paper confirmation, please review it carefully for confirmation and next steps. Contact the Dell Benefits Center immediately if you have questions about your coverage or do not receive a Confirmation of Enrollment.

Note: As a new hire, if you elect "electronic" as your delivery preference, you will receive the initial Confirmation of Enrollment statement via email (in addition to the one you receive in the mail) and all future Confirmation of Enrollment statements will be delivered only via email. You may change this preference at any time on My Well at Dell. Log in to personalized content by clicking the **Change your coverage** link, or click the My Well at Dell link from MyHR when logged on to the Dell network. You may also call the Dell Benefits Center at 1-888-335-5663.

Coverage Begins

Your coverage begins on:

- The date you become eligible if you are a newly eligible team member (new hire eligibility is your hire date);
- January 1 following annual enrollment for current team members making annual enrollment coverage choices; or
- The date of a status change if your coverage changes due to a qualified status change.

While coverage begins as described above, if you elect an amount of Supplemental Life Insurance that requires Evidence of Insurability ([EOI] or Statement of Health), the amount of insurance above the guaranteed issue amount (the lesser of three times annual earnings or $500,000), will go into effect on the date your EOI is approved**.** For Spouse/Domestic Partner Supplemental Life Insurance, the amount of insurance that is above one-half your benefit-eligible earnings or $50,000, will go into effect on the date your EOI is approved.

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Cost of Benefit Coverage

The cost of benefit coverage under the Plan is shared by you and Dell as follows:

- You and Dell share the cost of the Medical, Dental and Vision Programs for you and your family:
  - Your cost for the Medical Program is based on your Team Member career level, how you respond to enrollment questions and whether your spouse or domestic partner is employed and eligible for medical benefits through his or her employer and the coverage choices you make (for example, team member only, team member plus spouse, etc.). You can compare your costs for your available medical options on My Well at Dell or by calling the Dell Benefits Center at 1-888-335-5663.
  - You pay your share of the cost for the Medical, Dental and Vision Programs on a before-tax basis. This means that your contribution is taken from your pay before federal and most state taxes are withheld, which lowers your taxable income and helps you pay less in taxes.
  - You pay the full amount of the working spouse contribution, as applicable, for the Medical Program on a before-tax basis.
- You pay the full amount that you elect to contribute to a Health Care and/or Dependent Care (Day Care) Flexible Spending Accounts and/or Health Savings Account (U.S. team members only) on a before-tax basis.
- You and Dell share the cost of the Long-Term Disability Program. You pay your share of the cost for Long-Term Disability coverage on an after-tax basis. Therefore, if you become disabled and receive Plan benefits, the Plan benefits you receive will be taxed on the portion of benefit that represents an equally weighted portion of the premium cost paid by Dell.
- Dell pays the full cost of the Health Rewards program, Employee Assistance Program, Short-Term Disability, Basic Life and AD&D Insurance and Business Travel Accident Insurance.
- You pay the full cost of any Supplemental Life Insurance including any Dependent life insurance. You pay your share of the cost for this coverage on an after-tax basis.
- For U.S. team members: You pay the full cost of any Critical Illness Insurance or Accidental Injury Insurance, including any Dependent coverage. You pay your share of the cost for this coverage on an after-tax basis.
- For U.S. team members: You pay the full cost of coverage for the MetLife Legal Plans. You pay your share of the cost for this coverage on an after-tax basis.
- For U.S. team members: You pay the full cost of coverage for the Identity Theft Protection Plan. You pay your share of the cost for this coverage on an after-tax basis.

The Medical Program and the Working Spouse Contribution

In addition to your contribution for any medical coverage for your spouse or domestic partner, if your spouse or domestic partner is employed and eligible for medical benefits through his or her employer and you choose to cover your spouse or domestic partner under the Plan, you will be required to pay an additional working spouse contribution for this medical coverage. The amount of the additional fee depends on your team member career level and will be provided with your enrollment materials. If both you and your spouse or domestic partner work for Dell, you will not pay the additional contribution.

You must provide information about your spouse's or your domestic partner's eligibility for medical coverage under another employer plan when you first enroll and during each annual enrollment period. Any contribution required will be implemented as soon as administratively possible.

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If you do not fully report information regarding your employed spouse's or domestic partner's eligibility for coverage under another employer plan, this may lead to disciplinary action, up to and including termination of employment.

If your spouse's or domestic partner's medical eligibility through his or her employer changes at any time, you must report it through the Dell Benefits Center at 1-888-335-5663, within 31 days of the qualified status change. Any change will be implemented as soon as administratively possible. Working spouse contributions will not be refunded retroactively.

Health Rewards

To help you and your family achieve and maintain a healthy lifestyle, Dell has established the Health Rewards program which gives you support and resources for healthy living. The Health Rewards program is provided by Dell at no cost to you, except as otherwise indicated. For more information on this program, see the "Health Rewards" section.

Taxation of Domestic Partner Benefits

You must pay your share of the cost of coverage on an after-tax basis for any covered individual not recognized as a dependent by the IRS. In addition, the value of any contribution provided by Dell for these individuals will be considered imputed income for applicable state and federal income tax purposes and must be reported on your W-2 Form. The amount of imputed income is based on the value of the coverage provided.

You should consult with your tax and legal advisors regarding whether your domestic partner or a child of your domestic partner would qualify as your dependent for tax purposes. Dell will automatically impute income for your covered domestic partner and covered children of your domestic partner unless you notify Dell that they are your dependents for federal tax purposes.

Changing Your Election

Generally, once enrolled, your coverage stays in effect for the rest of the plan year (January 1 through December 31). However, you can make changes to your coverage during the plan year if you:

- Have a qualified status change and report the change within 31 calendar days of the qualified status change event (or within 60 days when adding a new child due to a birth, adoption or placement for adoption for medical coverage);
- Experience a special enrollment event and report the change within 31 calendar days of the special enrollment event; or
- Are subject to a QMCSO.

Changes may be made to your Medical, Dental, Vision, Health Care Flexible Spending Account, Dependent Care (Day Care) Flexible Spending Account, Long-Term Disability, Critical Illness Insurance, Accidental Injury Insurance, MetLife Legal Plans, Identity Theft Protection Plan or Supplemental Life Insurance Programs (including any Dependent life insurance). However, any change in benefits must be consistent with your status change, special enrollment event or QMCSO. Any change will be implemented as soon as administratively possible.

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If, as the result of a qualified status change, you want to change your Supplemental Life Insurance for:

- Yourself, you may increase your coverage with Evidence of Insurability (EOI). If EOI is denied, you will keep your current level of coverage. Your coverage will then go into effect on the date your EOI is approved. If you, whether sane or insane, commit suicide within two years from the effective date of any contributory life insurance, our liability with respect to that coverage will be limited to an amount equal to the premiums paid for the coverage. If there has been an increase in your amount of contributory life insurance for which you were required to apply or for which we required EOI, and if you die by suicide within two years of the effective date of the increase, our liability with respect to that increase will be limited to the premiums paid and attributable to such increase.
- Your spouse or domestic partner, you may elect up to $50,000 without EOI. Coverage will go into effect on the date of the election of the coverage due to the qualified status change if EOI is required. If EOI is required, coverage will go into effect on the date MetLife approves your spouse's/domestic partner's EOI. If you are not sure if you have been approved for Supplemental Life Insurance coverage for your spouse or domestic partner, or if you have other questions regarding the status of a submitted EOI form, contact MetLife's Statement of Health Unit at 1-800-638-6420 (prompt #1). For enrollment or other questions related to Supplemental Life Insurance, contact the Dell Benefits Center at 1-888-335-5663.

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 (does not apply to life insurance);
- 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.

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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.

Special Enrollment

If you decline enrollment for yourself or your dependents (including your spouse or domestic partner) for medical, dental or vision coverage, because you or they have other employer-provided coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other employer-provided coverage or later need coverage because a dependent's employer stops contributing toward the employer-provided coverage. You must enroll within **31 calendar days** after your or your dependents' other employer-provided coverage ends (or after the employer stops contributing toward the other coverage). Coverage will be effective as of the date of loss of other coverage.

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

To make changes to your benefit elections, go to My Well at Dell and click the **Change your coverage** link when logged on to the Dell network. Once you finish making your changes, you must submit your elections and you will receive immediate online confirmation (via the Completed Successfully screen; print a copy of this screen for your records). If you do not submit your elections, benefit elections you have made will **not** be saved by the system and will not take effect. For assistance, contact the Dell Benefits Center at 1-888-335-5663. You are encouraged to print any records of your benefit changes because certain electronic records of your attempt to make benefit elections cannot be retrieved.

Any change will be implemented as soon as administratively possible.

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When Coverage Ends

For Team Members

Coverage under all programs ends on the earliest of the:

- Date the Plan terminates;
- Date a Plan Program terminates (coverage under that Program ends);
- End of the period for which any required contribution is paid if any required contribution for the subsequent period is not paid when due;
- Date you die;
- Date you are no longer a member of an eligible class of team members;
- Date you terminate employment with Dell;
- Date you retire;
- Date you elect to stop Plan coverage or any Plan Program as permitted by the Plan's change rules;
- Last day of the plan year for the Health Care and Dependent Care (Day Care) Flexible Spending Account if you do not re-enroll for the next year; or
- Last day of the plan year for the Health Care Flexible Spending Account if you do not re-enroll for the next year and have a zero balance in your account. **Note:** You are eligible to roll over up to 20% of the Health Care Flexible Spending Account IRS maximum one plan year to the next. If you have an account balance on the last day of the plan year less than 20% of the Health Care Flexible Spending Account IRS maximum salary reduction, your participation may continue into the next plan year until your balance is exhausted, even if you did not re-enroll for the next plan year.

For Eligible Dependents

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

- 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 or any Program in the Plan as permitted by the Plan's change rules;
- End of the period for which any required contribution for the dependent's coverage is paid, if any required contribution for the subsequent period is not paid when due;
- Date dependent coverage under the Program is no longer offered; or
- Date you are no longer eligible to enroll a dependent in dependent coverage.

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. For child life insurance, you must actively discontinue participation in this Program when you no longer have dependent children under age 26.

Note: For the Employee Assistance Program only, in the event of your termination or death, you and/or your eligible dependents will continue to have access for three years.

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When Coverage Continues

Under certain circumstances, you and/or your dependents may continue medical (including prescription drug and mental health and substance use disorder), dental, vision, Employee Assistance Program (EAP) and Health Care Flexible Spending Account coverage. See the “COBRA Continuation Coverage” section.

In addition, you may port or convert your Basic Employee Life Insurance and any Supplemental Life Insurance within 31 days of your termination of coverage. In the event of a loss under one of these Life Insurance Programs during that 31-day porting or conversion period, your coverage under the program before your termination of coverage date will apply regardless of whether you have completed the porting or conversion process. For more information on converting life insurance coverage, contact MetLife at 1-877-275-6387. For more information on porting life insurance coverage, contact MetLife at 1-888-252-3607. If you are a U.S. team member, you may also port your Critical Illness Insurance and Accidental Injury Insurance within 31 days of your termination of coverage. For more information on porting these coverages, contact Cigna at 1-800-754-3207 The Identity Theft Protection Plan is also portable at the same rates offered through payroll deduction. For more information, call Allstate Identity Protection at 1-800-789-2720. If you wish to continue your legal plan benefit after retiring or terminating employment, you must enroll for portable enrollment within 30 days of your last day of employment. Enrollment is prepaid via remittance of a lump-sum payment equal to the legal plan’s monthly rate times 30 months. For more information, call the MetLife Legal Plans at 1-800-821-6400.

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’s Medical (including prescription drug and mental health and substance use disorder), Employee Assistance Program (which includes Lyra Health’s services), Prescription Drug, Dental, Vision and Health Care Flexible Spending Account.

Your rights and obligations under the law are summarized below. 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.

In general, to elect COBRA continuation coverage, you and your dependents must have been covered under the Plan on the day before the event that caused coverage to terminate. However, any children born to or placed for adoption with you while you are covered under COBRA will automatically be covered under the Plan you elect, provided you report the birth or adoption to the Dell Benefits Center at 1-888-335-5663 and enroll the child within 60 days of the event.

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

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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 right to purchase continued coverage through COBRA following a change in your employment status with Dell, your entitlement to Medicare or your death.

If you become disabled—see the "Disability Extension (while on COBRA)" section—or 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 either enroll in COBRA online at My Well at Dell or contact the Dell Benefits Center at 1-888-335-5663. If you do not enroll in COBRA within the 60-day period, you will lose your right to elect COBRA.

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.

Surviving dependents of team members who pass away while actively employed by Dell receive COBRA at no cost for the first 60 days of coverage, provided they were previously covered by the team member on the Plan. Enrollment for surviving, covered dependents is automatic upon the team member's death. If you change your marital status or if you, your spouse or your dependent changes addresses, notify the COBRA Administrator immediately at 1-888-335-5663.

If you were enrolled in the Kaiser Permanente California DHMO, 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 18-month or 36-month COBRA period.

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COBRA Qualifying Events and Continuation Coverage Period

The chart below summarizes who is eligible for COBRA, the situations required for eligibility and the maximum length of time that COBRA is available.

Qualifying Events	Who is eligible for COBRA coverage?	What is the maximum COBRA coverage period?
Your employment with Dell ends for reasons other than gross misconduct (voluntarily or involuntarily)	▪ You, if you were receiving health coverage under the Plan when you lost your job. ▪ Your dependents (spouse/domestic partner* and children) who were receiving health coverage under the Plan when your employment ends.	▪ 18 months. ▪ Coverage can be extended to 29 months if someone in the family becomes disabled as determined by the Social Security Administration (SSA) within the first 60 days of COBRA coverage; you must provide a copy of the SSA's disability determination letter to the COBRA Administrator as described under the "Disability Extension (while on COBRA)" section. ▪ Coverage can be extended to 36 months if there is a divorce, legal separation or loss of dependent status while on COBRA. **Note:** If your employment ends within 18 months after you became entitled to Medicare, your dependents' maximum period of coverage is the later of: 18 months (29 if disabled) from termination of employment or 36 months from your Medicare entitlement.

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Qualifying Events	Who is eligible for COBRA coverage?	What is the maximum COBRA coverage period?
You are no longer an eligible team member because your hours are reduced (refer to "Eligibility" section)	▪ You, if you were receiving health coverage under the Plan when you stopped being eligible for the Plan. ▪ Your dependents (spouse/domestic partner* and children) who were receiving health coverage under the Plan when you stopped being eligible for the Plan.	▪ 18 months. ▪ Coverage can be extended to 29 months if someone in the family becomes disabled within the first 60 days of COBRA coverage as determined by the SSA; you must provide a copy of the SSA's disability determination letter to the COBRA Administrator as described under the "Disability Extension (while on COBRA)" section. ▪ Coverage can be extended to 36 months if there is a divorce, legal separation or loss of dependent status while on COBRA. **Note:** If your hours are reduced within 18 months after you became entitled to Medicare, your dependents' maximum period of coverage is the later of: 18 months (29 if disabled) from reduction of hours or 36 months from your Medicare entitlement.
You are no longer an eligible team member because you are an Inter-Country Transfer (ICT) and are employed by Dell outside of the U.S.	▪ You, if you were receiving health coverage under the Plan when you stopped being eligible for the Plan. ▪ Your dependents (spouse/domestic partner* and children) who were receiving health coverage under the Plan when you stopped being eligible for the Plan.	▪ 18 months. ▪ Coverage can be extended to 29 months if someone in the family becomes disabled within the first 60 days of COBRA coverage as determined by the SSA; you must provide a copy of the SSA's disability determination letter to the COBRA Administrator as described under the "Disability Extension (while on COBRA)" section.

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Qualifying Events	Who is eligible for COBRA coverage?	What is the maximum COBRA coverage period?
		▪ Coverage can be extended to 36 months if there is a divorce, legal separation or loss of dependent status while on COBRA. ▪ **Note:** If you were transferred by Dell outside of the U.S. within 18 months after you became entitled to Medicare, your dependents' maximum period of coverage is the later of: 18 months (29 if disabled) from reduction of hours or 36 months from your Medicare entitlement.
You die	▪ Your dependents (spouse/domestic partner* and children) who were receiving health coverage under the Plan when you died.	▪ 36 months. ▪ **Note:** Any dependent covered under the Plan at the time of your death will automatically be enrolled in COBRA continuation coverage, and the first 60 days of coverage will be paid by Dell.
You divorce or legally separate from your spouse	▪ Your dependents (spouse/domestic partner* and children) who were receiving health coverage under the Plan when you divorced or legally separated.	▪ 36 months
Your dependent child no longer meets the eligibility requirements (for example, your dependent turns age 26)	▪ Your dependent child, if your dependent was receiving health coverage as a dependent under the Plan.	▪ 36 months

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*Domestic partners are not eligible for COBRA; however, Dell offers continuation coverage that is similar to COBRA coverage to domestic partners and their children.

If during an 18-month period of COBRA continuation coverage a second qualifying event takes place that entitles your spouse or dependent child to COBRA continuation coverage (such as divorce, legal separation or losing dependent status), your spouse's COBRA continuation coverage and/or dependent child's COBRA continuation coverage may be extended by another 18 months. You must notify the COBRA Administrator at 1-888-335-5663 of the second qualifying event within 60 days of the event. COBRA continuation coverage for your spouse and/or your dependent child cannot extend for more than a total of 36 months from the date of the initial event.

Disability Extension (while on COBRA)

If you have an 18-month qualifying event and the SSA determines that you (or your spouse or dependent child) are disabled at any time during (or prior to) the first 60 days of the COBRA continuation coverage period, your COBRA continuation coverage period as well as your spouse's and any dependent's periods may be extended from 18 months to 29 months. To qualify for the additional months of COBRA, you or your spouse or eligible child must:

- Have a ruling from the SSA that you or your dependent became disabled within (or prior to) the first 60 days of COBRA continuation coverage; and
- Send the Dell Benefits Center and/or the Leave and Disability Center a copy of the SSA ruling letter within 60 days of the latest of: the date on the letter, the date of the qualifying event or the date of the loss of coverage. However, the letter must be provided before the expiration of the 18-month period of COBRA.

The ruling from the SSA must:

- Be dated before or within the 18-month COBRA continuation period;
- Specify the specific date you or your dependent was deemed disabled; and
- Indicate that the disability began before or within the first 60 days of the COBRA qualifying event.

If the above requirements are met, all eligible members of the family qualify for the additional 11 months of COBRA continuation coverage. You may be charged up to 150% of the total cost of coverage for the 11-month extension period.

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The right to a disability extension may be terminated if the SSA determines that the qualified beneficiary is no longer disabled. You or your dependent must notify the COBRA Administrator within 30 days of the SSA's determination. If you recover within the initial 18-month COBRA period, you may keep your COBRA continuation coverage for the remainder of the 18-month period. If you recover in the 19th through the 28th month, your COBRA continuation coverage will cease at the end of the month in which you are determined to no longer be disabled.

Health Care Flexible Spending Account
Please note, notwithstanding the above, COBRA coverage is offered under the Health Care Flexible Spending Account (Health Care FSA) only to qualified beneficiaries who lose coverage under the Health Care FSA. Further, COBRA coverage under the Health Care FSA will terminate at the end of the plan year (and cannot be extended), and you may not enroll in Health Care FSA coverage at annual enrollment.

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 to any of its active team members;
- You do not pay the premium for your coverage;
- You become entitled to Medicare;
- In the case of a 29-month extension due to disability, a determination is made that the individual is no longer disabled (after the first 18 months);
- You do not timely provide the SSA's disability determination letter; 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.

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Medical Program

National Plans

If you are a U.S. team member*, national coverage options include:

- 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.

Regional Plans

Regional coverage is available for the following:

- California;
- Hawaii; and
- U.S. Expatriates.

California

Depending on where you live in California, you can enroll in the Kaiser Permanente California DHMO.

You automatically receive mental health and substance abuse coverage and prescription drug coverage through the Kaiser Permanente California DHMO medical coverage option.

You will receive materials directly from the Kaiser Permanente California DHMO that provides details about your Plan coverage. Such materials, together with this document, constitute the Summary Plan Description for that Regional coverage option, and together with the Plan document, constitute (and contain the terms of) the Plan with respect to that Regional coverage option.

Hawaii

If you live in Hawaii, the Dell Medical Program offers you the Kaiser Permanente POS Program. If you elect medical coverage, you automatically receive mental health and substance abuse coverage and prescription drug coverage as part of your medical coverage through Kaiser.

*Excludes Hawaii team members

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You will receive materials directly from the Kaiser Permanente POS Program that provide details about your Plan coverage. Such materials, together with this document, constitute the Summary Plan Description for this coverage option, and together with the Plan document, constitute (and contain the terms of) the Plan with respect to that coverage option.

U.S. Expatriates

If you are a U.S. expatriate, the Dell Medical Program offers you the Aetna International Program. If you elect medical coverage, you automatically receive mental health and substance use disorder coverage and prescription drug coverage as part of your medical coverage. In addition, you also receive dental and vision coverage as part of the Aetna International Program.

You will receive materials directly from the Aetna International Program that provide details about your Plan coverage. Such materials, together with this document, constitute the Summary Plan Description for this coverage option, and together with the Plan document, constitute (and contain the terms of) the Plan with respect to that coverage option.

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 to Dell members covered under the U.S. PPO, Health Fund and Indemnity medical plans.

Teladoc enables you to get the care you need without a trip to the doctor's office. Teladoc 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 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 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, call 1-800-TELADOC (835-2362) or visit **Teladoc.com/Dell**.

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Expert Medical Opinion

Dell offers the Expert Medical Opinion program at no cost through Teladoc 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, team members and their dependents must be enrolled in a Dell U.S. national, regional and/or U.S. expat medical plan. Team members 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 1-800-TELADOC (835-2362) to speak to a physician, or visit **Teladoc.com/Dell**. Registration is required on the Teladoc website before you can begin using services.

Cancer Support Line

Dell offers the AccessHope Cancer Support Line to U.S. team members and their household members who have been diagnosed with cancer.

The AccessHope Cancer Support Line connects team members and their household members with highly trained oncology nurses who can provide unparalleled support to cancer patients throughout their cancer journey.

Call AccessHope's Cancer Support Line to speak with experienced oncology nurses who can help you:

- Understand your specific type of cancer;
- Find answers to questions that arise during your cancer journey;
- Prepare for your appointments with an oncologist;
- Understand the types of treatments typically provided for your type of cancer;
- Access trusted educational materials; and
- Receive emotional support.

You don't need to enroll for this benefit. The AccessHope Cancer Support Line is voluntary and offered at no cost to you.

For additional information, call AccessHope at 1-833-983-DELL (3355) from 8 a.m. to 8 p.m. CT Monday through Friday (except holidays), or visit dell.myaccesshope.org.

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 team members and their covered dependents, including spouses/domestic partners and/or child(ren) who are enrolled in the PPO, Health Fund and Indemnity medical plans. Children under age 18 are eligible only for the diabetes management program. Adults 18 and over are eligible for all Livongo programs.

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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.

National Plans

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.

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- 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.

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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. Please see the “Health Savings Account” section for additional information.

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

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Aetna	Blue Cross Blue Shield of Illinois (BCBSIL)
Georgia	Kentucky
Kansas	Louisiana
Maryland	Massachusetts
Maine	Michigan
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.

Note: If you are a Hawaii team member, you have access to the Kaiser Permanente POS Program.

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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 **MyWellatDell.com > 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.

Health Savings Account

To be eligible for an HSA, an individual must be enrolled in the Health Fund high-deductible health care plan and not be covered under any other health plan that is not a high-deductible health plan other than coverage permitted under IRS HSA regulations. An HSA is an account you can use to help pay your deductible, eligible health care and prescription drug expenses (as determined by the IRS), and other out-of-pocket health care expenses for you, your spouse and your qualified tax dependent children, relatives and/or domestic partner.

If you are enrolled in the Health Fund, you can make before-tax payroll contributions to an HSA that is maintained by Alight Smart-Choice Accounts®. The HSA is an individual bank account you own. Any unused funds remaining in your HSA at the end of the year roll over to the following year and can be used for future eligible expenses, and your HSA continues to follow you through retirement. The money is all yours — there's no "use-it-or-lose-it" rule. A list of eligible HSA expenses can be found on the Alight Smart-Choice Accounts website at My Well at Dell; select the Smart-Choice Accounts tab or portal icon.

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Dell will contribute to your HSA just for enrolling in the Health Fund. For 2022, Dell will contribute:

- $750 for You only coverage.
- $1,500 for You plus your spouse or domestic partner coverage.
- $1,500 for You plus child(ren) coverage.
- $1,500 for You plus family coverage.

If you are hired after January 1 of the plan year and enroll in the Health Fund and HSA, you will receive a prorated amount based on your hire date. If you enroll in the Health Fund and HSA, or make any changes to your HSA or Health Fund enrollment after January 1, due to a qualified status change, you also will receive a prorated HSA contribution amount based on the date the change is implemented. **Please note:** If you enroll in the Health Fund in the middle of the year and are not HSA-eligible (for example, because you were enrolled in a general-purpose health care flexible spending account), you will not be eligible to receive any contributions from Dell to an HSA for that year.

The 2022 annual IRS contribution limits to an HSA for employee and employer contributions **combined** are $3,650 per individual and $7,300 per family. You can also make up to an extra $1,000 annual catch-up contribution if you are age 55 or older by the end of the year. You can start, stop or change your contributions to your HSA at any time during the year.

Keep in mind that your HSA is a bank account, meaning you will only be reimbursed if there are funds in your account. Your contributions will not be available to use until they are in your account and you're not able to spend ahead. If you have an established HSA from a previous employer, you can roll it over by contacting your former HSA custodian to request a transfer of assets.

If you are eligible for an HSA and have not yet elected it, you may elect an HSA by going to My Well at Dell and selecting the Smart-Choice Accounts tab or portal icon or by calling the Dell Benefits Center at 1-888-335-5663.

The terms and conditions of the HSA are governed by Alight Smart-Choice Accounts. Any claim dispute you may have with respect to your HSA should be directed to Alight Smart-Choice Accounts. Once you no longer meet eligibility rules, you may not contribute to your HSA account but can still receive distributions from the account for contributions made while eligible. You will need to call the Dell Benefits Center to discontinue contributions.

Dell is not contracted directly with the account custodian (WealthCare Saver). Under the terms and conditions agreed upon between you (the account holder) and the custodian, the custodian may change or apply fees with respect to your HSA.

Download the Smart-Choice Accounts Mobile App

Access and manage your Smart-Choice HSA anytime, from anywhere, and do things like:

- Use the eSignature feature to easily substantiate your expenses.
- Get instant texts confirming account activity.
- Scan health-related items directly (when you're in the store, for example) to see if they're eligible.

Note that an HSA account is not an employee benefit plan within the meaning of ERISA and is not subject to ERISA, the Health Insurance Portability and Accountability Act (HIPAA) or COBRA. The HSA is a self-directed, individual account. You are responsible for reporting to the IRS any contributions to and distributions from your HSA, determining your eligibility to receive before-tax contributions in your HSA account, determining whether HSA distributions are for non-taxable medical expenses and maintaining supporting documentation, managing your HSA account, and for payment of income and penalty taxes on amounts which were taxable.

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Prohibited Coverage

As set by IRS guidelines, if you are covered by a plan that is not HSA-compatible, you are not eligible to contribute to an HSA. If you are enrolled in Medicare, TRICARE or a spouse's non-high-deductible plan, you are not eligible to contribute to an HSA. If you currently receive health care benefits (other than preventive care) from a Veterans Administration facility and you do not have a disability rating from the VA or your spouse has a general-purpose health flexible spending account with their employer, you are also not eligible to contribute to an HSA. HSA eligibility is determined as of the first day of each month. For each month you contribute and you are not HSA-eligible, you will be required to pay income taxes and a penalty tax of 6% of your contributions.

If You Leave Dell

Your HSA is your personal account and it's entirely portable. Meaning, if you leave Dell, you can take the account with you.

One month after your separation from Dell you, as the accountholder, will become responsible for all fees associated with the account. Dell will no longer make contributions to your HSA; however, if you remain enrolled in the Health Fund by electing COBRA coverage, you can continue to contribute directly to the HSA and realize tax savings when you file your tax return at the end of the year. In addition, funds in the HSA can be used to pay for COBRA premiums.

If you leave Dell, you have the following options regarding your HSA:

- Keep your HSA with Alight Smart-Choice Accounts;
- Move/transfer your HSA funds to another Health Savings Account. The new financial institution you select can initiate and facilitate this process for you; or
- Close your HSA. Please remember that you may be subject to taxes and possible penalties if HSA funds are not used for eligible expenses or rolled over to another HSA. To close your account, you will need to complete an HSA Close Account form found on My Well at Dell and select the Smart-Choice Accounts tab or portal icon.

Investing Your HSA

You are eligible to invest the funds in your HSA once the balance in the HSA has reached a minimum of $1,000. Contact Alight Smart-Choice Accounts or go to My Well at Dell and select the Smart-Choice Accounts tab or portal icon for additional information. You are solely responsible for any investment decision. To use invested funds to pay for eligible expenses, you will need to transfer the funds from the investments to the HSA.

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.

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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 their individual in-network deductible.	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 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	Once Pat, his wife or his daughter pays $5,000 of **out-of-network** covered expenses

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Pat: Family coverage for himself, his wife and his daughter under the PPO Plan		
	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.	(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.

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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.

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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.

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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.

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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;
- 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 if the stay exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean section;

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- 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.

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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)

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	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.

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	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

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	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	***Lactation Counseling Services Facility or Office***	Not covered	***Lactation Counseling Services Facility or***	Not covered

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	PPO		Health Fund	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
and Counseling Services	***Visits:*** 100% per visit. No copay or deductible applies.		***Office Visits:*** 100% per visit. No copay or deductible applies.	
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)	60% of covered charge after deductible	85% after deductible	60% of covered charge after deductible

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	PPO		Health Fund	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	Otherwise; 90% after deductible			
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	Not covered	One surgical procedure per lifetime Pre-certification required	Not covered

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	PPO		Health Fund	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	Only covered at designated facility		Only covered at designated facility	
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			

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	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	100% preventive exam (as part of wellness exam); 85% after deductible for injury or illness	Not covered
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 ***Diagnostic:*** 90% after deductible for imaging, lab, X-ray at independent	***Preventive:*** Not covered	***Preventive:*** 100%*, no deductible ***Diagnostic:*** 85% after deductible for imaging, lab, X-ray at independent	***Preventive:*** Not covered

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	PPO		Health Fund	
Medical Benefits	**In-Network**	**Out-of-Network**	**In-Network**	**Out-of-Network**
	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	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 ***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

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

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	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

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.

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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.

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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

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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

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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.

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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;

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- 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. Repairs to teeth that are injured due to these activities may be covered under the Dental Program (see the "Dental Program" section);
- 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 team members 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.

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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.

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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, but may be covered under the Vision Program. See the "Vision Program" section for more information.

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.

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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.

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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.

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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 PPO, Health Fund and Indemnity medical plans.

The Plan's fertility benefits include:

- Expanded fertility and egg freezing benefits for team 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

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- 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.

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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.

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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 Fertility, 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 team members enrolled in the PPO, Health Fund and Indemnity medical plans.

Download Ovia Fertility, 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.

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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.

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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.

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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.

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- 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.

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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

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    - 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.

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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.

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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—removal of hair for male to female patients (only for hair removal on skin graft for gender reassignment surgery)
    - 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.
- Electrolysis or laser hair removal (except for skin graft preparation for genital 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.

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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.

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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.

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- 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 (U.S. Team Members)" and/or "Employee Assistance Program (EAP)" sections 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:

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- 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.

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- 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:

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        - 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 (U.S. Team Members)" 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:

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        - 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 (U.S. Team Members)” 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.

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- 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;

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    - 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 (U.S. Team Members)

If you're enrolled in the PPO, Health Fund or Indemnity 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.

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Mental Health and Substance Use Disorder Benefit Summary

Regardless of which option you are covered under, if you elect coverage under the PPO, Health Fund or Indemnity Plan option, 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.

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- 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.

In the event of a team member's termination, mental health and substance use disorder counseling may be continued if the team member or eligible dependent elects continued coverage of the medical program through COBRA.

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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.

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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.

Additional services may be available through the EAP. See the "Employee Assistance Program (EAP)" section for more information.

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.

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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

Regional Plans

Kaiser Permanente California Deductible DHMO Plan—For California Team Members

The Kaiser Permanente Deductible Health Maintenance Organization (DHMO) plan provides coverage for a broad range of medical services and supplies, including mental health and substance abuse coverage and prescription drug coverage. This section contains a brief overview of how the plan works and some of the benefits available. For more detailed information on how this plan works and what benefits are provided, see the Evidence of Coverage (EOC) provided by Kaiser Permanente.

Note: If you elect coverage under the Kaiser Permanente DHMO, you are not eligible for the mental health and substance use disorder coverage or prescription drug coverage described in this SPD.

How the Kaiser Permanente California DHMO Program Works

The Kaiser Permanente DHMO plan provides benefits through a network of providers, including physicians, specialists, hospitals, clinics, labs, etc. You must receive care from an in-network provider to receive benefits under the plan.

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

- **Preventive Care:** Preventive care is provided at 100%, with no deductible required. Preventive care is subject to the age and/or gender guidelines of the USPSTF. See the definition of preventive care in the "Glossary" section for additional organizations and agencies that have guidelines that must be followed. Contact your health plan if you have a question on whether a specific service is considered preventive care.
- **Deductible:** A deductible is the amount of covered expenses that you and your family pay each calendar year before the plan 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 deductibles 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.
- **Copay:** For certain covered services, such as doctor's office visits, you pay a copay per visit and then the plan pays the rest.
- **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 the care provided.
- **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 abuse. 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.
    - The out-of-pocket maximum includes deductibles, copays 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. There is no overall lifetime maximum amount the plan will pay.

The deductibles and out-of-pocket maximums do not apply to every covered service and some expenses may be covered differently or are subject to benefit maximums, as shown in the "Kaiser Permanente California DHMO Benefit Summary" section.

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Kaiser Permanente California DHMO Pre-Certification

Kaiser Permanente is a fully integrated health care model. Because you are part of an integrated system where the insurance, doctor's office and hospital services are interconnected, no pre-certification or pre-authorization is required for services within the Kaiser Permanente network. And, there are no claims to be filed for all services within the Kaiser Permanente network. The care plan you and your doctor decide on is the care you receive within the parameters of your benefits. In general, out-of-network services are not covered unless pre-authorization is granted by your Kaiser Permanente physician.

You and your provider are ultimately responsible for determining the course of treatment to be followed.

Kaiser Permanente California DHMO Benefit Summary

The following summary chart is intended as an overview only and all benefits are subject to the medically necessary requirement. More detailed information is available in the EOC or by contacting Kaiser Member Services at 1-800-464-4000.

The following table highlights what the plan pays.

For a complete list of covered and not covered expenses, refer to the materials provided by Kaiser Permanente online or by request through Kaiser Member Services at 1-800-464-4000.

Medical Benefits	
Plan Facts	
Annual Deductible	$300 individual (per calendar year) $600 family (per calendar year)
Hospital Admission Deductible	Annual deductible applies. No separate hospital admission deductible.
Primary Care Office Visits	$20 copay per visit, no deductible
Specialist Office Visits	$50 copay per visit, no deductible
Coinsurance (Plan Pays)	90% (unless noted otherwise)
Annual Out-of-Pocket Maximum	$2,000 individual (per calendar year) $4,000 family (per calendar year)
Non-Notification Penalty	Not applicable
Lifetime Maximum	Unlimited
Family Planning	
Female Tubal Ligation	100% covered when provided as a contraceptive method; 90% covered when provided for a non-contraceptive purpose
Fertility/Infertility Services	50% coinsurance
Fertility/Infertility Limit	Annual policy limits apply

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Medical Benefits	
Male Vasectomy	Plan pays 90% after deductible
Hospital Services	
Inpatient Hospital Visits	Plan pays 90% after deductible
Inpatient Surgeon	Plan pays 90% after deductible
Emergency Services	
Ambulance Services	Plan pays 90% after deductible
Emergency Room	Plan pays 90% after deductible
Emergency Room Detail	Non-emergency care not covered. Deductible not waived when emergency room visit is followed by admission.
Urgent Care Center	$20 copay per visit, no deductible
Maternity Care	
Birthing Centers	Plan pays 90% after deductible
Birthing Centers Limitation	Must use Kaiser Permanente facilities
Midwives	Plan pays 90% after deductible
Midwives Limitation	Must use Kaiser Permanente Medical providers
Mother—Facility Services	Plan pays 90% after deductible
Mother—Physician Services	***Pre-Natal:*** Schedule pre-natal care 100%, no deductible ***Inpatient:*** Plan pays 90% after deductible ***Post-Natal:*** 1st visit—100% covered, no deductible
Newborn Services	Plan pays 90% after deductible—covered under mother for first 31 days
Other Services	
Allergy Tests and Treatment	Injections covered at $10 copay per visit after deductible. Tests covered at office visit copay, no deductible.
Chiropractic/Spinal Manipulation	$15 copay per visit. Chiropractic services are administered through American Specialty Health, Inc. A PCP referral is not required to receive chiropractic services. Providers can be located through ashlink.com/ash/kp or by calling 1-800-678-9133.
Chiropractic/Spinal Manipulation Limit	20 visits per calendar year
Durable Medical Equipment (DME)	Plan pays 90% for most items; sexual dysfunction devices 50%, no deductible
Hearing Aids	Not covered
Hearing Aid Limit	Not covered

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Medical Benefits	
Hearing Exam/Screening (Routine)	Preventive care covered at 100%
Hearing Exam Limit	1 exam per year unless deemed medically necessary
Home Health Care	100% covered
Home Health Care Limit	2 hours maximum per visit, 3 visits maximum per day, 100 visit(s) maximum per calendar year
Hospice Care	100% covered
Hospice Care Limit	No limit
Obesity Surgery	Plan pays 90% after deductible
Obesity Surgery Limitations	Based on physician's recommendation
Occupational Therapy	$20 copay per visit after deductible
Occupational Therapy Limit	Based on physician's recommendation
Physical Therapy	$20 copay per visit after deductible
Physical Therapy Limit	Based on physician's recommendation
Private Duty Nursing	Not covered
Skilled Nursing Facility	Plan pays 90% after deductible
Skilled Nursing Facility Limit	100 days per benefit period
Speech Therapy	$20 copay per visit after deductible
Speech Therapy Limit	Based on physician's recommendation
Transplants	Plan pays 90% after deductible
Transplants Detail	Based on physician's recommendation
Vision Exam/Screening (Routine)	Preventive care covered at 100%
Vision Exam/Screening Detail (Routine)	Based on physician's recommendation
Outpatient Care	
Outpatient Surgery	Plan pays 90% after deductible
X-Ray, Laboratory and Nuclear Medicine Services	***Preventive lab/X-ray:*** 100%, no deductible ***Diagnostic lab/X-ray:*** Plan pays 90% after deductible
MRI, CT Scans and Laboratory Services	Plan pays 90% after deductible
Diagnostic X-Ray, PET Scans and Other Nuclear Imaging Services	Plan pays 90% after deductible
Preventive Care	
Preventive Care	100%, no deductible
Annual Adult Physical Exam	100%, no deductible

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Medical Benefits	
Annual Well-Woman Exam	100%, no deductible
Cancer Screenings	100%, no deductible
Cardiovascular Screenings	100%, no deductible
Colonoscopy	100%, no deductible
Immunizations	100%, no deductible
Mammogram	100%, no deductible
Pap Smears	100%, no deductible
Well-Child Exams	100%, no deductible
Well-Man Prostate-Specific Antigen (PSA)	100%, no deductible
Mental Health and Substance Abuse	
Outpatient Treatment	$20 copay per Individual Therapy visit, no deductible. Group Mental Health Treatment: $10 copay per visit, no deductible; Group Substance Abuse Treatment: $5 copay per visit, no deductible.
Inpatient Treatment	Plan pays 90% after deductible
Prescription Drug Benefits	
Out-of-Pocket Maximum	Combined with the Medical Annual Out-of-Pocket Maximum
Infertility Medications Maximum	50%
Retail Pharmacy	
Maximum Supply Per Prescription	Up to 30-day supply
Generic Medication	$8 copay per prescription
Formulary/Preferred Brand-Name Medication	Plan pays 75% per prescription ($70 maximum)
Non-Formulary/Non-Preferred Brand-Name Medication	Covered the same as preferred brand-name drugs when approved through an exception process
Preventive Care Drugs	Plan pays 100%
Home Delivery/Mail Order Pharmacy	
Maximum Supply Per Prescription	Up to 100-day supply
Generic Medication	$16 copay per prescription
Formulary/Preferred Brand-Name Medication	Plan pays 75% per prescription ($70 maximum)
Non-Formulary/Non-Preferred Brand-Name Medication	Covered same as preferred brand-name drugs when approved through an exception process
Specialty Pharmacy	
Generic Medication	$8 copay per prescription

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Medical Benefits	
Formulary/Preferred Brand-Name Medication	Plan pays 75% per prescription ($70 maximum)
Non-Formulary/Non-Preferred Brand-Name Medication	Covered same as preferred brand-name drugs when approved through an exception process

Kaiser Permanente POS Program—For Hawaii Team Members

The Kaiser Permanente POS Program provides coverage for a broad range of medical services and supplies, including mental health and substance abuse coverage and prescription drug coverage. This section contains a brief overview of how the Program works and some of the benefits available. For more detailed information on how this insured Program works, what benefits are provided, and applicable exclusions and limitations, see the materials provided by Kaiser Permanente.

How the Kaiser Permanente Hawaii POS Program Works

The Kaiser Permanente POS (Point of Service) Program provides benefits through a network of providers, including physicians, specialists, hospitals, clinics, labs, etc., at negotiated rates.

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

- **Preventive Care:** Preventive care is provided at 100%, with no deductible required when you use in-network providers, and up to 100% of the maximum allowable charge for non-contracted providers. Preventive care is subject to the age and/or gender guidelines of the USPSTF. See the definition of preventive care in the "Glossary" section for additional organizations and agencies that have guidelines that must be followed.
- **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. Out-of-network expenses do not cross apply. That means that amounts you pay for in-network covered expenses apply to the in-network and out-of-network deductible; but amounts you pay for out-of-network covered expenses only apply to the out-of-network deductible.
- **Copay:** For certain covered services, such as doctor's office visits, you pay a copay per visit and then the Plan pays the rest.
- **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.

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- **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 abuse. 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 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 and out-of-network maximum; but 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 certain copays (chiropractic, acupuncture and massage therapy office visits), non-covered services, pre-certification penalties and charges that exceed the maximum allowable charge do not apply toward meeting your maximum.
- **Benefit Maximums:** The Plan pays certain covered expenses up to specific limits. There is no overall lifetime maximum amount the Plan will pay.

The deductibles and out-of-pocket maximums do not apply to every covered service, and some expenses may be covered differently or are subject to benefit maximums, as shown in the “Kaiser Permanente Hawaii POS Benefit Summary” section.

Kaiser Permanente Hawaii POS Pre-Certification

Pre-certification, sometimes called pre-authorization, pre-admission certification or pre-treatment review, determines if a service, treatment, supply or facility is medically necessary for the care and treatment of an illness or injury. It also lets you know what benefits, if any, are payable under the Program. In most cases, network providers will handle any pre-certification for you. However, it is always a good idea to confirm that this has been done. In general, you are required to request pre-certification for out-of-network services. Contact Kaiser Permanente for more information.

Pre-certification does not restrict the course of treatment that you and your provider may decide is appropriate or necessary. You and your provider are ultimately responsible for determining the course of treatment to be followed.

Kaiser Permanente Hawaii POS Benefit Summary

The following summary chart is intended as an overview only, and all benefits described therein are subject to the medically necessary requirement and certain exclusions and limitations. More information can be obtained by contacting your Medical Claims Administrator directly.

All out-of-network provider charges are paid based on the maximum allowable charge, as defined by your Medical Claims Administrator. In-network charges are paid based on a negotiated rate with the provider (referred to in the table as “applicable charges”). The following table highlights what the Plan pays.

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For a complete list of covered and not covered expenses, refer to the materials provided by Kaiser Permanente.

Medical Benefits	In-Network	Out-of-Network
Plan Facts		
Annual Deductible	$0	$100 individual $300 family (3 or more members)
Hospital Admission Deductible	None	None
Primary Care Office Visits	$15 copay per visit	80% of maximum allowable charges (MAC) after deductible; pre-certification required for certain services
Specialist Office Visits	$15 copay per visit	80% of MAC after deductible; pre-certification required for certain services
Coinsurance (Plan Pays)	100% (unless noted otherwise)	80% of MAC after deductible; pre-certification required for certain services
Annual Out-of-Pocket Maximum	$2,000 (Individual); $6,000 (Family)	$2,000 (Individual) $6,000 (Family)
Non-Notification Penalty	Not applicable	Pre-certification required for certain services. Failure to pre-certify may result in a penalty up to $300 per occurrence.
Lifetime Maximum	Unlimited	Unlimited
Family Planning		
Female Tubal Ligation FDA-Approved Contraceptive Methods and Devices and Counseling Services	No charge	80% of MAC after deductible; pre-certification required for certain services
Fertility/Infertility Services	$15 copay	80% of MAC after deductible; pre-certification required for certain services
Fertility/Infertility Limit	See benefit summary from Kaiser Permanente	See benefit summary from Kaiser Permanente
Male Vasectomy	Outpatient: $15 copay Inpatient: $75 copay per day	80% of MAC after deductible; pre-certification required for certain services
Hospital Services		

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Medical Benefits	In-Network	Out-of-Network
Inpatient Hospital Visits	$75 per day	80% of MAC after deductible; pre-certification required for certain services
Inpatient Surgeon	$0 if in a hospital setting	80% of MAC after deductible; pre-certification required for certain services
Emergency Services		
Ambulance Services	80% of applicable charges	80% of MAC after deductible; pre-certification required for certain services
Emergency Room	$75 copay per visit	$75 copay per visit after deductible
Emergency Room Detail	Non-emergency services received in an emergency care setting are generally not covered	Non-emergency services received in an emergency care setting are generally not covered
Urgent Care Center	$15 copay per visit	80% of MAC after deductible; pre-certification required for certain services
Maternity Care		
Birthing Centers	$75 copay per day (hospital inpatient care applies)	80% of MAC after deductible; pre-certification required for certain services
Birthing Centers Limitation	See benefit summary from Kaiser Permanente	80% of MAC after deductible; pre-certification required for certain services
Midwives	Part of hospital inpatient care	80% of MAC after deductible; pre-certification required for certain services
Midwives Limitation	See benefit summary from Kaiser Permanente	80% of MAC after deductible; pre-certification required for certain services
Mother—Facility Services	Part of hospital inpatient care	80% of MAC after deductible; pre-certification required for certain services
Mother—Physician Services	Part of hospital inpatient care	80% of MAC after deductible; pre-certification required for certain services
Newborn Services	Part of hospital inpatient care (see benefit summary from	80% of MAC after deductible; pre-certification required for certain services

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Medical Benefits	In-Network	Out-of-Network
	Kaiser Permanente for additional information)	
Other Services		
Allergy Tests and Treatment	Inpatient: Part of inpatient hospital care Outpatient: 90% of applicable charges	80% of MAC after deductible; pre-certification required for certain services
Chiropractic/Spinal Manipulation	$15 copay per visit, includes acupuncture and massage therapy	Not covered
Chiropractic/Spinal Manipulation Limit	20 visits per calendar year (provided by ASHN provider)	N/A
Durable Medical Equipment (DME)	DME and External Prosthetics: 80% of applicable charges; Internal Prosthetics, Devices and Aids: 100%	DME and External Prosthetics: 80% of MAC after deductible; pre-certification required for certain services, includes external prosthesis; Internal Prosthetics, Devices and Aids; Contracted Provider: 80% of MAC after deductible; pre-certification required for certain services; Non-Contracted Provider: 80% of MAC after deductible; pre-certification required for certain services
Hearing Aids	60% of applicable charges	Not covered
Hearing Aid Limit	Up to two hearing aids every 36 months.	Not covered
Hearing Exam/Screening (Routine) (except if covered as Preventive Care)	$15 copay	80% of MAC after deductible; pre-certification required for certain services
Hearing Exam Limit	1 per year unless medically necessary	80% of MAC after deductible; pre-certification required for certain services
Home Health Care	$0 copay when prescribed by a physician	80% of MAC after deductible, limited to a combined benefit maximum of 150 days per calendar year

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Medical Benefits	In-Network	Out-of-Network
Home Health Care Limit	See benefit summary from Kaiser Permanente	See benefit summary from Kaiser Permanente
Hospice Care	$0 copay when prescribed by a physician	80% of MAC after deductible, limited to a combined benefit maximum of 210 days while insured
Hospice Care Limit	See benefit summary from Kaiser Permanente	See benefit summary from Kaiser Permanente
Obesity Surgery	Outpatient setting: $15 copay Inpatient setting: $75 copay per day	80% of MAC after deductible (unless noted otherwise); pre-certification required for certain services
Obesity Surgery Limitations	Must meet criteria to be eligible for obesity surgery benefit	Subject to pre-certification: 80% of MAC after deductible
Occupational Therapy	$15 copay	80% of MAC after deductible (unless noted otherwise); pre-certification required for certain services
Occupational Therapy Limit	None	80% of MAC after deductible; limited to a combined maximum of 60 outpatient visits per calendar year. Therapy must be for a condition that is subject to significant improvement within 2 months.
Physical Therapy	$15 copay	80% of MAC after deductible (unless noted otherwise)
Physical Therapy Limit	None	80% of MAC after deductible; limited to a combined maximum of 60 outpatient visits per calendar year. Therapy must be for a condition that is subject to significant improvement within 2 months.
Private Duty Nursing	Not covered	Not covered
Skilled Nursing Facility	No charge, limited to 120 days per accumulation period	80% of MAC after deductible; limited to a combined benefit maximum of 120 days per calendar year
Skilled Nursing Facility Limit	No charge, limited to 120 days per accumulation period	80% of MAC after deductible; limited to a combined benefit maximum of 120 days per calendar year

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Medical Benefits	In-Network	Out-of-Network
Speech Therapy	$15 copay	80% of MAC after deductible (unless noted otherwise)
Speech Therapy Limit	Subject to significant, measurable improvement in physical function; Kaiser Permanente clinical guidelines apply	80% of MAC after deductible; limited to a combined maximum of 60 outpatient visits per calendar year. Therapy must be for a condition that is subject to significant improvement within 2 months.
Transplants	Outpatient setting: $15 copay Inpatient setting: $75 per day (hospital copay)	Not covered
Transplants Detail	Including kidney, heart, heart-lung, liver, lung, simultaneous kidney-pancreas, bone marrow, cornea, small bowel and small bowel-liver transplants	Not covered
Vision Exam/Screening (Routine)	$15 copay	80% of MAC after deductible (unless noted otherwise)
Vision Exam/Screening Detail (Routine)	$15 copay	80% of MAC after deductible (unless noted otherwise)
Outpatient Care		
Outpatient Surgery	$15 copay per visit	80% of MAC after deductible
MRI, CT Scans and Laboratory Services	90% of applicable charges	80% of MAC after deductible
Diagnostic X-Ray, PET Scans and Other Nuclear Imaging Services	90% of applicable charges	80% of MAC after deductible
Preventive Care		
Annual Adult Physical Exam	100% (Preventive)	Out-of-Network Contracted: No charge Out-of-Network Non-Contracted: 100% of MAC
Annual Well-Woman Exam	Routine OB-GYN Office Visit: 100%; limited to 1 per calendar year	Routine OB-GYN Office Visit: 80% of MAC after deductible; limited to 1 per calendar year
Cancer Screenings	$0 copay when prescribed by a physician	80% of MAC after deductible (unless noted otherwise); pre-certification required for certain services

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Medical Benefits	In-Network	Out-of-Network
Cardiovascular Screenings	100% (Preventive)	80% of MAC after deductible
Colonoscopy	100% (Preventive)	80% of MAC after deductible
Immunizations	100%	100% of MAC; coverage only for covered dependents up to age 5
Mammogram	100% (Preventive)	80% of MAC after deductible
Pap Smears	100% (Preventive)	80% of MAC after deductible
Well-Child Exams	100%	80% of MAC—coverage only for covered dependents up to age 5
Well-Man Prostate-Specific Antigen (PSA)	100% (Preventive)	100% of MAC after deductible
Mental Health and Substance Abuse		
Outpatient Treatment	$15 copay per visit; includes day treatment/partial hospitalization	80% of MAC after deductible
Inpatient Treatment	$75 copay per day (including non-hospital residential services)	80% of MAC after deductible
Prescription Drug Benefits		
Out-of-Pocket Maximum	Included with medical	Included with medical
Infertility Medications Maximum	See benefit summary from Kaiser Permanente	See benefit summary from Kaiser Permanente
Retail Pharmacy		
Maximum Supply Per Prescription	30-day supply	30-day supply
Generic Medication	$10 copay (other generic) per 30-day supply; $3 copay (generic maintenance) per 30-day supply	80% of charge, not less than $10 copay per prescription at contracted out-of-network pharmacies (not covered at non-contracted pharmacies)
Formulary/Preferred Brand-Name Medication	$35 copay per 30-day supply; $70 copay per 90-day supply (mail-order)	80% of charge, not less than $35 copay per prescription at contracted out-of-network pharmacies (not covered at non-contracted pharmacies)
Non-Formulary/Non-Preferred Brand-Name Medication	$35 copay per 30-day supply; $70 copay per 90-day supply (mail-order)	80% of charge, not less than $35 copay per prescription at contracted out-of-network pharmacies (not covered at non-contracted pharmacies)
Home Delivery/Mail Order Pharmacy		

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Medical Benefits	In-Network	Out-of-Network
Maximum Supply Per Prescription	3-month supply	Not covered
Generic Medication	$20 copay per 3-month supply	Not covered
Formulary/Preferred Brand-Name Medication	$70 copay per 3-month supply	Not covered
Non-Formulary/Non-Preferred Brand-Name Medication	$70 copay per 3-month supply	Not covered
Specialty Pharmacy		
Generic Medication	Retail: $200 copay per 30-day supply	80% of charge, not less than $200 copay per prescription at contracted out-of-network pharmacies (not covered at non-contracted pharmacies)
Formulary/Preferred Brand-Name Medication	$200 copay per 30-day supply	80% of charge, not less than $200 copay per prescription at contracted out-of-network pharmacies (not covered at non-contracted pharmacies)
Non-Formulary/Non-Preferred Brand-Name Medication	$200 copay per 30-day supply	80% of charge, not less than $200 copay per prescription at contracted out-of-network pharmacies (not covered at non-contracted pharmacies)

Aetna International Program—For U.S. Expatriates

The Aetna International Program provides coverage for a broad range of medical services and supplies, including mental health and substance use disorder and prescription drug coverage. This section contains a brief overview of how the Program works and some of the benefits available. For more detailed information on how this insured Program works and what benefits are provided, log in to aetnainternational.com or contact Aetna Member Services at 1-800-231-7729 or 1-813-775-0190.

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How the Aetna International Program Works

The Aetna International Program provides benefits through a network of physicians and specialists around the world. These physicians have been combined with other selected health care providers, including hospitals, clinics, labs, etc., to form a broad network that agrees to provide your health care at lower, negotiated rates.

- You have the freedom to visit a doctor or medical facility of your choice without a referral, anywhere in the world. The only things that may differ are coverage levels and payment responsibilities in the United States (U.S.) vs. outside of the U.S, and whether you use an in-network or out-of-network provider in the U.S.
- You do not have to select a primary care physician (PCP), nor is a referral to an in-network specialist required. However, your out-of-pocket costs may be lower if you use in-network providers when available in the U.S.
- When outside of the U.S., it is your responsibility to seek the care you require, pay for services provided and submit claims for reimbursement of covered services. Make sure you identify yourself or your dependent as a member.
- Direct settlement is also available outside of the U.S. Direct settlement refers to arrangements that Aetna International has established with leading hospitals and health care providers throughout the world to reduce your out-of-pocket costs. When you use an Aetna International direct settlement provider, your out-of-pocket expenses may be reduced because Aetna International has negotiated a lower cost with that provider.
- When accessing care within the U.S., this option works like one of the U.S. PPO medical options. You may need to request pre-certification before you access certain medical services or procedures. This is not required when you access care outside of the U.S.

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

- **Preventive Care:** Preventive care is provided at 100%, with no deductible required; however, for out-of-network providers in the U.S. and providers outside the U.S. who are not direct settlement providers, payment is based on recognized charges. Preventive care is subject to the age and/or gender guidelines of the United States Preventive Services Task Force (USPSTF). See the definition of preventive care in the "Glossary" section for additional organizations and agencies that have guidelines that must be followed.
- **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 deductibles for in-network, out-of-network and outside of the United States.
- **Copay:** For certain covered services received in the U.S., such as in-network doctor's office visit, you pay a copay per visit and then the Plan pays the rest.

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- **Coinsurance:** Once you or your family meets the annual deductible, the Plan pays a percentage of covered expenses and you pay the rest. The percentage the Plan pays varies depending on whether you use in-network or out-of-network providers in the U.S. and whether you are in the U.S. or outside the U.S. If you use an in-network provider or an Aetna International direct settlement provider, the percentage will be of a negotiated rate with the provider. If you use an out-of-network provider or a provider outside the U.S. who is not a direct settlement provider, the percentage will be of the recognized rate, as determined by Aetna.
- **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, out-of-network, and outside of the United States 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 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, coinsurance and copay amounts you pay for covered expenses and outpatient prescription drugs when outside the U.S. Amounts you pay for non-covered services and charges that exceed the covered charge do not apply toward meeting your maximum.
    - The out-of-pocket maximums for outpatient prescription drugs outside the U.S. or obtained out-of-network in the U.S. are separate from the medical out-of-pocket maximums. Outpatient prescription drugs obtained in-network in the U.S. apply toward the medical out-of-pocket maximums.
- **Visit Limits:** The Plan pays certain covered expenses up to specific limits. There is no overall lifetime maximum amount the Plan will pay.

The deductibles and out-of-pocket maximums do not apply to every covered service, and some expenses may be covered differently or are subject to benefit maximums, as shown in the “Aetna International Summary” section.

Aetna International Pre-Certification

Pre-certification, sometimes called pre-authorization, pre-admission certification or pre-treatment review, determines if a service, treatment, supply or facility is medically necessary for the care and treatment of an illness or injury. It also lets you know what benefits, if any, are payable under the Program. Pre-certification is not required when you access care outside of the U.S. In most cases, network providers in the U.S. will handle any pre-certification for you. However, it is always a good idea to confirm that this has been done.

Outside the U.S., a provider may ask you to provide a Letter of Authorization (LOA) before receiving services. These documents are similar to a pre-authorization or referral. The LOA authorizes treatment and lets doctors know your Aetna International Program will pay for their services.

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Pre-certification does not restrict the course of treatment that you and your provider may decide is appropriate or necessary. You and your provider are ultimately responsible for determining the course of treatment to be followed.

Aetna International Summary

The following summary chart is intended as an overview only, and all benefits described therein are subject to the medically necessary requirement and the limitations and exclusions found in the materials produced by Aetna. More information can be obtained by contacting your Medical Claims Administrator directly.

All out-of-network provider charges and charges outside the U.S. are paid based on the recognized charge, as defined by your Medical Claims Administrator. In-network charges or charges by an Aetna International direct settlement provider are paid based on a negotiated rate with the provider. The following table highlights what the Plan pays.

For a complete list of covered and not covered expenses, refer to the materials provided by Aetna International.

Medical Benefits	**Outside U.S.**	**In-Network in U.S.**	**Out-of-Network in U.S.**
Plan Facts			
Annual Deductible	None	$500 individual $1,000 family	$1,000 individual $2,000 family
Hospital Admission Deductible	None	None	None
Primary Care Office Visits	100%, no deductible	$20 copay per visit	60% after deductible
Specialist Office Visits	100% of the recognized charge per visit, no deductible	$50 copay per visit; then the plan pays 100% of the balance of the negotiated charge per visit thereafter; no deductible	60% of the recognized charge per visit, after deductible
Coinsurance (Plan Pays)	100%, no deductible (unless noted otherwise)	90% after deductible (unless noted otherwise)	60% after deductible (unless noted otherwise)
Annual Out-of-Pocket Maximum	None	$2,500 individual $5,000 family	$5,000 individual $10,000 family
Non-Notification Penalty	No penalty	No penalty	$400
Lifetime Maximum	Unlimited	Unlimited	Unlimited

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Medical Benefits	Outside U.S.	In-Network in U.S.	Out-of-Network in U.S.
Family Planning			
Female Tubal Ligation FDA-Approved Contraceptive Methods and Devices and Counseling Services	100%, no deductible	100%, no deductible	60% after deductible
Fertility/Infertility Services	100%, no deductible	90% after deductible	60% after deductible
Basic Infertility Services (covered according to the type of benefit and the place where the service is received)	100%, no deductible	90% after deductible	60% after deductible
(Basic plan coverage includes coverage limited to the testing and treatment of underlying condition)			
Comprehensive Infertility Services	100%, no deductible	90% after deductible	60% after deductible
(Comprehensive plan coverage includes coverage for Artificial Insemination and Ovulation Induction)			
ART Infertility Services	100%, no deductible	90% after deductible	60% after deductible
(6 cycles per lifetime for Advanced Reproductive Technology (ART) coverage with cryopreservation, storage and unlimited embryo transfers)			
Male Vasectomy	100%, no deductible	90% after deductible	60% after deductible
Hospital Services			
Inpatient Hospital Visits	100%, no deductible	90% after deductible	60% after deductible
Inpatient Surgeon	100%, no deductible	90% after deductible	60% after deductible
Emergency Services			
Ambulance Services	100%, no deductible	90% after deductible	60% after deductible
Emergency Room	***Emergency:*** 100%, no deductible ***Non-Emergency:*** 100%, no deductible	***Emergency:*** 90% after deductible ***Non-Emergency:*** 50% after deductible	***Emergency:*** 90% after deductible ***Non-Emergency:*** 50% after deductible
Urgent Care Center	100%, no deductible	$50 copay per visit	60% after deductible
Maternity Care			

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Medical Benefits	Outside U.S.	In-Network in U.S.	Out-of-Network in U.S.
Birthing Centers	100%, no deductible	90% after deductible	60% after deductible
Midwives	100%, no deductible	90% after deductible	60% after deductible
Mother—Facility Services	100%, no deductible	90% after deductible	60% after deductible
Mother—Physician Services	100%, no deductible	90% after deductible	60% after deductible
Newborn Services	100%, no deductible	90% after deductible	60% after deductible
Other Services			
Allergy Tests and Treatment	100%, no deductible	90% after deductible	60% after deductible
Chiropractic/Spinal Manipulation	100%, no deductible	$10 copay	75% after deductible
Chiropractic/Spinal Manipulation Limit	Unlimited	Unlimited	Unlimited
Chiropractic/Spinal Manipulation Detail			Copays and coinsurance for chiropractic visits are capped at 25% of the amount due to the chiropractor
Durable Medical Equipment (DME)	100%, no deductible	90% after deductible	60% after deductible
Hearing Aids	100%, no deductible	90% after deductible	60% after deductible
Hearing Aid Limit	$1,000 per hearing aid every 3 calendar years; limited to age 24	$1,000 per hearing aid every 3 calendar years; limited to age 24	$1,000 per hearing aid every 3 calendar years; limited to age 24
Hearing Exam/Screening (Routine)	100%	100%	100%
Hearing Exam Limit	1 exam every 24 months	1 exam every 24 months	1 exam every 24 months
Home Health Care	100%, no deductible	90% after deductible	60% after deductible
Home Health Care Limit	120 visits per calendar year	120 visits per calendar year	120 visits per calendar year
Hospice Care	100%, no deductible, includes 3 bereavement sessions	90% after deductible, includes 3 bereavement sessions	60% after deductible, includes 3 bereavement sessions
Hospice Care Limit	30 days inpatient/unlimited outpatient	30 days inpatient/unlimited outpatient	30 days inpatient/unlimited outpatient

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Medical Benefits	Outside U.S.	In-Network in U.S.	Out-of-Network in U.S.
Obesity Surgery	Not covered	Not covered	Not covered
Obesity Surgery Limitations	Not covered	Not covered	Not covered
Occupational Therapy	100%, no deductible	$10 copay per visit	75% after deductible
Occupational Therapy Limit	60 visits per calendar year (combined physical, occupational and speech therapy)	Unlimited visits per calendar year	Unlimited visits per calendar year
Physical Therapy	100%, no deductible	$10 copay per visit	75% after deductible
Physical Therapy Limit	60 visits per calendar year (combined physical, occupational and speech therapy)	Unlimited visits per calendar year	Unlimited visits per calendar year
Private Duty Nursing	100%, no deductible	90% after deductible	60% after deductible
Private Duty Nursing Limit	120 visits per calendar year	120 visits per calendar year	120 visits per calendar year
Skilled Nursing Facility	100%, no deductible (convalescent facility)	90% after deductible (convalescent facility)	60% after deductible (convalescent facility)
Skilled Nursing Facility Limit	120 days per calendar year	120 days per calendar year	120 days per calendar year
Speech Therapy	100%, no deductible	$50 copay per visit	60% after deductible
Speech Therapy Limit	60 visits per calendar year (combined physical, occupational and speech therapy)	60 visits per calendar year (combined physical, occupational and speech therapy)	60 visits per calendar year (combined physical, occupational and speech therapy)
Transplants	100%, no deductible	Office visit: $50 copay per visit; Other physicians: 90% after deductible	60% after deductible
Vision Exam/Screening (Routine)	100%, no deductible	100%, no deductible	100%, no deductible
Vision Exam/Screening Detail (Routine)	1 routine exam every 12 months	1 routine exam every 12 months	1 routine exam every 12 months
Outpatient Care			
Outpatient Surgery	100%, no deductible	90% after deductible	60% after deductible

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Medical Benefits	Outside U.S.	In-Network in U.S.	Out-of-Network in U.S.
MRI, CT Scans and Laboratory Services	100%, no deductible	90% after deductible	60% after deductible
Diagnostic X-Ray, PET Scans and Other Nuclear Imaging Services	100%, no deductible	90% after deductible	60% after deductible
Preventive Care			
Annual Adult Physical Exam (Frequency limits may be adjusted to meet the definition of Preventive Care)	100%, includes immunizations ***Ages 22-65:*** 1 exam per 12 months ***Ages 65 and Older:*** 1 exam per 12 months	100%, includes immunizations ***Ages 22-65:*** 1 exam per 12 months ***Ages 65 and Older:*** 1 exam per 12 months	100%, includes immunizations ***Ages 22-65:*** 1 exam per 12 months ***Ages 65 and Older:*** 1 exam per 12 months
Annual Well-Woman Exam	100%, includes annual pap smear, mammogram and related lab fees	100%, includes annual pap smear, mammogram and related lab fees	100%, includes annual pap smear, mammogram and related lab fees
Cancer Screenings	100%, no deductible	100%, no deductible	100%, no deductible
Cardiovascular Screenings	100%, no deductible	100%, no deductible	100%, no deductible
Colonoscopy	100%, no deductible; limited to ages 45 and over	100%, no deductible; limited to ages 45 and over	100%, no deductible; limited to ages 45 and over
Immunizations	100%, no deductible	100%, no deductible	100%, no deductible
Mammogram	100%, no deductible	100%, no deductible	100%, no deductible
Pap Smears	100%, no deductible	100%, no deductible	100%, no deductible
Well-Child Exams (Frequency limits may be adjusted to meet the definition of Preventive Care)	100%, includes immunizations and tuberculosis testing First Year of Life: 7 exams Second Year of Life: 3 exams Third Year of Life: 3 exams Thereafter: 1 exam per 12 months to age 22 (includes immunizations)	100%, includes immunizations and tuberculosis testing First Year of Life: 7 exams Second Year of Life: 3 exams Third Year of Life: 3 exams Thereafter: 1 exam per 12 months to age 22 (includes immunizations)	100%, includes immunizations and tuberculosis testing First Year of Life: 7 exams Second Year of Life: 3 exams Third Year of Life: 3 exams Thereafter: 1 exam per 12 months to age 22 (includes immunizations)
Well-Man Prostate-Specific Antigen (PSA)	100%, no deductible	100%, no copay	100%, no deductible

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Medical Benefits	Outside U.S.	In-Network in U.S.	Out-of-Network in U.S.
Mental Health and Substance Use Disorder			
Outpatient Treatment	100%, no deductible	$50 copay per visit	60% after deductible
Inpatient Treatment	100%, no deductible	90% after deductible	60% after deductible
Prescription Drug Benefits			
Out-of-Pocket Maximum	None	Combined with medical out-of-pocket limit	Combined with medical out-of-pocket limit
Infertility Medications Maximum	Oral and injectable fertility drugs are included. Reimbursed under the normal prescription coverage.	Oral and injectable fertility drugs are included. Reimbursed under the normal prescription coverage.	Oral and injectable fertility drugs are included. Reimbursed under the normal prescription coverage.
Retail Pharmacy			
Maximum Supply Per Prescription	365-day supply	365-day supply	365-day supply
Generic Medication	100%, no deductible	$8 copay per 31-day supply	60% after deductible
Formulary/Preferred Brand-Name Medication	100%, no deductible	$30 copay per 31-day supply	60% after deductible
Non-Formulary/Non-Preferred Brand-Name Medication	100%, no deductible	$50 copay per 31-day supply	60% after deductible
Home Delivery/Mail Order Pharmacy			
Maximum Supply Per Prescription	Not covered	One copay per 31-day supply (home delivery); 365-day supply maximum	Not covered
Generic Medication	Not covered	$8 copay per 31-day supply	Not covered
Formulary/Preferred Brand-Name Medication	Not covered	$30 copay per 31-day supply	Not covered
Non-Formulary/Non-Preferred Brand-Name Medication	80% after deductible	$50 copay per 31-day supply	60% after deductible
Specialty Pharmacy			
Generic Medication	100%, no deductible	90% after deductible	60% after deductible

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Medical Benefits	Outside U.S.	In-Network in U.S.	Out-of-Network in U.S.
Formulary/Preferred Brand-Name Medication	100%, no deductible	90% after deductible	60% after deductible
Non-Formulary/Non-Preferred Brand-Name Medication	100%, no deductible	$50 copay per 31-day supply	60% after deductible

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.

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- ***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.

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- ***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.

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"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.

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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 team member;
- Team member'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.

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- 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.

Filing an Aetna International Program Claim

If you choose a doctor in the direct settlement network, you can usually access care without having to submit a claim.

If you choose to go outside the network for care, you'll need to pay at the time of service and then submit a claim for reimbursement.

Before You Submit Your Claim

- You'll need to submit your claim within 180 days of your treatment.
- Have all supporting documents on hand, including original receipts, certificates and X-rays.
- Put your Member ID number on each document you submit.
- Be ready to provide complete details of your visit, including the reason for it and a description of services provided.
- Know what currency and method — check, wire or electronic funds transfer (EFT) — you'd like to be reimbursed in. (Aetna doesn't charge processing fees for EFT, wire transfers or direct deposits, but your bank might, so make sure you check.)

You can submit your claim through the member portal at aetnainternational.com or contact Aetna International Member services for assistance.

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

Provider	Address
Aetna International	Aetna International P.O. Box 981543 El Paso, TX 79998-1543
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 80510 Chicago, IL 60680
Kaiser Permanente Northern California DHMO Claims Filing Address	Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 12923 Oakland, CA 94604-2923

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Provider	Address
Kaiser Permanente POS Program	Kaiser Permanente Hawaii Claims Administration P.O. Box 378021 Denver, CO 80237 Customer Service Toll-Free: 1-877-875-3805
Kaiser Permanente Southern California DHMO Claims Filing Address	Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004

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.

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Employee Assistance Program (EAP)

Overview

In addition to mental health coverage through your medical plan, you also have access to Lyra Health, providing free, expert and compassionate short-term emotional and mental health support how, when and where you need it.

Lyra Health provides free mental health coaching and short-term therapy. Whether you're experiencing burnout, anxiety or depression, caregiver stress, racial stress or trauma, or even looking into improving your relationships, Lyra Health has a care option that's right for you. The program is open to all U.S. and Puerto Rico team members (including Expatriates) and their dependents (spouse, domestic partner and children, i.e., immediate family). You don't need to be enrolled in a Dell medical plan.

EAP Benefits

You, your spouse or domestic partner and children up to age 26 are each eligible for up to 12 free live sessions per year, with any combination of coaching or therapy. You can work with your coach or therapist via video, messaging or over the phone, or talk to your therapist in-person.

This program can help you with issues such as:

- Substance use ;
- Co-dependency;
- Relationship issues;
- Loss/grief;
- Family communication;
- Financial stress;
- Depression; and
- Parenting issues.

Lyra Health offers an enhanced and unique provider network that has a strategic focus on diversity and inclusion. For example, at least 40% of providers are people of color, and at least 60% specialize in caring for LGBTQ+ participants.

Receiving EAP Benefits

The Employee Assistance Program is available 24 hours a day, seven days a week. Just visit dell.lyrahealth.com or call Lyra Health at 1-877-222-4258. You can meet with coaches and therapists via live video, live messaging, phone or in-person. You can receive one-on-one coaching, therapy or self-guided care. Through Lyra Health's digital platform, you can message directly with your therapist, schedule appointments online, find educational resources, and track your symptoms and progress in care.

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If you're enrolled in the PPO, Health Fund or Indemnity medical plan: Lyra Clinical Associates P.C. (LCA), Lyra Health and Dell have developed a new program offered through the medical benefits of your Dell Group Health Plan — Aetna and Blue Cross and Blue Shield of Illinois — designed to help you and your enrolled dependents connect with effective and convenient care for your mental well-being. After using all 12 no-cost visits, you can continue seeing your Lyra Health provider, and the sessions are covered in-network (subject to normal cost share) under your medical plan's mental health coverage. Any psychiatric counseling services that the Medical Program does not pay for may be reimbursable from the Health Care Flexible Spending Account or Health Savings Account (if you are contributing to these accounts) if the services meet the requirements for these programs. For more information contact your Medical Claims Administrator or Lyra Health.

Join a Mindfulness Meditation webinar
Learn simple ways to build mindfulness into your daily life. Practicing mindfulness meditation can:

- Improve attention.
- Build resiliency.
- Reduce emotional stress and physical pain.

Sign up on the **Mindfulness Meditation page on inside Dell Technologies**.

The medical treatment of a condition is not included under EAP coverage. However, the counseling related to your or your eligible dependent's ability to handle a situation may be covered by the EAP, within the limits of the EAP program. Please contact Lyra Health if you have questions. LCA's providers and coaches do not deliver services for or cover the costs of inpatient, residential treatment, partial hospitalization, long-term care or counseling, prescription medication, disability assessments, autism spectrum disorder, services for remedial education, non-evidence-based behavioral health care or emergency care. If an outpatient provider is not an appropriate fit for your needs, and you are looking for additional support for a mental health issue, contact your medical plan to identify additional resources to support you.

Note: While U.S. Expatriates are on assignment outside of the U.S., they can contact the Global EAP at livewell.optum.com. When U.S. Expatriates are home in the U.S., they can contact Lyra Health at dell.lyrahealth.com.

Billing

There is no cost to you for therapy and coaching services up to the 12 sessions offered through the Lyra Health EAP. If you receive medication management psychiatry services, or you continue care beyond the 12 covered EAP sessions, LCA will directly file a claim with your Dell Aetna or Blue Cross Blue Shield of Illinois medical plan for services it delivers. To the extent that you owe a contribution for the cost of the service (copay, deductible or coinsurance), LCA will bill you directly for the amounts you owe based on your plan.

Coordination of Benefits

Lyra can only file a claim to the Dell PPO, Health Fund or Indemnity medical plan . If you need help understanding your health plan and costs associated with using Lyra, reach out to your Benefit Pro.

If you have a plan other than a Dell PPO, Health Fund or Indemnity medical plan, you will be charged the full amount by Lyra. You are responsible for sending the claims to your primary and secondary insurance, as applicable, to be reimbursed directly by your medical plan(s). You can e-mail Lyra at care@lyrahealth.com to request a superbill to assist you with your submission to the primary and/or secondary insurance for payment.

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Late Cancellations and No-Shows

Lyra providers require 24 hours' notice of cancellation or request to reschedule a session. This applies to all sessions, including the 12 covered EAP sessions. To the extent that you do not show up to an appointment with your provider or coach, or you cancel your appointment with less than 24 hours' notice to the provider or coach, you may be charged a fee according to the provider's or coach's late-cancellation/no show policy.

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Prescription Drug Program (U.S. Team Members)

Introduction

If you are a participant in a National coverage option through the Dell Medical Program, 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.

Regional Plans

If you are covered under the Kaiser Permanente California DHMO, Kaiser Permanente POS Program or U.S. Expatriate Medical Plan, prescription drug benefits are provided by your medical plan, as described in separate materials—you are not eligible for the prescription drug benefits described in this section.

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.

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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 **MyWellatDell.com > 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**.

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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.

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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.

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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.

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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
CVS Specialty	

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Plan Feature	Coverage
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.

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- 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.

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- 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.

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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.

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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.
- Insulin pumps.
- 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.

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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.

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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.

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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.

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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.

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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

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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.

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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.

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Health Rewards

Overview

Your health, and the health of your spouse or domestic partner, is a key component of Dell's success. To help you and your family achieve and maintain a healthy lifestyle, Dell has established the Health Rewards program. Its purpose is simple: to help you reach your full health and well-being potential. Through Health Rewards resources and programs, you'll have support to improve in ways that are meaningful and personalized to you. All of the Health Rewards activities can easily be accessed through the Dell Wellness Hub platform that is described below.

The Health Rewards program is provided by Dell at no cost to you, except as otherwise indicated.

Dell Wellness Hub

The Dell Wellness Hub is a global wellness platform that is powered by Virgin Pulse. It is a personalized and innovative approach that puts you in charge of your total health and wellness. Dell's partnership with Virgin Pulse brings you a digitally transformative wellness experience that makes it easy and fun to securely interact with wellness activities at work, at home or on the go, on the five-star-rated Virgin Pulse app via smartphone or desktop. The Dell Wellness Hub offers choice and flexibility, allowing you to do wellness your way.

The Dell Wellness Hub gives you:

- Access to programs such as meQuilibrium (a personalized online stress management tool to help you learn to stay calm and focused so you can deal with life's challenges in a healthy way)
- The chance to work with a certified health coach
- The ability to track steps, sleep or workouts, and to set wellness goals all year long
- Apps and activities to help with mindfulness (RethinkCare), fitness (Wellbeats [see the "Additional Benefits to Help You Manage Your Life" section for additional information]) and nutrition (Foodsmart by Zipongo)
- The opportunity to participate in challenges year-round and even create your own challenges and groups, so you can connect with and support fellow team members locally and around the globe

Eat, Sleep, Connect and Be Well

Through the Dell Wellness Hub — powered by Virgin Pulse — you can embrace overall wellness while connecting with colleagues, friends and family across the globe. Whether you're focused on nutrition, sleep, fitness or all of the above, you'll find something to help on Dell Wellness Hub.

Find these resources at **DellWellnessHub.com**:

Focus Areas	Resources
Eat well	**Foodsmart by Zipongo** offers healthy, delicious recipes, meal planning, and the ability to organize and create your grocery list.
Sleep better	The **Sleep Guide** allows you to create a sleep profile and get customized tips to help you fall asleep and stay asleep. Plus, you can track your sleep to gain a better understanding of your overall sleep health.

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Focus Areas	Resources
Connect with others	Add friends to your network on the Dell Wellness Hub. Invite them to a **Challenge** focused on things like drinking more water, following a nutrition plan, leaving kind comments on social media or being mindful each day.
Build healthy habits	Daily practice of healthy behaviors helps build good habits, and with those daily successes come big changes over time. Set the **Healthy Habits** that matter to you to personalize your Dell Wellness Hub experience.

Health Rewards Program Eligibility

U.S. Team Members

Participation in the Health Rewards program is encouraged, but is completely voluntary. You must be actively employed and you (and your spouse or domestic partner) must be enrolled in a Dell medical option to earn the Health Rewards medical premium discount. Both you and your spouse or domestic partner are eligible and can earn the medical premium discount provided you both satisfy the Health Rewards program requirements. For more information, see the “Health Rewards Program (U.S. Team Members)” section.

You are not eligible for the medical premium discount if you are:

- A Hawaii or Puerto Rico resident.
- An Aetna International Plan participant.
- An Inactive team member.

Hawaii Team Members and Expatriates

Participation in the Health Rewards program is completely voluntary since the premium reduction has already been factored into your payroll contributions. You must be actively employed and benefits-eligible to participate in the Program. For more information, see the “Health Rewards Program (Hawaii Team Members and Expatriates)” section.

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Health Rewards Program (U.S. Team Members)

The Health Rewards program rewards you with lower medical premiums when you take just two healthy steps by January 31 each year:

- Take the online health review on the Dell Wellness Hub— earn $200.
- Complete **ONE** of the following — earn $500:
    - Complete at least one Virgin Pulse Journey® through the Virgin Pulse app or Dell Wellness Hub desktop experience. See the "Virgin Pulse Journey" section for additional information.
    - Off-site biometric screening through Labcorp. See the "Biometric Screening" section for additional information.

Register to Earn Health Rewards
To earn Health Rewards and access wellness tools, register on the Dell Wellness Hub. Once you're registered, you can access the desktop version seamlessly through the Wellness sections on **MyWellatDell.com** and **My HR.**

- **Team members**: Sign up at **DellWellnessHub.com**.
- **Medically enrolled spouses/domestic partners**: Sign up at **join.virginpulse.com/dellspouse**.

Completing the Dell Wellness Hub Online Health Review

Check out the **Health** tab on the Virgin Pulse app to take the confidential health review to answer questions about your current health status and habits.

Customized recommendations are provided based on your results. You must complete the health review to qualify for $200 in medical premium discounts.

Note: Your medically covered spouse or domestic partner who wants to complete Health Rewards activities in order to earn the premium discount needs to log in under their own primary Dell Wellness Hub account. Please visit My Well at Dell for more detailed information about the program.

Virgin Pulse Journey

Journeys are self-guided, digital coaching courses offering daily support in areas like stress, sleep, nutrition, exercise, finances and more. Depending on the Journey you choose, you'll spend a few minutes per day over 10 to 18 days to complete your first Journey, which earns you $500 in Health Rewards medical premium discounts. Please be aware that this Journey must be completed by 11:59 p.m. in your time zone by the premium discount deadline, and you can only complete one step of the Journey each day. On the Dell Wellness Hub, choose and start your Journey under the **Programs** or **Health** tabs.

Note: If your eligible spouse or domestic partner completes the online health review and journey or biometric screening, they are also eligible for the $700 Health Rewards. That's a $1,400 reduction in your medical premiums.

Biometric Screening

An off-site biometric screening is an easy way to learn important numbers like cholesterol and keep track of your health over time. Through Labcorp you can select the type of screening that is most convenient for you. Your results will be available to view in your Dell Wellness Hub account and will help create a more personalized journey by offering relevant health and wellness content through the Hub.

Alternative: When You Object to Providing Personal Health Information or Have a Medical Inability to Complete the Program

For information on alternative ways for you to earn the Health Rewards medical premium discount, including alternatives that accommodate your physician's recommendations, contact Virgin Pulse Member Services at 1-888-317-1268. Alternative forms must be submitted by January 31 each year.

Medical Premium Discount Payment Details

The discount will be reflected in ongoing paychecks throughout the year. If you complete any of the activities before December 15 of a given year and also enroll in a Dell medical plan for the following year, your medical premium discount will be available with your first paycheck in January. The premium discount reduces the before-tax medical contributions you have taken out of your paycheck throughout the calendar year.

If you complete any activities after December 15 of a given year, you'll receive a lump-sum payment of the refund you missed to date in your paycheck within two pay periods (which will be added to your income and subject to tax), and the remainder of your medical contributions will be reduced throughout the rest of the calendar year.

Activity Rewards Program Overview

In addition to the Health Rewards program, there are more opportunities to engage in well-being activities. The Activity Rewards program gives you new and different ways to achieve well-being in your life. It's simple: complete activities that appeal to you and earn rewards. Select from the multiple activities and programs listed on the Dell Wellness Hub and start earning rewards today. Point values are assigned to each activity. When you and/or your medically enrolled spouse or domestic partner reach specified levels, you earn Pulse Cash (up to $200) to be redeemed for gift cards on the Dell Wellness Hub. There is also an opportunity to earn up to $100 by participating in the Global Fitness Challenge. Additional reward opportunities may be available upon completion of Level 4. More details about additional reward opportunities became available in July 2022.

To earn the Activity Rewards, you must be an active, benefits-eligible team member, including residents of Hawaii, Puerto Rico and Aetna International Plan participants. Spouses or domestic partners who are covered by a Dell medical plan are also eligible to participate.

The deadline to complete these activities is January 31, 11:59 p.m. local time.

Opting Out of Health Rewards

You and your spouse or domestic partner may participate in the Health Rewards program and utilize the program's resources at no cost to you. If you would like to opt out of the entire Health Rewards program, you must opt out annually by calling Virgin Pulse Member Services at 1-888-317-1268. It may take up to 60 days to process your opt-out request.

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Health Rewards Program (Hawaii Team Members and Expatriates)

Getting Started

Complete a Confidential Health Review

You can access the health review online on the **Health** tab on the Virgin Pulse app.

Spouses and domestic partners should complete the health review under their own primary Dell Wellness Hub account.

In the health review, you will be asked to provide information on your current health status and habits. Customized recommendations are provided based on your results.

Privacy of Your Health Information

Dell respects the privacy of your health information. Your participation in the Health Rewards program is with a third-party vendor. Information obtained as part of Dell's wellness and health improvement initiatives; individual survey responses, results and personal health information will not be shared with anyone at Dell. However, information concerning aggregate group participation will be shared with Dell so that Dell may continue to provide health programs that meet team members' needs. To view the most recent copy of Dell's privacy statement under HIPAA, see the "Notice of Privacy Practices for Protected Health Information" section or visit My Well at Dell.

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Dental Program

Overview

The Dental Program provides benefits for eligible dental expenses. When receiving services, you may obtain services from any dentist you choose.

Dell Dental Program for U.S. Team Members

The Dental Program has a two-tier provider network offered by Delta Dental: PPO and Premier. Both use provider networks, but the PPO network provides greater discounts. If you use a dentist from either provider network (in-network provider), he or she will typically charge less than an out-of-network provider. Therefore, using in-network providers will lower your out-of-pocket costs.

Find a New Dentist and Estimate Costs
Use The Provider Search & Pricing Tool to find out if your current dentist is in the PPO or Premier network, or to search for other high-quality dentists. To find out the cost of your visit before you go, the tool can also estimate the cost of services so you're prepared before you pay for them.

To find it, log on to **MyWellatDell.com** > **The Provider Search & Pricing Tool**.

How the Dental Program Works

The Dental Program covers 100% of preventive and diagnostic care services. For certain services, you must meet an annual deductible before the Plan begins to pay benefits (see the chart under the "Dental Program Benefit Summary" section for additional information). The annual deductible for out-of-network services and supplies is higher than the annual deductible for in-network, as shown later in this section. Please note that each covered individual can only apply a certain individual deductible amount toward the annual family deductible whether in- or out-of-network. (For example, if you or a family member incurs $200 of in-network expenses, only $50 will count toward the family deductible.) Once your family meets the family deductible, your remaining covered dependents do not have to meet their individual deductible amounts for the rest of the year.

For basic care and major care expenses, once you meet the deductible, you and the Plan share in the cost of your care, up to the annual maximum benefit per person as shown in the chart under the "Dental Program Benefit Summary" section. Benefits payable for preventive care, basic care and major care apply toward the maximum annual benefit. Orthodontic care has a separate lifetime maximum.

Benefits are paid based on the maximum contract allowance. The maximum contract allowance is the usual amount charged for specific services in a geographic area.

Coverage Tiers

There are four coverage tiers available in the Dental Program. Each coverage tier determines how many people may be covered and what dependents may be covered. You must be enrolled to enroll any eligible dependents in the Dental Program. The four coverage tiers are:

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

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Dental Program Benefit Summary

The following summary chart is intended as an overview only. More information can be obtained by contacting Delta Dental directly at 1-800-693-2659.

Dental Benefits	In-Network	Out-of-Network
Annual Deductible	$50 per person $150 per family	$75 per person $225 per family
Preventive and Diagnostic Care	Plan pays 100%; no deductible required	Plan pays 100% of the maximum contract allowance; no deductible required
Basic Restorative Care	Plan pays 80% after deductible	Plan pays 70% of the maximum contract allowance, after deductible
Major Restorative Care	Plan pays 50% after deductible	Plan pays 50% of the maximum contract allowance, after deductible
Annual Maximum Benefit	$2,000 per person, combined in- and out-of-network; does not apply to orthodontia	$2,000 per person, combined in- and out-of-network; does not apply to orthodontia
Orthodontic Treatment	Plan pays 50%, up to the lifetime orthodontia maximum; no deductible required	Plan pays 50%, up to the lifetime orthodontia maximum; no deductible required
Orthodontia Lifetime Maximum	$2,000 per person; combined in- and out-of-network	$2,000 per person; combined in- and out-of-network

Dental Program Covered Expenses

Preventive and Diagnostic Care Services

Preventive and diagnostic care services include routine cleanings, X-rays and similar types of expenses. These procedures include:

- Office visits:
  - Two exams per calendar year;
- Fluoride:
  - Benefit is limited to one fluoride procedure within a calendar year for individuals under age 19;
- Cleanings:
  - Two cleanings (prophylaxis) per calendar year;
  - Two periodontal cleanings per calendar year (total cleanings between preventive and basic services not to exceed four);
- X-rays:
  - Bitewing X-rays once per year for individuals age 18 or older; twice per calendar year for individuals under age 18;
  - Full mouth X-rays once every five years;
  - Entire series of at least 10 films, which include bitewings, limited to once every five years or panoramic survey once every five years, which includes maxillary and mandibular views; and

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- Sealants, limited to one application per tooth (teeth without caries) every five years up to age 19.

Basic Restorative Care

Basic care services include visits and exams related to:

- Periodontics—periodontics surgery once every 36 months, periodontal scaling/root planing once every 24 months;
- Two periodontal cleanings per calendar year (total cleanings between preventive and basic services not to exceed four);
- Occlusal adjustments;
- Most oral surgery procedures;
- Anesthetics;
- Restorative dentistry, such as fillings (including white fillings for molars) and repairs of inlays, onlays and crowns; and
- Space maintainers up to age 14.

Major Restorative Care

Major care services include:

- Restorative care, such as inlays, onlays and crowns;
- Replacement of crowns, bridges and prosthetics once every seven years, per tooth;
- Extraction of impacted teeth;
- Root canals once per lifetime, per tooth;
- Endodontics once every 24 months per tooth;
- Periodontal grafts, two teeth per quadrant every three calendar years;
- Prosthodontics once every seven calendar years;
- Implants once every seven calendar years;
- Occlusal guards and repair once every three calendar years; and
- Bruxing appliances once every three calendar years.

Orthodontic Treatment

Orthodontic care includes braces and other related appliances used for orthodontic treatment and similar types of expenses.

The Dental Program pays 50% of the maximum contract allowance for services received from any dental provider.

Pre-certification of your orthodontic treatment plan is recommended before beginning any orthodontic procedure. Certain diagnostic services, including oral/facial photographic images, diagnostic casts and cephalometric X-rays, may be utilized in conjunction with orthodontic treatment but are payable as a diagnostic service. See “Dental Program Exclusions and Limitations,” as age limits may apply.

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Dental Pretreatment Estimates

A pretreatment estimate allows you to find out, before you incur any expenses:

- Estimated cost for treatment;
- Estimated benefit payment; and
- Possible alternative treatments that may be more cost-effective.

A pretreatment estimate does not guarantee benefits from the Plan. However, it can help you understand more about how the Plan works for your specific need so you can make an informed decision about treatment.

You may request a pre-determination any time before receiving dental treatment. Pre-determination of benefits is recommended if a proposed course of treatment is expected to involve charges over $300. This often applies to services such as crowns, bridges, inlays, periodontics and orthodontics. A pretreatment estimate will be sent to you and your dentist detailing an estimate of what services the Plan will pay and at what payment level.

To receive a pretreatment estimate, simply have your dentist submit one online at deltadentalins.com/dell or call 1-800-693-2659 and follow the simple prompts for pretreatment estimate request submission.

Dental Program Exclusions and Limitations

Benefits will not be paid for any of the following services, treatments, items or supplies:

- Services or supplies received before coverage under this Plan begins.
- Services not performed by a dentist, except for those services of a licensed dental hygienist that are supervised and billed by a dentist and that are for cleaning and scaling of teeth or fluoride treatments.
- Cosmetic surgery, treatment or supplies unless required for the treatment or correction of a congenital anomaly of a newborn dependent child.
- Replacement of a lost, missing or stolen crown, bridge or denture.
- Repair or replacement of an orthodontic appliance.
- Self-administered orthodontics.
- Services or supplies that are covered by any workers' compensation laws or occupational disease laws.
- Services or supplies that are covered by any employers' liability laws.
- Services or supplies any employer is required by law to provide in whole or in part.
- Services or supplies received through a medical department or similar facility that is maintained by the patient's employer.
- Services or supplies received for which no charge would have been made in the absence of dental coverage for that patient.
- Services or supplies for which the patient is not required to pay.
- Services or supplies that are deemed experimental in terms of generally accepted dental standards.
- Services or supplies received due to dental disease, defect or injury due to an act of war or a warlike act in time of peace that occurs while coverage under this Plan is in effect.
- Adjustment of a denture or bridgework that is made within six months after it is installed by the same dentist who installed it. However, if the adjustment must be made by a different dental office, the adjustment procedure can be submitted and considered for payment.

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- Any duplicate appliance or prosthetic device.
- Use of material or home health aides to prevent decay, such as toothpaste or fluoride gels, other than the topical application of fluoride.
- Instruction for oral care such as hygiene or diet.
- Periodontal splinting.
- Services or supplies to the extent that benefits are otherwise provided under this Plan or under any other plan that the employer (or an affiliate) contributes to or sponsors.
- Charges for missed appointments.
- Charges by the dentist for completing dental forms.
- Temporary or provisional restorations.
- Temporary or provisional appliances.
- Sterilization supplies.
- Services or supplies furnished by a family member.
- Treatment of temporomandibular joint disorders.

Dental Claims and Appeals

Depending on your dentist's policy, you may need to pay him or her directly for services and then file a claim to be reimbursed by the Plan. Or your dentist may file a claim for you and allow time for the Plan to pay first. Call Delta Dental to get a claim form and filing instructions.

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

Dell Dental Program for Expatriates

If you are enrolled in the Aetna International medical option, insured dental benefits are provided through that plan. Below is a summary of the dental plan features available to you. Full plan details are available in separate materials that you will receive directly from the Plan. Such materials, together with this document, constitute the Summary Plan Description for this coverage, and together with the Plan document, constitute (and contain the terms of) the Plan with respect to that coverage option.

Plan Feature	**Comprehensive Dental (Aetna International Plan)**
Annual deductible	Individual coverage: $50 per calendar year Family coverage: $150 per calendar year
Annual maximum benefit	$2,000 per person, combined outside U.S. and inside U.S.; does not apply to orthodontia
Preventive and diagnostic care	Covered at 100% (no deductible)
Basic restorative care	After deductible, plan pays 80%
Major restorative care	After deductible, plan pays 50%
Orthodontia treatment (for dependent children up to age 26)	Plan pays 50% after deductible; up to $2,000 per person, combined outside U.S. and inside U.S. lifetime limit. Previous treatments are considered in the lifetime maximum amount.

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Dental Claims and Appeals for Expatriates

Filing an Aetna International Program Claim

If you choose a dentist in the direct settlement network, you can usually access care without having to submit a claim.

If you choose to go outside the network for care, you'll need to pay at the time of service and then submit a claim for reimbursement.

Before You Submit Your Claim

- You'll need to submit your claim within 180 days of your treatment.
- Have all supporting documents on hand, including original receipts, certificates and X-rays.
- Put your Member ID number on each document you submit.
- Be ready to provide complete details of your visit, including the reason for it and a description of services provided.
- Know what currency and method — check, wire or electronic funds transfer (EFT) — you'd like to be reimbursed in. (Aetna doesn't charge processing fees for EFT, wire transfers or direct deposits, but your bank might, so make sure you check.)

You can submit your claim through the member portal at aetnainternational.com or contact Aetna International Member services for assistance.

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

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Vision Program

Overview

The Vision Program provides benefits for eligible vision expenses. When receiving services, you may obtain services from any vision provider you choose.

Dell Vision Program for U.S. Team Members

The Vision Program is administered by VSP. This Program features a nationwide network of over 39,000 doctors who have agreed to provide services at a discount to participants. You may use any provider you choose, whether in-network or out-of-network. However, the Program generally pays higher benefits (often much higher) when you use a VSP network provider.

How the Vision Program Works

Here is a look at how the Program works:

- The Program pays a percentage of contracted rates or fees.
- You pay the remaining portion of charges, called coinsurance, after any required copay (a copay is a flat dollar amount you are responsible for paying at the time of service). Your coinsurance amount depends on whether you receive in-network or out-of-network services:
    - **In-Network Providers:** You receive higher benefits because the Program has negotiated lower rates for services in advance. In-network providers submit claims for any services they provide.
    - **Out-of-Network Providers:** The Program pays benefits according to a fixed schedule. You may need to pay the full amount for services up front and file your own claims for reimbursement.

To find a VSP provider, call VSP at 1-800-877-7195 or visit vsp.com. There is no charge to receive provider lists or directories.

When you make an appointment with the VSP doctor you select, identify yourself as a VSP member and a Dell team member. Your doctor and VSP will handle the rest. When you receive services or buy eyewear, you pay the required copay as well as the cost of any services and eyewear that VSP does not cover. VSP will pay directly to the VSP doctor the covered amounts for the care you receive.

Vision Coverage Tiers

There are four coverage tiers available in the Vision Program. Each coverage tier determines how many people may be covered and what dependents may be covered. You must be enrolled in the Vision Program to enroll any eligible dependents in the Program. The four coverage tiers are:

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

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Vision Program Benefit Summary

Vision Benefits	Frequency of Benefit Availability	VSP Network Provider (in-network)	Non-VSP Provider (out-of-network)
Well Vision Exam	Once per plan year	VSP pays 100% after you pay a $10 copay	You pay a $10 copay; VSP reimburses up to $55, any remaining balance is your responsibility
Prescription Glasses		The copay for lenses and frames is $20 in total, whether lenses, frame or both are purchased	The copay for lenses and frames is $20 in total, whether lenses, frame or both are purchased
Lenses Lens Enhancements	Once per plan year	***Single vision, lined bifocal and lined trifocal lenses:*** VSP pays 100% after you pay a $20 copay ***Standard progressives:*** VSP pays 100%; no copay applies ***Premium progressives:*** $80-$90 ***Custom progressives:*** $120-$160 ***Average savings of*** 35%-40% on other lens enhancements	You pay your copay; VSP reimburses up to ▪ $50 for single vision ▪ $75 for lined bifocal ▪ $75 for progressive ▪ $100 for lined trifocal ▪ $125 for lenticular lenses Other lens options are not covered
Frames	Once every other plan year	You pay a $20 copay; VSP pays up to a $150 allowance for the frame of your choice; you are eligible for 20% off any amount above the allowance	You pay your copay; VSP reimburses up to $70
Contacts	Once every plan year instead of frames and lenses (includes contacts, evaluation exam and fitting)	▪ ***Medically necessary:*** VSP pays 100% after you pay a $20 copay ▪ ***Elective:*** VSP pays up to $130; no copay applies	▪ ***Medically necessary:*** You pay a $20 copay; VSP reimburses up to $210 ▪ ***Elective:*** VSP reimburses up to $105; no copay applies

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Vision Covered Expenses

VSP covers most routine eye care. Whether or not you use a VSP network doctor, here are some of the services and eyewear that are covered:

- **Eye Exam:** Complete initial vision analysis, which includes an appropriate examination of visual functions, including the prescription of corrective eyewear when indicated.
- **Lenses:** Spectacle lens coverage is designed to provide covered single vision, lined bifocal, lined trifocal or lenticular lenses and professional services related to:
    - Prescribing and ordering proper lenses;
    - Verifying the accuracy of finished lenses; and
    - Polycarbonate lenses for children and handicapped dependents.
- **Frames:** A wide selection of frames is available; if you choose a frame that costs more than the Plan's allowance, you will receive a 20% discount on any out-of-pocket costs for the frame.
- **Contacts:** Lenses needed to maintain your visual health, which are covered if bought instead of frames and lenses. Contact lenses that are medically necessary are those used after cataract surgery, to correct extreme visual problems that spectacle lenses cannot correct and for certain conditions of anisometropia and keratoconus. All other contact lenses are considered elective.

If you use a VSP doctor, you are eligible for certain added discounts, such as:

- Glasses and sunglasses:
    - Average 35%-40% savings on lens enhancements such as scratch-resistant and anti-reflective coatings; and
    - 30% savings on additional glasses and sunglasses, including lens enhancements from the same VSP provider on the same day as your eye exam. Or save 20% from any VSP doctor within 12 months of your last eye exam.
- Contacts: 15% off cost of elective contact lens exam (fitting and evaluation).
- Retinal screening: No more than a $39 copay on routine retinal screening as an enhancement to an eye exam.
- Laser Vision Correction: VSP has arranged for participants to receive PRK, LASIK and custom LASIK at a discounted fee, which could add up to hundreds of dollars in savings. Discounts vary by location, but will average 15% off of the contracted laser center's reasonable and customary price. If the participating laser center is offering a temporary price reduction, VSP members will receive 5% off of the promotional price. The maximum fee a member will pay is:
    - $1,500 per eye for PRK;
    - $1,800 per eye for LASIK; and
    - $2,300 per eye for custom LASIK (custom LASIK using wavefront technology).

Low Vision Coverage

This benefit is available for those patients having vision loss sufficient enough to prevent reading, moving around in unfamiliar surroundings and completing desired tasks. Patients with low vision have visual impairments not fully treatable by medical, surgical or conventional eyewear or contact lenses. VSP's Low Vision Plan offers members low vision evaluations and low vision aids, up to a maximum of $1,000, every two years.

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Benefits under this plan include, but are not limited to:

- Supplemental testing for low vision evaluation;
- Low vision prescription services; and
- Optical and non-optical aids.

Essential Medical Eye Care (EMEC)

Supplemental Essential Medical Eye Care is designed for the detection, treatment and management of ocular conditions and/or systemic conditions which produce ocular or visual symptoms. Under the plan, eyecare professionals provide treatment and management of urgent and follow-up services. Essential Medical Eye Care also involves management of conditions that require monitoring to prevent future vision loss and may provide additional benefits. Any medical services not paid by your medical coverage (or if the covered person doesn't have medical coverage) will be considered for payment under Essential Medical Eye Care.

If eligible for this program, additional benefits from a VSP network provider are:

- Retinal screening for members with diabetes, $0 copay;
- Additional exams and services for members with diabetes, glaucoma or age-related macular degeneration, $20 per exam;
- Treatment and diagnoses of eye conditions, including pink eye, vision loss and cataracts available for all members, $20 per exam;
- Diabetic eye examination covered in full after a $20 copay (covered up to $100 after a $20 copay if by a non-network provider); and
- Special ophthalmological services covered in full (covered up to $120 per service if by a non-network provider)

Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply.

Vision Program Exclusions

The Vision Program does not cover the following types of services:

- Orthoptics or vision training and any associated supplemental testing.
- Plano lenses (that is, when patient's refractive error is less than a +/- 0.50 diopter power) or to change eye color cosmetically.
- Corrective vision treatment of an experimental nature.
- Medical or surgical treatment of the eyes.
- Two pairs of glasses instead of bifocals (a second pair of glasses may be obtained at a 20% discount through the value-added discounts associated with this Program).
- Replacement of lenses and frames furnished under this Program, except at the normal intervals when services are available.

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Essential Medical Eye Care program exclusions:

- Frames, lenses, contact lenses or any other ophthalmic materials;
- Orthoptics or vision training and any associated supplemental testing;
- Surgery of any type, and any pre- or post-operative services;
- Treatment for any pathological conditions;
- An eye exam required as a condition of employment;
- Insulin or any medications or supplies of any type; and
- Local, state and/or federal taxes, unless VSP is required to pay by law.

Vision Claims

The Vision Program is easy to use. If you go to a VSP network doctor, you will not have to file a claim for benefits. If your benefit claim is denied, you may appeal that decision.

If you obtained services from a VSP provider, VSP will pay their share of the cost to your vision care professional directly. If you do not go to a VSP provider, you must pay your provider in full and submit a claim within one year (365 days) of your date of service to VSP for partial reimbursement. Call VSP for filing instructions.

If your claim is denied, see the "Claims and Appeals Procedures" section for details on the appeals process.

Dell Vision Program for Expatriates

If you are enrolled in the Aetna International medical option, insured vision benefits are provided through that plan. Below is a summary of the vision plan features available to you. Full plan details are available in separate materials that you will receive directly from the Plan. Such materials, together with this document, constitute the Summary Plan Description for this coverage, and together with the Plan document, constitute (and contain the terms of) the Plan with respect to that coverage option.

Plan Feature	**Aetna International Vision**
Annual deductible	None
WellVision Exam®	Plan pays 100% Limited to one exam every 12 consecutive months
Vision Care Supplies	$250 maximum for vision care supplies

Vision Claims and Appeals for Expatriates

Filing an Aetna International Program Claim

If you choose a vision provider in the direct settlement network, you can usually access care without having to submit a claim.

If you choose to go outside the network for care, you'll need to pay at the time of service and then submit a claim for reimbursement.

Before You Submit Your Claim

- You'll need to submit your claim within 180 days of your treatment.
- Have all supporting documents on hand, including original receipts.

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- Put your Member ID number on each document you submit.
- Be ready to provide complete details of your visit, including the reason for it and a description of services provided.
- Know what currency and method — check, wire or electronic funds transfer (EFT) — you'd like to be reimbursed in. (Aetna doesn't charge processing fees for EFT, wire transfers or direct deposits, but your bank might, so make sure you check.)

You can submit your claim through the member portal at aetnainternational.com or contact Aetna International Member services for assistance.

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

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Health Care Flexible Spending Account Program

Overview

The Health Care Flexible Spending Account Program, administered by Alight Smart-Choice Accounts, allows you to set aside before-tax money to pay for eligible health care expenses that are not covered or are only partially covered under your medical, dental or vision coverage. Note that under the Health Care Flexible Spending Account, your domestic partner and his or her children do not qualify as dependents unless they otherwise qualify as tax dependents as defined by the IRS.

The amount you contribute is deducted from each paycheck **before** taxes are withheld. This means that your contributions are deducted from your paycheck before federal and most state and local taxes are withheld. This lowers your taxable income.

Deciding How Much to Contribute

If you enroll in the Health Care Flexible Spending Account, you may contribute any amount between $120 and $2,750 each plan year. When deciding how much to contribute, you should first estimate your out-of-pocket health care expenses for the plan year. The Alight Smart-Choice Accounts website (My Well at Dell and select the Smart-Choice Accounts tab or portal icon) has a tool that can help you estimate your health care expenses for the plan year. You may also want to review the eligible expenses section below.

It is important to plan carefully because:

- If you contribute more to the Account than you claim in expenses during the year, federal law requires you to forfeit the leftover money in your Account (except as noted below that you can carry over to the next year).
- You cannot start or stop contributing or change your contribution amount during the year unless you have certain qualified status changes.
- You cannot use extra funds in your Health Care Flexible Spending Account to fund a shortfall in your Dependent Care (Day Care) Flexible Spending Account or vice versa.
- You cannot use the funds for expenses incurred after the Plan ends, or after you leave Dell (except as noted below); any remaining funds will be forfeited.
- When you terminate from Dell, you are eligible to continue Health Care Flexible Spending Account participation through COBRA continuation coverage. If you have a remaining balance in your Account at the time of termination and you do not elect Health Care Flexible Spending Account COBRA continuation, you may not submit claims for expenses incurred after your termination date.

HSA Coordination With Your Health Care Flexible Spending Account

If you are a U.S. team member and you enroll in the Health Fund and HSA, you'll only be able to use your Health Care Flexible Spending Account to pay for out-of-pocket eligible dental and vision expenses. Once your out-of-pocket medical and prescription expenses reach the IRS limit of $1,400 (or $2,800 if you have family coverage), you can begin using your Health Care Flexible Spending Account for medical expenses too, including prescriptions, coinsurance and doctor fees, since the Alight Smart-Choice Account automatically updates your Health Care Flexible Care Spending Account once the IRS limit is met.

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Health Care Flexible Spending Account Eligible Expenses

You may use the Health Care Flexible Spending Account to pay for any health care expenses considered tax deductible by the IRS, except for health insurance premiums. Please note that you must be a participant actively making contributions to the Plan at the time that your expense is incurred for it to be an eligible expense.

Expenses must meet the requirements set forth in Internal Revenue Code 213(d). A complete listing of eligible expenses can be found in IRS Publication 502. Following is a sample listing of eligible expenses; this list does not include every possibility:

- Acupuncture;
- Allergy testing and treatment;
- Medical, prescription drug, dental and vision deductibles, copays and/or coinsurance;
- Non-covered orthodontic expenses;
- Organ donor expenses;
- Orthopedic shoes;
- Over-the-counter drugs and medicines used to treat illness or injury;
- Over-the-counter insulin, medical devices (crutches, blood sugar monitors, etc.) and items such as bandages, contact lens solution, etc. used to treat illness or injury;
- Prescribed birth control pills;
- Services of a Christian Science practitioner;
- Special equipment installed in your home or car for medical reasons;
- Special school costs for physically or mentally handicapped child(ren), including tutoring fees;
- Special telephone equipment for the deaf;
- Vitamins prescribed by a physician;
- Tutoring for certain learning disabilities; and
- Personal protective equipment such as masks, hand sanitizer and disinfecting wipes that are purchased for the primary purpose of preventing the spread of COVID-19.

Expenses Not Eligible for Health Care Flexible Spending Account Reimbursement

This list is intended to provide examples of items that are not covered and is not intended to be all-inclusive. A complete list of expenses that cannot be reimbursed through your Health Care Flexible Spending Account can be found in IRS Publication 502. If you have questions about the eligibility of an expense, you should contact Alight Smart-Choice Accounts at 1-888-335-5663.

Examples of expenses that cannot be reimbursed through your Health Care Flexible Spending Account include, but are not limited to, expenses for:

- Bottled water;
- Contributions and/or premiums for medical or dental coverage;
- Cosmetic surgery (nonreconstructive);
- Cosmetics, sundries and toiletries;
- Domestic help (apart from nursing services), even if recommended by a physician;
- Expenses for weight reduction or smoking cessation programs for general health purposes and unrelated to specific ailments;

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- Hair treatments and medication to prevent hair loss, even if prescribed by a physician (for example, Rogaine);
- Health care treatments, medicine or services that are not legal;
- Health programs offered by resorts, health clubs or gyms;
- Marriage/family counseling fees;
- Maternity clothes;
- Scientology fees; and
- Patent medicines or tonics, even if prescribed by a physician.

In addition, you cannot be reimbursed for expenses for services that are:

- Not received within the plan year (except for carryover amounts, as discussed below); or
- Incurred after you stop participating in the Plan. (You may still have a balance, but you may only submit for reimbursement for expenses for services incurred while you were participating.)

Online Access

You can access your Account online at My Well at Dell and select the Smart-Choice Accounts tab or portal icon. Once online:

- You have 24/7 access to your Account and funds.
- Provide your email address and/or mobile phone number and you can receive important email updates, text messages and claim status notifications.
- Your transaction activity will enable you to access, review and print your real-time Account information at any time.
- Review your transaction activity and download it real-time.
- Check the complete list of eligible expenses.
- Order additional Alight Smart-Choice debit cards for your family.

Download the Smart-Choice Accounts Mobile App
Access and manage your Smart-Choice FSA anytime, from anywhere, and do things like:

- Use the eSignature feature to easily substantiate your expenses.
- Get instant texts confirming account activity.
- Scan health-related items directly (when you're in the store, for example) to see if they're eligible.

Health Care Flexible Spending Account Claims

You have several ways to access your Health Care Flexible Spending Account, including:

- Using your Alight Smart-Choice debit card. If you need additional cards (up to a maximum of five cards), contact Alight Smart-Choice Accounts at 1-888-335-5663.
- Utilizing the Auto reimbursement feature.
- Filing a claim online by submitting claims through the consumer website at My Well at Dell and select the Smart-Choice Accounts tab or portal icon.
- Utilizing the mobile app, which is called the "Smart-Choice Mobile App."
- Filing a paper claim: by mail at Alight Smart-Choice Accounts, P.O. Box 660114, Dallas, TX 75266-0114.
- Filing a claim by email at My Well at Dell and select the Smart-Choice Accounts tab or portal icon or by fax at 1-855-673-6719. (**Note:** This is for claim submission only. If you require customer service assistance, please call 1-888-335-5663.)

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Up to 20% of the Health Care Flexible Spending Account IRS maximum election amount of your unused Health Care Flexible Spending Account balance can be carried over from one plan year to the next. The IRS allows plan participants to carry over up to 20% of the year's maximum contribution. Amounts in excess of 20% of the Health Care Flexible Spending Account IRS maximum for which you do not incur an eligible health care expense by December 31 of the plan year will be forfeited.

All claims must be submitted by the April 30 following the end of the plan year.

Auto Reimbursement Feature

If you want your Health Care Flexible Spending Account claims reimbursed automatically, you will need to contact Alight Smart-Choice Accounts to activate this feature at 1-888-335-5663 or you can do so on the Alight Smart-Choice Accounts website (My Well at Dell and select the Smart-Choice Accounts tab or portal icon). This feature allows for your carriers (Aetna, BCBSIL, CVS Caremark, Delta Dental and VSP) to send claims information directly to Alight Smart-Choice Accounts in order for you to be automatically reimbursed from your Health Care Flexible Spending Account. You pay for the eligible expense out of pocket and then Alight Smart-Choice Accounts reimburses you. There are no receipts to submit because the providers submit the documentation on your behalf.

Note: While this feature is enabled, your Payment Card for health care claims will be unavailable (your Payment Card can be used for prescription expenses). The Alight Smart-Choice debit card is suggested for your primary reimbursement method.

Alight Smart-Choice Debit Card

When you enroll in the Health Care Flexible Spending Account Program, you will receive an Alight Smart-Choice debit card that you can use to pay for eligible health care expenses. A new card is issued every three years. After you receive the card you have the opportunity to choose to:

- Use the card.
- Pick and pay a claim from the list of claims provided by the carrier.
- Opt for auto-pay to send a check as soon as the charge shows up in the account.

You can use your card for eligible goods and services at health care providers and select pharmacies. If the provider or pharmacy does not have an IRS-approved inventory system, you may be required to submit a receipt or Explanation of Benefits (EOB) to verify the transaction was for an eligible health care good or service.

You may purchase an over-the-counter (OTC) item using your Alight Smart-Choice debit card.

If you lose your card, call Alight Smart-Choice Accounts immediately to report the missing card and order a new one. You will be responsible for any charges on the card until you report the lost card.

The Alight Smart-Choice debit card can only be used to pay eligible expenses through December 31 of the current plan year. If paying for an expense from the prior plan year, before the April 30 deadline, you should use the "**Submit Claim**" feature under the "**Take Action**" section on the Alight Smart-Choice Accounts site.

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Alight Smart-Choice Debit Card Transaction Verification

If Alight Smart-Choice Accounts is unable to determine that your card was used to pay for eligible health care products and services, you are required to:

- Submit a detailed receipt that describes exactly what you paid for;
- Submit a substitute receipt; or
- Send a payment to repay your Account for the amount.

Alight Smart-Choice Accounts will notify you of any card transactions that require attention by email and when you log in to your Account.

While your Alight Smart-Choice debit card and Account offer a great deal of convenience, both are regulated by IRS rules that all participants are required to follow. In most instances, you will be able to use your card with little or no inconvenience. However, there are situations where the card will be declined or you will be required to submit receipts and/or other documentation to verify that the item or service purchased was eligible.

File a Claim Online

You can file a claim online to request reimbursement for your eligible expenses. Log in to your Account at My Well at Dell and select the Smart-Choice Accounts tab or portal icon, and the system will walk you through what is required.

To speed processing, remember to save receipts that show exactly what service was incurred, the patient's name, the provider's name, the amount and the date of service. Most claims are processed within one to two days after they are received and payments are sent shortly thereafter.

File a Paper Claim

If you prefer to submit a claim by fax or mail, go to My Well at Dell and select the Smart-Choice Accounts tab or portal icon to download a general claim form and follow the instructions on the form for submissions.

Claims Processing

Make sure your receipts meet the requirements for verification. For the receipt (or any documentation) to be valid, it must include the five specific pieces of information required by the IRS:

- The patient name;
- Provider name;
- Date of service;
- Type of service; and
- The amount you were charged or your cost (for example, your deductible or copay amount or the portion not covered by your insurance).

For approved health care claims, the Plan will pay up to the full amount of your health care annual election less any previously paid health care claims — even if you have not yet contributed that amount to your Health Care Flexible Spending Account.

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Additionally, the annual election used for calculating the amount available for reimbursement of eligible expenses is based on the amount available on the date the expense is incurred.

Here is an example:

John		**Mary**	
January 1	Enrolls with an annual election of $1,000	**January 1**	Enrolls with an annual election of $1,500
February 1	Incurs an eligible expense	**March 1**	Qualifying event occurs; changes annual election to $2,500
February 15	Submits a claim	**April 15**	Submits a claim for expense incurred on February 1
Claim Processed	Amount available to reimburse eligible expense is $1,000 even though he has not yet contributed $1,000 to his Account	**Claim Processed**	Amount available to reimburse eligible expense is $1,500 since that was the elected amount as of the date the expense was incurred

For more information on changing your election, see the “Changing Your Election” section.

Claims Ordering Rules

Reimbursements are based on the dates of service, and services must be provided within the plan year, except that up to 20% of the Health Care Flexible Spending Account IRS maximum allowance can be carried over and used to reimburse expenses incurred in the following plan year. Claims for expenses that are incurred in the current plan year are reimbursed first from unused amounts (up to 20% of the Health Care Flexible Spending Account IRS maximum allowance) carried over from the prior plan year and then from the current year’s available balance, if applicable. Any unused amounts from the prior plan year that are used to reimburse a current year expense reduce the amounts available to pay prior plan year expenses during the run-out period.

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Dependent Care (Day Care) Flexible Spending Account Program

Overview

The Dependent Care (Day Care) Flexible Spending Account (FSA) Program allows you to set aside before-tax money to pay for certain dependent day care expenses if you (or you and your spouse) need these services so you can work, look for work or attend school. **The benefits described in this section are not subject to ERISA, the federal law governing employee benefits.**

The amount you contribute is deducted from each paycheck **before** taxes are withheld. This means that your contributions are deducted from your paycheck before federal and most state and local taxes are withheld. This lowers your taxable income.

To use the Dependent Care (Day Care) FSA, you must meet one of the following requirements:

- You are a single parent either working or seeking paid employment;
- You are married and must pay dependent care (day care) expenses so you and your spouse can work or look for work;
- You are married, you work and your spouse is a full-time student for at least five months in a plan year;
- You are married, you work and your spouse is disabled and unable to care for himself or herself and has the same principal residence as you do for more than half the year; or
- You are divorced or legally separated, and you have custody of your dependent child for more than half of the year (even if the other parent claims the dependent for tax purposes).

Special Note for Leave of Absence: You may not participate in the Dependent Care (Day Care) FSA Program while on leave of absence. Your participation and contributions will automatically be stopped effective the first day of your leave of absence. To begin participating again, when you return to active status, you must contact the Dell Benefits Center at 1-888-335-5663 within 31 days of your return to work. You may continue to submit claims for reimbursement up to the plan's claim submission deadline, but only for services received during the dates of your participation.

Deciding How Much to Contribute

If you enroll in the Dependent Care (Day Care) FSA, you may contribute any amount between $120 and the lesser of:

- Your earned income for the year;
- Your spouse's earned income for the year; or
- $5,000 ($2,500 if you are married and file a separate tax return).

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To help you determine the maximum amount you can contribute, refer to the following chart. Keep in mind, you are considered married if you are married at the end of the plan year.

If you are. . .	**You can contribute up to . . .**
Single	$5,000 per calendar year ($192.31 per biweekly pay period)
Married, filing jointly and your spouse earns at least $5,000 per year	$5,000 per calendar year ($192.31 per biweekly pay period)
Married, filing jointly and your spouse earns less than $5,000 per year	Your spouse's total earnings for the year
Married, filing jointly and your spouse is a student or disabled	$250 per month (up to $3,000 a year) for one dependent or $500 a month (up to $5,000 a year) for two or more dependents
Married, filing separately	$2,500 per calendar year ($96.15 per biweekly pay period)

Contributions for highly compensated team members—as defined by the IRS—are subject to special contribution limits. Highly compensated team members are generally those whose annual earnings exceeded the IRS threshold in the prior year. For 2022, the IRS threshold is $135,000 earned in 2021. If you are affected, you will be notified. Your contribution may be refunded or reduced during the plan year if needed to prevent the Plan from becoming discriminatory or violating the Internal Revenue Code.

When deciding how much to contribute to the Dependent Care (Day Care) FSA Program, you should first estimate your out-of-pocket dependent care expenses for the plan year. The Alight Smart-Choice Accounts website (My Well at Dell and select the Smart-Choice Accounts tab or portal icon) includes information on qualified expenses. You may also want to review the "Qualified Dependent Care Expenses" section.

It is important to plan carefully because:

- If you contribute more to the Account than you claim in expenses during the plan year, federal law requires you to forfeit the leftover money in your Account.
- You cannot start or stop contributing or change your contribution amounts during the plan year unless you have a qualified status change.
- You cannot use extra funds in your Dependent Care (Day Care) FSA to fund a shortfall in your Health Care Flexible Spending Account or vice versa.

Changing Your Dependent Care (Day Care) FSA Contribution

Once you elect the amount you want to contribute, you may not change your election until the next annual enrollment unless you have a qualified status change. For more information on changing elections and qualified status changes, see the "Qualified Status Changes" section.

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Dependent Care (Day Care) FSA vs. Federal Income Tax Credit

For some people, the federal income tax credit may save more money in taxes than the Dependent Care (Day Care) FSA Program. When you use the federal income tax credit, you take a credit on your federal income tax return at year-end.

The federal income tax credit is 35% of employment-related child care expenses, reduced by 1% for each $2,000 of adjusted gross income in excess of $15,000.

In general, families with a combined taxable income of more than $24,000 a year will benefit more from using the Dependent Care (Day Care) FSA Program for their dependent day care expenses.

You should consult your tax advisor for help determining whether to contribute to the Dependent Care (Day Care) FSA or take the income tax credit.

Taxation of Dependent Care Expenses

The IRS limits the amount of dependent care benefits you may receive on a tax-free basis. Dependent care benefits you receive in excess of these limits are taxable to you as income. Amounts you contribute to your Dependent Care (Day Care) FSA count against the limit. For example, if you elect to contribute $4,000 to your Dependent Care (Day Care) FSA, you may only receive up to $1,000 in emergency backup care benefits on a tax-free basis, if your limit is $5,000. Dell will withhold income taxes from your compensation for any dependent care benefits you receive in excess of IRS limits. More information is available in Section 129 of the Internal Revenue Code.

Eligible Dependents for the Dependent Care (Day Care) FSA

You can only receive reimbursement for qualified dependent care expenses for your eligible dependents. An eligible dependent means an individual you can legally claim as a dependent on your income tax return, as long as:

- The child is your dependent child under the age 13;
- The dependent is physically or mentally incapable of caring for himself or herself and lives with you more than half of the year; for example, a spouse, dependent parent or grandparent; or
- If you are a divorced parent, the child is your eligible dependent that you are able to claim an exemption on your federal income tax return for the child or you are the parent who has custody for the longest period during the year (even if you cannot claim a dependent exemption).

Qualified Dependent Care Expenses

Eligible expenses for the Dependent Care (Day Care) FSA may include care provided:

- In or out of your home;
- In an elder care center or a child care center that complies with all state and local regulations; or
- By a housekeeper whose services include, in part, care of an eligible dependent.

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The types of care that can be reimbursed include:

- Babysitter expenses for care during your working hours inside or outside the home;
- Care provided by a housekeeper whose services include care of an eligible dependent;
- Licensed elder care center, child care center and nursery school charges, if the facility complies with local, state and federal regulations; and
- Social Security and other taxes you pay for an eligible dependent care provider.

For more information on eligible expenses, go to My Well at Dell.

Expenses must be paid to a dependent care service provider. A dependent care service provider may be a(n):

- **Dependent Care Center**, which is any facility that provides care for more than six individuals (other than individuals who reside at the center), receives a fee, payment or grant in return for the services and complies with all applicable state and local licensing laws and regulations.
- **Individual** (including a relative) who provides dependent care services in your home, excluding your (or your spouse's) dependents and any child who is under the age of 19.

Online Access

You can access your Account online at My Well at Dell and select the Smart-Choice Accounts tab or portal icon. Once online:

- You have 24/7 access to your Account and funds.
- Provide your email address and you can receive important email updates and claim status notifications.
- Your online *Statement of Activity* will enable you to access, review and print your real-time Account information at any time of the day or month.
- Check the complete list of eligible expenses.

Download the Smart-Choice Accounts Mobile App
Access and manage your Smart-Choice FSA anytime, from anywhere, and do things like:

- Use the eSignature feature to easily substantiate your expenses.
- Get instant texts confirming account activity.

Expenses Not Eligible for Dependent Care (Day Care) FSA Reimbursement

The following are examples of some of the expenses that are not reimbursable; if you have questions about a specific expense, you should contact Alight Smart-Choice Accounts directly at 1-888-335-5663:

- Expenses that are educational in nature. Generally, full amounts paid to nursery schools are qualified expenses even if educational services are provided. Educational expenses for a child in kindergarten and up are not qualified expenses. Kindergarten is reimbursable only if eligible daycare expenses at the school can be separated from classroom education.
- Expenses for overnight camps. Summer day camps are qualified expenses.
- Expenses for evening baby-sitting, unless the expense is incurred because both parents work in the evening.
- Transportation, entertainment and food, unless these costs cannot be separated from the cost of the care provided.

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- Household services unless the household services are provided in the participant's home and are "ordinary and usual" and "necessary to the maintenance of the household" (for example cook, maid, housekeeper); **and** the household services provided also include the services to care for the dependent's well-being and safety.

Dependent Care (Day Care) FSA Claims

If you participate in the Dependent Care (Day Care) FSA, you can only be reimbursed up to the amount in your Account at the time of your claim. If your reimbursement request exceeds your Account balance at the time of your claim, you will receive only the amount in your Account. Then, as additional contributions are made, additional reimbursements up to the amount of the expense will be paid to you automatically.

The Plan includes a grace period of 2½ months following the end of each plan year. If you incur eligible Dependent Care (Day Care) FSA expenses during this grace period (by March 15), expenses will be reimbursed from any unused amounts remaining in your Account for the prior plan year. The grace period is only applicable if you are enrolled in the Dependent Care (Day Care) FSA on December 31 of the prior plan year.

All claims must be submitted by the April 30 following the end of the plan year.

File a Claim Online

You can file a claim online to request reimbursement for your eligible expenses. Log in to your Account at My Well at Dell and select the Smart-Choice Accounts tab or portal icon and the system will walk you through what is required.

File a Paper Claim

If you prefer to submit a claim by fax or mail, go to My Well at Dell and select the Smart-Choice Accounts tab or portal icon to download a general claim form and follow the instructions on the form for submissions.

Dependent care expenses may not be filed as a lump-sum annual claim at the beginning of the year following the current plan year. Claims must be filed after the services are provided and the expenses are incurred. For complete details on claims submissions, go to My Well at Dell and select the Smart-Choice Accounts tab or portal icon and follow the instructions provided on the website.

All claims must be submitted by the April 30 following the end of the plan year. Any money left in your Account after that day will be forfeited.

For additional information on claims and appeals, see the "Claims and Appeals Procedures" section.

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Voluntary Benefits (U.S. Team Members)

Overview

Dell offers voluntary benefit plans to help provide financial protection for you and your family when the unexpected happens.

If you experience an illness like cancer or a heart attack, Critical Illness Insurance kicks in to help you pay expenses for medical services or even taking care of your mortgage payment or rent. Accidental Injury Insurance pays a benefit to help offset expenses if you or a covered dependent suffers injuries that require a range of specified medical services.

Dell also offers group legal services through MetLife Legal Plans. Legal services can help you address a wide range of legal and financial issues — from traffic tickets and debt matters to estate planning.

Identity theft protection services are also offered through Allstate Identity Protection with a comprehensive identity and financial protection plan to monitor and help you protect yourself against the impact of identity theft.

Key Features That Apply to Both Critical Illness Insurance and Accidental Injury Insurance

- These voluntary benefit plans are considered “guaranteed issue,” which means there are no medical questions to answer at your initial enrollment.
- Coverage is also available for your dependents.
- Benefits are paid regardless of any other medical or disability coverage.
- There are no pre-existing limitations.
- Evidence of Insurability is not required.

Critical Illness Insurance

Critical Illness Insurance pays a cash benefit that can be used for non-medical expenses that health insurance might not cover. You can elect Critical Illness Insurance coverage in the amount of $15,000 or $30,000. If you choose spouse coverage, your spouse would receive 100% of your benefit amount, and if you choose dependent child coverage, your child would receive 50% of your benefit amount. The lump-sum cash benefit is based on the percentage payable for the condition as shown in the chart below. For a complete list of conditions covered, see the Cigna Certificate of Coverage.

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Cancer Conditions	% of Initial Benefit Amount	Recurrence % of Initial Benefit Amount
Invasive Cancer	100%	100%
Carcinoma In Situ	25%	25%
	Benefit Amount	
	$250	Not Available
Vascular Conditions	**% of Initial Benefit Amount**	**Recurrence % of Initial Benefit Amount**
Heart Attack	100%	100%
Stroke	100%	100%
Coronary Artery Disease	100%	100%
Nervous System Conditions	**% of Initial Benefit Amount**	**Recurrence % of Initial Benefit Amount**
Advanced Alzheimer's Disease	25%	Not Available
Amyotrophic Lateral Sclerosis (ALS)	25%	Not Available
Parkinson's Disease	25%	Not Available
Multiple Sclerosis	25%	Not Available
Other Specified Conditions	**% of Initial Benefit Amount**	**Recurrence % of Initial Benefit Amount**
Benign Brain Tumor	100%	100%
Blindness	100%	Not Available
Coma	25%	25%
End-Stage Renal (Kidney) Disease	100%	100%
Major Organ Failure	100%	100%
Paralysis	100%	100%

Healthy Living and Health Screening Test Benefits

Under Critical Illness Insurance coverage you can receive benefits for health screening tests.

Healthy Living Wellness Benefit

If you or your covered dependents undergo or receive health screening testing as listed below, a benefit amount is payable.

If you choose employee coverage, you receive 100% of your benefit amount of $500, if you choose spouse coverage, your spouse would receive 50% of your benefit amount, and if you choose dependent child coverage, your child would receive 25% of your benefit amount.

Health Screening Test Benefit

This benefit provides limited health screening test benefits. Benefits are paid for each one-hour period of treatment, examination, testing, procedure or service. This benefit has a maximum of one health screening test per year.

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If you choose employee coverage, you receive 100% of your benefit amount of $50 per day, once per year. If you choose spouse or dependent child coverage, benefits are also payable at 100% of your benefit amount.

Health Screening Tests for Healthy Living Wellness and Health Screening Test Benefits

Listed below are the screening tests included in the Healthy Living Wellness Benefit and the Health Screening Test Benefit:

- Mammography
- Pap Smear for women over age 18
- Flexible Sigmoidoscopy
- Hemoccult Stool Specimen
- Colonoscopy
- Prostate Specific Antigen (for prostate cancer)
- Stress test on a bicycle or treadmill
- Fasting blood glucose test
- Blood test for triglycerides
- Serum Cholesterol test to determine levels of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Serum Protein Electrophoresis (blood test for myeloma)
- Thermography

Exclusions

Benefits are not payable from Critical Illness Insurance if your illness is caused by, contributed to by, or results from any of the following circumstances:

- Intentionally self-inflicted injury, suicide or any attempt while sane or insane.
- Commission or attempt to commit a felony or an assault.
- Declared or undeclared war or act of war.
- A covered loss that results from active duty service in the military, naval or air force of any country or international organization. Upon receipt of proof of service, Cigna will refund any premium paid for this time. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
- Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage.
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant. “Under the influence of alcohol” for purposes of this exclusion means intoxicated, as defined by the law of the state in which the covered loss occurred.

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- A diagnosis not in accordance with generally accepted medical principles prevailing in the United States at the time of the diagnosis.

This list doesn't include all of the exclusions. For more details on Critical Illness Insurance exclusions, see the Cigna Certificate of Coverage.

Accidental Injury Insurance

Most major medical insurance plans only pay a portion of the bills when you have an accident. Accident Insurance is supplemental in that it pays in addition to other coverage you may already have in place. Accident Insurance is not subject to Evidence of Insurability (EOI).

Accident Insurance pays you cash benefits that correspond with hospital and intensive care confinement. The cash benefits can be used to help pay for deductibles, treatment, house payments and more.

There are two plan options to choose from listed in the charts below. If you choose employee, spouse and/or child coverage, you, your spouse and/or child would receive 100% of your benefit amount.

Plan 1

Benefit Type	**Benefit Amount**	
Initial Care and Emergency Care Benefits		
Emergency Care Treatment	$150	
Physician Office Visit	$100	
Diagnostic Exam	$50	
Ground Ambulance	$300	
Water Ambulance	$300	
Air Ambulance	$1,200	
Hospitalization Benefits		
Hospital Admission (no benefit waiting period)	$1,000	
Hospital Stay (no benefit waiting period)	$200 per day (up to 365 days)	
Intensive Care Unit Stay (no benefit waiting period)	$400 per day (up to 365 days)	
Fractures Benefit (must be diagnosed and treated by a physician within 90 days of a covered accident)		
	Non-Surgical/Closed	**Surgical/Open**
Skull Pays for non-depressed or depressed skull fractures but not bones of face	$2,000	$4,000
Hip or Thigh	$2,000	$4,000
Vertebrae or Pelvis Pays for vertebrae, body of vertebrae or pelvis fracture. Will not pay for coccyx, leg or vertebral processes fractures	$2,000	$4,000

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Benefit Type	Benefit Amount	
Upper Arm Pays for arm fractures located between elbow and shoulder. Will not pay for shoulder, lower arm or elbow fractures	$500	$1,000
Shoulder or Collarbone Pays for shoulder or collarbone fractures only. Will not pay for upper arm fractures	$500	$1,000
Leg Will not pay for thigh, knee or ankle fractures	$1,000	$2,000
Ankle Will not pay for leg, foot or heel fractures	$400	$800
Kneecap Will not pay for leg fractures	$400	$800
Lower Arm Pays for arm fractures located to the elbow and below the elbow. Will not pay for upper arm or bones of wrist fractures	$400	$800
Foot Will not pay for toe, ankle or heel fractures	$400	$800
Hand or Wrist Will not pay for lower arm or finger fractures	$400	$800
Upper Jaw Will not pay for lower jaw, teeth or bones of face fractures	$300	$600
Lower Jaw Will not pay for upper jaw, teeth or bones of face fractures	$300	$600
Bones of Face or Nose Will not pay for upper jaw, lower jaw or teeth fractures	$300	$600
Vertebral Process	$300	$600
Rib More than 1 rib fracture pays 2 times the benefit amount	$100	$200
Coccyx Will not pay for vertebrae or pelvis fractures	$100	$200
Finger More than 1 finger pays 2 times the benefit amount. Cigna will not pay for fractures to hand or wrist	$50	$100

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Benefit Type	Benefit Amount	
Toe More than 1 toe fracture pays 2 times the benefit amount shown on schedule. Cigna will not pay for foot, heel or ankle fractures	$50	$100
Sternum	$50	$100
Heel Cigna will not pay for foot, toe or ankle fractures	$50	$100
Chip Fracture Cigna will not pay in addition to closed fracture benefit	25% of closed fracture benefit	Not applicable
Multiple Fractures Cigna will not pay multiple fracture benefits in addition to single fracture benefits	200% of the single fracture benefit for multiple fractures to the same bone	Not applicable
Dislocations **Must be diagnosed and treated by a doctor within 90 days of a covered accident**		
	Non-Surgical/Closed	**Surgical/Open**
Hip Joint	$2,000	$4,000
Knee Joint	$2,000	$4,000
Bones of Foot	$2,000	$4,000
Ankle Cigna will not pay for bones of foot or toes	$500	$1,000
Wrist	$400	$800
Elbow	$300	$600
Shoulder	$500	$1,000
Hand	$200	$400
Collarbone	$200	$400
Lower Jaw	$200	$400
Finger or Toe More than 1 finger or toe pays 2 times the benefit	$50	$100
Follow-Up Care		
Follow-Up Physician Office Visit Benefit is limited to 10 treatments per accident	$50	
Follow-Up Physical Therapy Visit Benefit is limited to 10 treatments per accident	$25	

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Plan 2

Benefit Type	Benefit Amount	
Initial Care and Emergency Care Benefits		
Emergency Care Treatment	$250	
Physician Office Visit	$200	
Diagnostic Exam	$100	
Ground Ambulance	$500	
Water Ambulance	$500	
Air Ambulance	$2,000	
Hospitalization Benefits		
Hospital Admission (no benefit waiting period)	$2,000	
Hospital Stay (no benefit waiting period)	$400 per day (up to 365 days)	
Intensive Care Unit Stay (no benefit waiting period)	$800 per day (up to 365 days)	
Fractures Benefit (must be diagnosed and treated by a physician within 90 days of a covered accident)		
	Non-Surgical/Closed	**Surgical/Open**
Skull Pays for non-depressed or depressed skull fractures but not bones of face	$4,000	$8,000
Hip or Thigh	$4,000	$8,000
Vertebrae or Pelvis Pays for vertebrae, body of vertebrae or pelvis fracture. Will not pay for coccyx, leg or vertebral processes fractures	$4,000	$8,000
Upper Arm Pays for arm fractures located between elbow and shoulder. Will not pay for shoulder, lower arm or elbow fractures	$1,000	$2,000
Shoulder or Collarbone Pays for shoulder or collarbone fractures only. Will not pay for upper arm fractures	$1,000	$2,000
Leg Will not pay for thigh, knee or ankle fractures	$2,000	$4,000
Ankle Will not pay for leg, foot or heel fractures	$800	$1,600
Kneecap Will not pay for leg fractures	$800	$1,600

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Benefit Type	Benefit Amount	
Lower Arm Pays for arm fractures located to the elbow and below the elbow. Will not pay for upper arm or bones of wrist fractures	$800	$1,600
Foot Will not pay for toe, ankle or heel fractures	$800	$1,600
Hand or Wrist Will not pay for lower arm or finger fractures	$800	$1,600
Upper Jaw Will not pay for lower jaw, teeth or bones of face fractures	$600	$1,200
Lower Jaw Will not pay for upper jaw, teeth or bones of face fractures	$600	$1,200
Bones of Face or Nose Will not pay for upper jaw, lower jaw or teeth fractures	$600	$1,200
Vertebral Process	$600	$1,200
Rib More than 1 rib fracture pays 2 times the benefit amount	$200	$400
Coccyx Will not pay for vertebrae or pelvis fractures	$200	$400
Finger More than 1 finger pays 2 times the benefit amount. Cigna will not pay for fractures to hand or wrist	$100	$200
Toe More than 1 toe fracture pays 2 times the benefit amount shown on schedule. Cigna will not pay for foot, heel or ankle fractures	$100	$200
Sternum	$100	$200
Heel Cigna will not pay for foot, toe or ankle fractures	$100	$200
Chip Fracture Cigna will not pay in addition to closed fracture benefit	25% of closed fracture benefit	Not applicable

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Benefit Type	Benefit Amount	
Multiple Fractures Cigna will not pay multiple fracture benefits in addition to single fracture benefits	200% of the single fracture benefit for multiple fractures to the same bone	Not applicable
Dislocations Must be diagnosed and treated by a doctor within 90 days of a covered accident		
	Non-Surgical/Closed	**Surgical/Open**
Hip Joint	$3,000	$6,000
Knee Joint	$3,000	$6,000
Bones of Foot	$3,000	$6,000
Ankle Cigna will not pay for bones of foot or toes	$1,000	$2,000
Wrist	$800	$1,600
Elbow	$600	$1,200
Shoulder	$1,000	$2,000
Hand	$400	$800
Collarbone	$400	$800
Lower Jaw	$400	$800
Finger or Toe More than 1 finger or toe pays 2 times the benefit	$100	$200
Follow-Up Care		
Follow-Up Physician Office Visit Benefit is limited to 10 treatments per accident	$75	
Follow-Up Physical Therapy Visit Benefit is limited to 10 treatments per accident	$50	

Enhanced Accident Benefits

If you choose employee, spouse and/or child coverage, you, your spouse and/or child would receive 100% of your benefit amount.

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Plan 1

Benefit Type	Benefit Amount
Small Burns	$100
Large Burns (3rd degree pays 10x multiple)	$750
Skin-Graft Benefit	50% of the applicable benefit amount for small burns or large burns
Small Lacerations	$50
Large Lacerations	$400
General Anesthesia Benefit	$100
Medicine Benefit	$10
Medical Supply Benefit	$10
Abdominal or Thoracic Surgery	$1,000
Tendon, Ligament, Rotator Cuff or Knee Surgery – Repair	$200
Tendon, Ligament, Rotator Cuff or Knee Surgery – Exploratory	$100
Ruptured Disc Surgery – Repair	$500
Eye Injury Surgery	$200
Eye Injury – Removal of Foreign Object	$100
Emergency Dental – Extraction	$100
Emergency Dental – Broken Tooth	$50
Concussion	$100
Coma	$5,000
Diagnostic Advanced	$150
Appliance	$400
Prosthesis	$800
Paralysis – Paraplegia	$5,000
Paralysis – Quadriplegia	$10,000
Blood, Plasma, Platelets	$200
Transportation	$400
Family Lodging	$100 per day

Plan 2

Benefit Type	Benefit Amount
Small Burns	$300
Large Burns (3rd degree pays 10x multiple)	$1,000
Skin-Graft Benefit	50% of the applicable benefit amount for small burns or large burns
Small Lacerations	$100
Large Lacerations	$600
General Anesthesia Benefit	$200
Medicine Benefit	$20
Medical Supply Benefit	$30
Abdominal or Thoracic Surgery	$1,500
Tendon, Ligament, Rotator Cuff or Knee Surgery – Repair	$400
Tendon, Ligament, Rotator Cuff or Knee Surgery – Exploratory	$150
Ruptured Disc Surgery – Repair	$750

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Benefit Type	Benefit Amount
Eye Injury Surgery	$400
Eye Injury – Removal of Foreign Object	$200
Emergency Dental – Extraction	$150
Emergency Dental – Broken Tooth	$75
Concussion	$150
Coma	$10,000
Diagnostic Advanced	$200
Appliance	$800
Prosthesis	$1,600
Paralysis – Paraplegia	$7,500
Paralysis – Quadriplegia	$15,000
Blood, Plasma, Platelets	$400
Transportation	$400
Family Lodging	$200 per day

For a complete list of benefits covered, see the Cigna Certificate of Coverage.

Exclusions

Benefits are not payable from Accidental Injury Insurance if your loss is caused by, contributed to by, or results from any of these circumstances:

- Intentionally self-inflicted injury, suicide or any attempt while sane or insane.
- Commission or attempt to commit a felony or an assault.
- Declared or undeclared war or act of war.
- A covered loss that occurs while on active duty service in the military, naval or air force of any country or international organization. Reserve or National Guard active duty training is not excluded unless it extends beyond 31 days.
- Voluntary ingestion of any narcotic, drug, poison, gas or fumes, unless prescribed or taken under the direction of a physician and taken in accordance with the prescribed dosage.
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it. ‘’Under the influence of alcohol’’ for purposes of this exclusion, means intoxicated, as defined by the law of the state in which the covered loss occurred.
- Bungee jumping, parachuting, skydiving, parasailing or hang-gliding.
- Flight in, boarding or alighting from an aircraft or any craft designed to fly above the Earth’s surface:
  - Except as a fare-paying passenger on a regularly scheduled commercial airline;
  - Being flown by the covered person or in which the covered person is a member of the crew;
  - Being used for:
    - Crop dusting, spraying or seeding, giving and receiving flying instruction, firefighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
    - Any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
  - Designed for flight above or beyond the earth’s atmosphere;
  - An ultra-light or glider;
  - Being used for the purpose of parachuting or skydiving;

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    - Being used by any military authority, except an aircraft used by the Air Mobility Command or its foreign equivalent;
- Travel in any aircraft owned, leased or controlled by Dell, or any of its subsidiaries or affiliates. An aircraft will be deemed to be ‘’controlled’’ by Dell if the Aircraft may be used as Dell wishes for more than 10 straight days, or more than 15 days in any year;
- In addition, benefits will not be paid for services or treatment rendered by a physician, nurse or any other person who is:
    - Employed or retained by Dell;
    - Providing homeopathic, aroma-therapeutic or herbal therapeutic services;
    - Living in the Covered Person’s household;
    - A parent, sibling, spouse or child of the covered person;
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.

This list doesn’t include all of the exclusions. For more details on Accidental Injury Insurance exclusions, see the Cigna Certificate of Coverage.

Claims for Critical Illness and Accidental Injury Insurance

Notice of Claim

You must notify Cigna within 31 days after a covered loss occurs, or as soon as is reasonably possible. When providing notice, you should include the:

- Company’s name (Dell)
- Policy number
- Covered person’s name and address
- Policy and Certificate number

Claim Forms
Once Cigna is notified of your claim, Cigna will send you claim forms with written instructions for filing proof of loss.

Proof of Loss
You must provide Cigna with proof of loss within 90 days of the loss for which the claim is being made. If benefits are payable as periodic payments and each payment is contingent upon continuing loss, then proof of loss must be submitted within 90 days after the termination of each period. If notice is not given within that time, claims will not be invalidated or reduced it if it found that such notice was given as soon as was reasonably possible. In any case, proof must be given not more than one year after the time it is otherwise required.

Payment of Claims
Benefits will be paid not more than 60 days after proof of loss. All benefits are payable to the covered person, if living, except if the covered person is a dependent child, then the benefits will be payable to the employee. If the covered person dies while any of these benefits remain unpaid, benefits will be paid to the covered person’s spouse, if living, or otherwise to the executors or administrators of the covered person’s estate. Benefits for loss of life will be payable to the covered person’s beneficiary named under this policy.

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If your claim is denied, see the “Claims and Appeals Procedures” section for details on the appeals process. This plan may be portable after termination. You have 30 days after termination to port your coverage. You’ll receive a portability letter in the mail from Cigna, or you can contact Cigna at 1-800-754-3207, Monday through Friday, 8 a.m. to 8 p.m. CT.

MetLife Legal Plans

Overview

The MetLife Legal Plans were established to provide personal legal services for eligible employees, their spouses, and dependent children. If you choose to join the MetLife Legal Plans, the coverage available to you and your family can help you with many of your personal legal needs. You pay the cost of your legal coverage through after-tax payroll deductions.

MetLife Legal Plans, Inc. has been selected to provide your Legal Plan benefits. The services will be provided through a panel of carefully selected participating law firms. Lawyers in this network are called Plan Attorneys.

How to Use the MetLife Legal Plans

To use the MetLife Legal Plans, visit legalplans.com, use the MetLife Legal Plans mobile app, or call the MetLife Legal Plans’ Client Service Center at 1-800-821-6400.

When you call the Client Service Center, the Client Service Representative will:

- Verify your eligibility for services;
- Make an initial determination of whether and to what extent your case is covered (the Plan Attorney will make the final determination of coverage);
- Give you a case number that is similar to a claim number (you will need a new case number for each new case you have);
- Give you the telephone number of the Plan Attorney most convenient to you; and
- Answer any questions you have about your Legal Plan.

Then call the Plan Attorney and identify yourself as a legal Plan Member referred to them by MetLife Legal Plans. You should request an appointment for a consultation. You should be prepared to give them your Case Number, the name of the legal plan you belong to and the type of legal matter you are calling about. If you wish, you may choose an out-of-network attorney. In a few areas, where there are no Participating Law Firms, you will be asked to select your own attorney. In both circumstances, MetLife Legal Plans will reimburse you for these non-Plan attorneys’ fees based on a set fee schedule.

Summary of Benefits

The MetLife Legal Plans entitle you and your eligible dependents to receive certain personal legal services. The available benefits are very comprehensive, but there are limitations and other conditions that must be met. The following services are covered under the Plan. This listing doesn’t include all of the covered services. For a complete list of services provided, refer to your coverage summary and other program materials.

Office Consultation and Telephone Advice

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Plan Attorney will explain the Participant's rights, point out his or her options and recommend a course of action. The Plan Attorney will identify any further coverage available under the Plan, and will undertake representation if the Participant so requests. If representation is covered by the Plan, the Participant will not be charged for the Plan Attorney's services.

If representation is recommended but is not covered by the plan, the Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation.

Debt Matters

This service provides Participants with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, foreclosure, repossession or garnishment, up to and including trial if necessary. It includes a motion to vacate a default judgment. It does not include counter, cross- or third-party claims; bankruptcy; and action arising out of family law matters, including support and post-decree issues; or any matter where the creditor is affiliated with Dell.

Defense of Civil Lawsuits

Administrative Hearing Representation – This service covers Participants in defense of civil proceedings before a municipal, county, state or federal administrative board, agency or commission. It includes the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post-judgment matters or litigation of a job-related incident.

Civil Litigation Defense – This service covers the Participant in defense of arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post-judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counterclaims, third-party or cross-claims.

Incompetency Defense – This service covers the Participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the Participant incompetent.

Document Preparation

Deeds – This service covers the preparation of any deed for which the Participant is either the grantor or grantee.

Demand Letters – This service covers the preparation of letters that demand money, property or some other property interest of the Participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the Participant. Negotiations and representation in litigation are not included.

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Mortgages – This service covers the preparation of any mortgage or deed of trust for which the Participant is the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

Promissory Notes – This service covers the preparation of any promissory note for which the Participant is the payor or payee.

Document Review – This service covers the review of any personal legal document of the Participant, such as letters, leases or purchase agreements.

Family Law

Name Change – This service covers the Participant for all necessary pleadings and court hearings for a legal name change.

Adoption and Legitimization (Contested and Uncontested)

This service covers all legal services and court work in a state or federal court for an adoption for the Plan Member and spouse. Legitimization of a child for the Plan Member and spouse, including reformation of a birth certificate, is also covered.

Divorce, Dissolution and Annulment (Contested and Uncontested) – 20-Hour Maximum

This service is available to the Plan Member only, not to a spouse or dependents, for the first 20 hours of service. This service includes preparing and filing all necessary pleadings, motions and affidavits, drafting settlement agreements, and representation at the hearing or trial, whether the Plan Member is a plaintiff or defendant. This service does not include disputes that arise after a decree is issued. It is the Plan Member's responsibility to pay fees beyond the first 20 hours.

Guardianship or Conservatorship (Contested and Uncontested) – This service covers establishing a guardianship or conservatorship over a person and his or her estate when the Plan member or spouse is being appointed as guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing and preparing the initial accounting. This service does not include representation of the person over whom guardianship or conservatorship is sought, any annual accountings after the initial accounting, or terminating the guardianship or conservatorship once it has been established.

Real Estate Matters

Eviction and Tenant Problems (Primary Residence – Tenant Only) – This service covers the Participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

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Refinancing of Home (Primary Residence) – This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a Participant's primary residence. This benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property, or property that is held for any rental, business, investment or income purpose.

Sale or Purchase of Home (Primary Residence) – This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's primary residence or of a vacant property to be used for building a primary residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.

Wills and Estate Planning

Living Trusts – This service covers the preparation of revocable and irrevocable living trusts for the Participant. It does not include tax planning or services associated with funding the trust after it is created.

Living Wills – This service covers the preparation of a living will for the Participant.

Powers of Attorney – This service covers the preparation of any power of attorney when the Participant is granting the power.

Wills and Codicils – This service covers the preparation of a simple or complex will for the Participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

General Exclusions

Certain matters are excluded from coverage under the Plan. No services, not even a consultation, can be provided on the following matters:

- Employment-related matters, including company or statutory benefits
- Matters involving the company, MetLife and affiliates, and Plan Attorneys
- Matters in which there is a conflict of interest between the employee and spouse or dependents, in which case services are excluded for the spouse and dependents
- Appeals and class actions
- Farm matters, business or investment matters, matters involving property held for investment or rental, or issues when the Participant is the landlord
- Patent, trademark and copyright matters
- Costs or fines
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the Participant becoming eligible for plan benefits

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Legal Plan Claims

For information about Legal Plan claims, see the “Claims and Appeals Procedures” section for details on the appeals process. You have an opportunity after termination of employment to continue on as a Legal Plan member for 12 months through a portable plan. Contact the client service center within 30 days of your last day of employment to enroll at 1-800-821-6400, Monday through Friday, 8 a.m. to 8 p.m. ET.

Identity Theft Protection

Overview

Identity Theft Protection is a benefit that monitors your personal and financial information 24 hours a day, seven days a week. It can also help you limit damage if your personal or financial information is stolen. Identity Theft Protection is administered by Allstate Identity Protection. You can choose the Allstate Identity Protection Pro or Allstate Identity Protection Pro Plus Plan. Family members are eligible to enroll as a part of the family plan.

Plan Features

Allstate Identity Protection Pro is a proactive monitoring service that alerts you at the first sign of fraud and fully restores your identity. The Allstate Identity Protection Pro plan provides credit monitoring through TransUnion, dark web monitoring, and full restoration services to help detect and recover from identity theft quickly.

Plan features include:

- Rapid alerts
- High-risk transaction monitoring
- Financial transaction monitoring
- Monthly updated credit score and annual credit report from TransUnion
- Dark web monitoring with human-sourced intelligence
- Digital wallet storage and monitoring
- Deceased family member coverage
- Data breach notifications
- Up to $1 million identity theft expense reimbursement
- Comprehensive identity and credit monitoring
- Identity health status
- Social media monitoring
- Pre-existing conditions covered at no additional cost
- Full-service, 24/7 remediation support
- Stolen fund reimbursement
- 401(k)/HSA fraud reimbursement

With Allstate Identity Protection Pro Plus, you receive all of the above benefits, plus:

- Tri-bureau credit monitoring
- Unlimited TransUnion credit scores
- Tri-bureau credit monitoring reports and scores
- Credit freeze assistance
- Credit lock (adult and child)
- 401(k) and HSA stolen fund reimbursement

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- Tax fraud refund advances
- Stolen funds reimbursement
- Allstate Digital Footprint℠
- Sex offender alerts
- Enhanced social media monitoring for account takeover
- IP address monitoring
- Senior family coverage, including parents, in-laws, and grandparents age 65+
- Expanded financial protection
  - Stolen tax refund advance
  - Deceased family member fraud expense reimbursement
  - Home title fraud expense reimbursement
  - Professional fraud

You are eligible to cancel coverage at any time.

Identity Theft Protection Claims

For information about Identity Theft Protection claims, see the “Claims and Appeals Procedures” section for claims details. You have the option to continue coverage after termination. You have 90 days after the date of termination to continue coverage by contacting Allstate Identity Protection at 1-800-789-2720 or sending an email to **customercare@aip.com**.

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Leaves of Absence

Overview

There are reasons that you may occasionally need to take a leave of absence from your job. There are different types of leaves of absence available to accommodate your needs.

This section includes information on:

- Family and Medical Leave Act (FMLA) leaves;
- Discretionary Family and Medical Leave;
- Domestic Partner Leave;
- Paid Parental Leave;
- Paid Caregiver Leave
- Military Leave of Absence; and
- Company Discretionary Leave Policy.

Family and Medical Leave

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid/job protected leave in a rolling 12-month period. To be eligible for an FMLA leave, you must have been employed at least one year and worked at least 1,250 hours within the previous 12 months and the leave must be due to:

- The birth, adoption or placement with you for adoption or foster care of a child;
- The care of a seriously ill spouse, parent or child;
- Your serious illness; or
- Military provisions under FMLA:
    - Military Family Leave—A qualifying urgent need for leave because your spouse, son, daughter or parent is on active duty or impending call or order to active duty in the armed services in support of a military operation; or
    - Military Caregiver Leave—To care for a covered service member with a serious injury or illness (up to 26 weeks).

To be eligible to request a Family and Medical Leave, the team member's serious health condition must make the team member unable to perform the essential functions of his or her position with or without reasonable accommodation, or render the family member incapable of self-care (as appropriate), for a period of more than three consecutive calendar days, as determined by the Leave and Disability Administrator.

For FMLA leave, a child, son or daughter includes a child you intend to be a parent to, regardless of your biological or legal relationship to the child. However, you may be required to submit documentation of the "family" relationship.

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During an FMLA leave, you may elect to drop coverage. Otherwise, you will maintain your health care benefits coverage—except that your participation in the Health Savings Account (U.S. team members only) and Dependent Care (Day Care) Flexible Spending Account will be suspended, while on leave—on the same basis as other similarly situated team members, provided any required premiums are paid. Your eligibility will be maintained until the end of the leave, as long as your leave is properly granted, as required under federal law.

You will be given the same health care benefits that would have been provided if you were working, with the same premium contribution ratio, if any. You must continue to pay your share of any premiums. If your payments are more than 30 days late, you will receive a written notice. The notice will state that coverage will be retroactively terminated to end on the last day for which premiums were paid. It will also give the date the retroactive termination will occur if payment is not received by that date. This notice will be mailed at least 15 days before the date coverage would be retroactively terminated.

Refer to the “How Your Benefits Are Impacted” section for details regarding how your benefits are affected by your FMLA leave.

You are required to use all your available Vacation and Personal Wellness Time (PWT) days. However, you may save up to a combined total of five PWT/Vacation days for use after you return from leave.

Refer to the “Benefits Coverage When Returning From Leave of Absence” section for details on reinstating or continuing coverage after your leave ends.

For additional information about Plan coverage during an FMLA leave, contact the Dell Benefits Center at 1-888-335-5663.

Note on returning to work: To be reinstated to active employment status and avoid any pay implications or system access issues upon your return from a leave, you must contact the Leave and Disability Center at 1-855-857-0325, and follow the prompts to confirm your return from the appropriate leave. You may also log on to mySedgwick.com/Dell and report your return to work within your claim. Your actual reinstatement to an active employment status occurs on the date you physically return to work.

Note on intermittent leaves: In some situations, you may take FMLA leave time on an intermittent basis. If you are on leave on an intermittent basis, you must notify the Leave and Disability Center at 1-855-857-0325 within 48 hours of returning to work. Not doing so may result in denial of your intermittent absence(s). You must also report your absences to your manager every time you go out.

Note on state or municipal leaves: You may be eligible for different leave entitlements based on your state or jurisdiction. Dell will comply with all applicable state and local requirements.

Discretionary Family and Medical Leave

An employee who is not eligible for FMLA or state-based leave or has exhausted his or her FMLA/state-based leave entitlement may request a discretionary, unpaid leave of absence for:

- Team member’s own serious health condition;
- Birth of a son or daughter and to care for a newborn child;
- Placement of a daughter or a son for adoption or foster care; or
- Care for a family member with a serious health condition.

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To be eligible to request a discretionary medical leave, the team member's serious health condition must make the team member unable to perform the essential functions of his or her position with or without reasonable accommodation, or render the family member incapable of self-care (as appropriate), for a period of more than three consecutive calendar days, as determined by the Leave and Disability Administrator. All requests for discretionary leave will be decided in Dell's sole discretion and will be subject to the needs of the business and such other considerations as Dell may deem appropriate. A team member requesting discretionary leave may be required to present such documentation as is deemed appropriate by Dell, subject to applicable law. A team member who is approved for discretionary leave may be eligible to receive Short-Term Disability or workers' compensation insurance benefits, subject to all applicable requirements. A team member's job is not protected during any period of discretionary leave, and a team member who takes discretionary leave is not guaranteed reinstatement.

Note on intermittent leaves: Intermittent leaves or reduced work schedules are not available with Discretionary Family and Medical Leave.

You are required to use all your available Vacation and Personal Wellness Time (PWT) days. However, you may save up to a combined total of five PWT/Vacation days for use after you return from leave.

During a Discretionary Family and Medical Leave, you will maintain your health care benefits coverage on the same basis as other similarly situated team members, provided any required premiums are paid. Your eligibility will be maintained until the end of the leave, as long as your leave is properly granted.

You will be given the same health care benefits that would have been provided if you were working and you will be responsible for the full employee cost of the coverage through direct billing from the benefits administrator. If your payments are more than 30 days late, you will receive a written notice. The notice will state that coverage will be retroactively terminated to end on the last day for which premiums were paid. It will also give the date the retroactive termination will occur if payment is not received by that date. This notice will be mailed at least 15 days before the date coverage would be retroactively terminated.

Refer to the "How Your Benefits Are Impacted" section for details regarding how your benefits are affected by your leave.

Domestic Partner Leave

The Domestic Partner Leave policy allows you to take up to 12 weeks of unpaid/job protected leave in a rolling 12-month period. To be eligible for a Domestic Partner Leave, you must have been employed at least one year and worked at least 1,250 hours within the previous 12 months and the leave must be due to the care of a seriously ill domestic partner (same or opposite gender).

All other aspects of Domestic Partner Leave are treated similar to FMLA. Refer to the "Family and Medical Leave" section for additional information regarding coordination of benefits, intermittent leave usage and return to work processes.

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Paid Parental Leave

Paid Parental Leave is a paid benefit that can be taken by parents within 12 months following the birth of a child or placement of a child relating to adoption or foster care. This leave is offered in addition to Short-Term Disability coverage, for birth mothers, and if applicable runs concurrently with FMLA leave except when taken intermittently. The purpose of Paid Parental Leave is to enable you to care for and bond with your new child.

Eligibility

To be eligible for Paid Parental Leave you must be a regular U.S. team member, scheduled to work at least 20 hours per week at the time of birth or placement for adoption or foster care.

Note: Birth mothers are eligible for Paid Parental Leave when Short-Term Disability benefits end.

Paid Parental Leave Benefits

The Paid Parental Leave Program pays 100% of your benefit-eligible earnings or total target compensation (TTC) for Sales roles for up to 12 weeks. The 12 weeks are provided within a rolling 12-month period and must be taken in at least one-week increments. If you return to work early, any Paid Parental Leave entitlement remaining for a partial week will be forfeited.

Any Paid Parental Leave benefit payments you receive are reduced by benefits you receive from any programs mandated by federal, state or local law and any benefits provided pursuant to a Company-sponsored disability program or a state or local disability program. If you are eligible for any of these programs and you do not properly apply for such benefits, your Paid Parental Leave benefits are calculated as if you are receiving such benefits.

You are not required to use your available Vacation and Personal Wellness Time (PWT) days during any Paid Parental Leave.

Initiating and Managing Paid Parental Leave

You must notify the Leave and Disability Center at least 30 days before taking Paid Parental Leave. Proof of adoption or foster care placement will be required. The Leave and Disability Center determines eligibility and approval for Paid Parental Leave.

Contact the Leave and Disability Center at 1-855-857-0325. You may also log on to mySedgwick.com/Dell to initiate and manage your claim.

Paid Parental Leave time will also run concurrently with FMLA and other leave types for which you may be eligible under any programs mandated by federal, state or local law. Note FMLA does not run concurrently with Paid Parental Leave taken in intermittent one-week increments.

Paid Parental Leave benefits end at the earliest of:

- When you have received 12 weeks of Paid Parental Leave;
- 12 months from the child's date of birth, adoption or foster care placement;
- Termination of employment; or
- When Dell modifies or terminates the Paid Parental Leave Program.

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Paid Caregiver Leave

Dell provides up to six weeks of paid caregiver leave to U.S. team members to care for a family member with a serious health condition.

Eligibility

To be eligible for Paid Caregiver Leave, you must be a regular U.S. Dell team member scheduled to work at least 20 hours per week.
Eligible family members include your:

- Spouse
- Domestic partner (same and opposite sex)
- Children up to age 26
- Disabled children of any age
- Parents

To be eligible for Paid Caregiver Leave, the family member must have a serious health condition as that term is defined by the Family and Medical Leave Act.

Paid Caregiver Leave Benefits

The Paid Caregiver Leave Program pays 100% of your benefit-eligible earnings or total target compensation (TTC) for Sales roles for up to six weeks. The six weeks are provided within a rolling 12-month period and must be taken in at least one-week increments. If you return to work early, any Paid Caregiver Leave entitlement remaining for a partial week will be forfeited.

Any Paid Caregiver Leave benefit payments you receive are reduced by benefits you receive from any programs mandated by federal, state or local law and any benefits provided pursuant to a Company-sponsored disability program or a state or local disability program. If you are eligible for any of these programs and you do not properly apply for such benefits, your Paid Caregiver Leave benefits are calculated as if you are receiving such benefits.

You are not required to use your available Vacation and Personal Wellness Time (PWT) days during any Paid Caregiver Leave.

Initiating and Managing Paid Caregiver Leave

You must notify the Leave and Disability Center to apply for Paid Caregiver Leave. If possible, approval and scheduling of Paid Caregiver Leave should be made in advance. The Leave and Disability Center determines eligibility and approval for Paid Caregiver Leave. Certification is required, and determination is made based on the Family and Medical Leave Act guidelines.

Contact the Leave and Disability Center at 1-855-857-0325. You may also log on to mySedgwick.com/Dell to initiate and manage your claim.

Paid Caregiver Leave time will also run concurrently with FMLA and other leave types for which you may be eligible under any programs mandated by federal, state or local law.

When Paid Caregiver Leave Benefits End

Paid Caregiver Leave benefits end at the earliest of:

- When you have received six weeks of Paid Caregiver Leave in a 12-month period.
- Termination of employment.
- When Dell modifies or terminates the Paid Caregiver Leave Program.

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Military Leave of Absence (effective May 1, 2022)

Team members should contact the Leave and Disability Center to initiate a Military Leave or reduction in hours due to service in the armed forces, army national guard, commissioned corps of the Public Health Service or any other category of person designated by the President in a time of war or national/state emergency or for certain military events such as annual training or weekend drills. Absences to perform military service are eligible for periods of paid leave based on certain factors. Dell recognizes that in a time of war or national/state emergency, special consideration should be given to meet the needs of our team members who serve our country in the military. During such periods of activation, if the team member contacts the Leave and Disability Center to initiate the Military Leave, Dell will supplement the base military pay of the eligible team member (as determined by orders) requiring time off for active duty up to 100% of your benefit-eligible earnings or total target compensation (TTC) for Sales roles.

Dell's U.S. military program also provides supplemental pay for team members who are required as a member of the U.S. Armed Forces, the Armed Forces Reserves or the National Guard to serve a standard two-week tour of annual duty or training attended in lieu of annual duty. Team members requesting time off for military training duty should contact the Leave and Disability Center to initiate the Military Leave. During such training duty, Dell will supplement the base military pay of the eligible team member (as determined by orders) requiring time off for training duty up to 100% of benefit-eligible earnings or total target compensation (TTC) for Sales roles.

During peacetime, team members who are not eligible for supplemental pay have the option to use available PWT/Vacation to cover any missed workdays for military service. In the event your PWT and Vacation balances are insufficient to cover your time off for military service, you will receive paid time off if your military leave is comparable to a Dell non-military paid leave based on: the duration of the absence, the purpose of the leave and your ability to choose when to take the leave. Open a MyHR case if your PWT/Vacation balance is insufficient to cover your missed workdays due to military service.

Military leave types eligible for supplemental pay include the following:

Extended Military Deployment
Dell's U.S. military program provides supplemental pay for team members called to active duty due to National Emergency, State of Conflict or Declared War. During this period of activation (as determined by orders), Dell will pay the difference between military base pay (excluding payments made to the team member for housing, travel and food) and the team member's Dell benefit-eligible earnings or total target compensation (TTC) for Sales roles. Under the Military Leave Supplemental Pay Program, team members will be eligible for both supplemental pay and continuation of benefits for a maximum of 18 months. Where required, receipt of a military Leave and Earnings Statement (LES), must be provided. Team members have the option to use available PWT/Vacation hours if orders do not qualify under the supplemental pay program in order to receive pay.

Annual Military Training
Dell's U.S. military program also provides supplemental pay for team members who are required as a member of the U.S. Armed Forces, the Armed Forces Reserves or the National Guard, to serve a standard two-week tour of annual duty or training attended in lieu of annual duty. During this scheduled period of training, Dell will pay the difference between military base pay (excluding payments made to the team member for housing, travel and food) and the team member's Dell benefit-eligible earnings or total target compensation (TTC) for Sales roles. Team members will be eligible for both supplemental pay and continuation of benefits for the length of training as determined by duty orders.. Where required, receipt of military pay statement must be provided. Team members have the option to use available PWT/Vacation hours if orders do not qualify under the supplemental pay program in order to receive pay.

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All Other Military Service

Dell's U.S. military program offers team members who are not eligible for supplemental pay the option to use available PWT/Vacation hours for all other military service. In the event your PWT and Vacation balances are insufficient to cover your time off for other military service, you will receive paid time off if your military leave is comparable to a Dell non-military paid leave based on: the duration of the absence, the purpose of the leave, and your ability to choose when to take the leave. Open a MyHR case if your PWT/Vacation balance is insufficient to cover your missed workdays due to military service.

Coordination of Benefits While on Military Leave

If you require a leave of absence or reduction in hours due to voluntary or involuntary service in the armed forces, army national guard, air national guard, commissioned corps of the Public Health Service or any other category of persons designated by the United States President in a time of war or national emergency, you may either:

- Continue your enrollment in the Plan and the enrollment of your covered dependents; or
- Suspend your and your dependent(s) enrollment in the Plan during your military leave.

To continue or suspend your coverage, you must contact the Dell Benefits Center at 1-888-335-5663 **before** leaving.

Refer to the "How Your Benefits Are Impacted" section for details regarding how your benefits are affected by your leave.

Regardless of whether you elect to continue your other benefits, if you participate in the Dependent Care (Day Care) Flexible Spending Account and/or make Health Savings Account contributions (U.S. team members only), your participation will be automatically stopped.

If you elect Uniformed Services Employment and Reemployment Rights Act (USERRA) coverage, you will continue to pay the full employee cost of the coverage through direct billing from the benefits administrator for as long as you are on unpaid leave, but are still an active Dell employee. If you elect USERRA coverage, you may not elect COBRA continuation coverage when your USERRA coverage ends. Likewise, if you elect COBRA continuation coverage during your military service, you may not elect USERRA coverage when COBRA ends.

If you elect to continue your coverage (or spouse or dependent children's coverage) under USERRA, you pay the same rates as while you were active, as long as you are an active Dell employee. Billing will be processed directly from the benefits administrator until your salary resumes through Dell payroll.

Refer to the "Benefits Coverage When Returning From Leave of Absence" section for details on reinstating or continuing coverage after your leave ends.

Upon returning to work, notify your leader and contact the Leave and Disability Administrator at 1-855-857-0325 in order to:

- Obtain information on what you will need to provide, such as your DD-214 for extended leaves.
- Be reinstated to active employment status and avoid any pay implications or system access issues.

Note: If you are on an extended leave, you will remain an active employee with the Company based on USERRA requirements.

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How Long Coverage Continues on Military Leave

When you take military leave, coverage can continue for up to five years. However, coverage will end earlier if a required premium payment is not made within the required time.

Your coverage will end if you do not notify your leader of your intent to return to work within the required period following completion of your military service by either reporting to work (if your military service was less than 31 days) or applying for reemployment (if your military service was for more than 30 days). The deadline for returning to work, depending on the period of military service, is as follows:

Period of Service	Return-to-Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period or, if that is unreasonable or impossible through no fault of your own, as soon as is possible.
More than 30 days, but less than 181 days	Within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, the first day on which it is possible to do so.
More than 180 days	Within 90 days after completion of your service.
Any period if for purposes of an examination for fitness to perform uniformed service	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period or, if that is unreasonable or impossible through no fault of your own, as soon as possible.
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Same as above depending on length of service period, except that period begins when you have recovered from your injury or illness rather than on completion of your service. The maximum period for recovering is limited to two years, but the two-year period may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above periods.

Company Discretionary Leave Policy

Dell recognizes that you may need to be absent for extended periods under special circumstances not covered by other leave policies. Dell's success depends on your commitment to Dell, and Dell is committed to accommodating your needs for longer absences whenever possible and in the best interest of Dell and you.

If you are not eligible for FMLA or your leave request is not for an FMLA or medical leave, you may request leave time for "limited personal reasons" due to extenuating circumstances:

- Family emergency not covered by another type of leave;
- The need to take care of Work Authorization papers; or
- Other approved, non-medical reasons.

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To request a discretionary leave:

- Discuss the leave with your manager and HR.
- Complete and submit a Company Discretionary Leave Request Form.

Formal written approval is required **before** the leave may begin. You may coordinate this through your manager. Any discretionary leave request must be approved and is subject to business needs.

Note: Senior Vice President approval is required as well as confirmation from the Immigration Team that the team member is working with them if request is for time off to obtain proper Work Authorizations.

A Company Discretionary Leave is not for extending maternity leaves, for family bonding leave, or for taking extended vacation or pleasure time to spend at home or to spend traveling.

You are required to use all your available Vacation and Personal Wellness Time (PWT) days starting on your first day of your discretionary leave.

During a Company Discretionary Leave, you will maintain your health care benefits coverage on the same basis as other similarly situated team members, provided any required premiums are paid. Your eligibility will be maintained until the end of the leave, as long as your leave is properly granted.

Refer to the “How Your Benefits Are Impacted” section for details regarding how your benefits are affected by your leave.

Note:

- The Company Discretionary Leave allows you to take up to 90 days of approved time away.
- Review the Company Discretionary Leave Request Form for more information.

Call 1-888-335-5663 for direct billing or outstanding 401(k) loan questions relating to a Company Discretionary Leave.

Note: To be reinstated to active employment status and avoid any pay implications or system access issues upon your return from a leave, you must contact the Leave and Disability Center at 1-855-857-0325 to confirm your return. You may also log on to mySedgwick.com/Dell and report your return to work within your claim.

How Your Benefits Are Impacted

You are allowed to make certain changes to your benefits when you go on a leave of absence. The changes you are allowed to make differ based on the type of leave you take, as described below. You must make changes within 31 days of beginning your leave of absence or any time during the FMLA period of your leave if you are approved for and taking an FMLA leave. In all cases, changes are effective on the date of the employment status change. Company-paid Life, AD&D and Short-Term Disability coverage remains in effect and is not affected by the employment status change. If you have a pay change while out on a leave of absence, the pay change will not update your base pay, life insurance and/or disability coverage amounts until you return to active status.

Note: Team members going on military leave are allowed to suspend their coverage while on leave and can request this through the Dell Benefits Center before the beginning of their military leave or within 31 days following their leave start date.

FMLA Leave

The following chart summarizes the changes allowed (or that will occur) if you go out on an **FMLA leave**, whether or not you are receiving disability pay benefits.

Note: For an FMLA leave accompanied by pay issued through Company payroll (e.g., Short-Term Disability, Paid Parental Leave or Paid Caregiver Leave), your benefit deductions (with the exception of Dependent Care (Day Care) Flexible Spending Account) continue to be deducted from your paychecks if you do not elect to drop coverage. Additionally, 401(k) deductions (when receiving STD Benefits) will automatically stop as described in the table below. If you are a U.S. team member, Health Savings Account contributions will continue to be deducted from your pay as long as the leave is accompanied by pay issued (Short-Term Disability, Paid Parental Leave or Paid Caregiver Leave) through Company payroll. If you are not receiving pay through Company payroll, you must make timely benefit contributions through the direct billing process or your coverage will be terminated. Long-Term Disability benefits and workers' compensation are not paid through Company payroll and thus require payment by direct billing.

Benefit Plan	Allowed Changes and Considerations
Medical, Dental and Vision	▪ You may drop coverage for yourself and/or your eligible dependents.
Health Care Flexible Spending Account	▪ You may stop participation.
Dependent Care (Day Care) Flexible Spending Account	▪ When you begin your leave of absence, your election will end and all contributions will stop. Expenses incurred on dates of service during your leave of absence will not be eligible for reimbursement. To reinstate your election and contribution, you must contact the Dell Benefits Center at 1-888-335-5663, within 31 days of returning to work.
Health Savings Account (HSA) Funding (U.S. team members only)	▪ When you begin your leave of absence, your HSA contributions will stop. Once you return from leave, you will need to contact the Dell Benefits Center at 1-888-335-5663 to reinstate your contributions. You do not have to do this within a specific time frame but will have to take action to reinstate your contributions.
Long-Term Disability	▪ If leave is for a team member's medical condition, you may drop coverage.

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Benefit Plan	Allowed Changes and Considerations
	▪ If leave is for a member of the team member's family, no changes allowed.
Supplemental Life Insurance—Team Member	▪ You may decrease or drop coverage.
Supplemental Life Insurance—Spouse or Domestic Partner and Child	▪ No changes allowed. If a team member drops coverage, any spouse/domestic partner and child coverage would also be dropped.
Critical Illness Insurance (U.S. Team Members)	▪ Coverage can continue if you make benefit contributions through the direct billing process.
Accidental Injury Insurance (U.S. Team Members)	▪ Coverage can continue if you make benefit contributions through the direct billing process.
Other Benefit Considerations	▪ 401(k) Plan deductions continue if you have eligible pay.

Non-FMLA and Non-Military Leave

The following chart summarizes the changes allowed if you go out on leave that is neither an FMLA leave nor a military leave (e.g., **Company Discretionary Leave or Discretionary Family Medical Leave**).

Note: For a non-FMLA leave accompanied by pay issued through Company payroll (e.g., Short-Term Disability, Paid Parental Leave or Paid Caregiver Leave), your benefit deductions continue to be deducted from your paychecks (except for Dependent Care [Day Care] FSA deductions, as described in the table below). If you are not receiving pay through Company payroll, you must make timely benefit contributions through the direct billing process or your coverage will be terminated. Long-Term Disability benefits and workers' compensation are not paid through Company payroll and thus require payment by direct billing.

Benefit Plan	Allowed Changes and Considerations
Medical, Dental and Vision	▪ No changes allowed.
Health Care Flexible Spending Account	▪ No changes allowed.
Dependent Care (Day Care) Flexible Spending Account	▪ When you begin your leave of absence, your election will end and all contributions will stop.

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Benefit Plan	Allowed Changes and Considerations
	Expenses incurred on dates of service during your leave of absence will not be eligible for reimbursement. To reinstate your election and contribution, you must contact the Dell Benefits Center at 1-888-335-5663, within 31 days of returning to work.
Health Savings Account (HSA) Funding (U.S. team members only)	▪ When you begin your leave of absence, your HSA contributions will stop. Once you return from leave, you will need to contact the Dell Benefits Center at 1-888-335-5663 to reinstate your contributions. You do not have to do this within a specific time frame but will have to take action to reinstate your contributions.
Long-Term Disability	▪ No changes allowed.
Basic Life Insurance	▪ The maximum age limit for coverage while on leave is the later of age 69 or 24 months after your leave began.
Supplemental Life Insurance—Team Member	▪ You may decrease or drop coverage. ▪ The maximum age limit for coverage while on leave is the later of age 69 or 24 months after your leave began.
Supplemental Life Insurance—Spouse or Domestic Partner and Child	▪ No changes allowed. If a team member drops coverage, any spouse/domestic partner and child coverage would also be dropped. ▪ The maximum age limit for coverage while on leave is the later of age 69 or 24 months after your leave began.
Critical Illness Insurance (U.S. Team Members)	▪ Coverage can continue if you make benefit contributions through the direct billing process.
Accidental Injury Insurance (U.S. Team Members)	▪ Coverage can continue if you make benefit contributions through the direct billing process.
Other Benefit Considerations	▪ 401(k) Plan deductions continue if you have eligible pay.

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Military Leave

The following chart summarizes changes allowed if you go out on an unpaid **military leave**.

Note: For a military leave accompanied by pay issued through Company payroll (e.g., Military Supplemental Leave Program), your benefit deductions continue to be deducted from your paychecks (except for Dependent Care (Day Care) FSA deductions as described in the table below). If you do not elect to suspend coverage and are not receiving pay through Company payroll, you must make timely benefit contributions through the direct billing process.

Benefit Plan	Allowed Changes and Considerations
Medical, Dental and Vision	▪ You may suspend coverage for yourself and/or your eligible dependents.
Health Care Flexible Spending Account	▪ You may stop participation.
Dependent Care (Day Care) Flexible Spending Account	▪ When you begin your leave of absence, your election will end and all contributions will stop. Expenses incurred on dates of service during your leave of absence will not be eligible for reimbursement. To reinstate your election and contribution, you must contact the Dell Benefits Center at 1-888-335-5663, within 31 days of returning to work.
Health Savings Account (HSA) Funding (U.S. team members only)	▪ When you begin your leave of absence, your HSA contributions will stop.
Long-Term Disability	▪ You may drop coverage.
Supplemental Life Insurance—Team Member	▪ You may decrease or drop coverage.
Supplemental Life Insurance—Spouse or Domestic Partner and Child	▪ No changes allowed. If a team member drops coverage, any spouse/domestic partner and child coverage would also be dropped.
Critical Illness Insurance (U.S. Team Members)	▪ Coverage can continue if you make benefit contributions through the direct billing process.
Accidental Injury Insurance (U.S. Team Members)	▪ Coverage can continue if you make benefit contributions through the direct billing process.

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Benefit Plan	Allowed Changes and Considerations
Other Benefit Considerations	▪ 401(k) Plan deductions continue if you have eligible pay.

Qualified Status Changes While on Leave

In general, when you are out on a leave, you can only make changes to your benefits if a qualified status change affects your, your spouse's/domestic partner's or your child's eligibility for benefits. If you are eligible to make a change, the change must be consistent with the qualified status change and the change must correspond to any change your spouse/domestic partner or child makes to his or her coverage under another employer's plan. For more information about qualified status changes and on when you can make related benefits coverage changes, refer to the "Life Events" section.

Contributions for Benefits Coverage While on Leave

When you are on a leave of absence, you are responsible for your contributions for benefits coverage. Generally, if you are being paid by Dell (such as for base pay, Paid Parental Leave, Paid Caregiver Leave or Short-Term Disability benefits), your contributions (except 401(k) contributions when on Short-Term Disability) will continue through Company payroll deductions. If you are approved for the Company's Military Supplemental Pay Program, contributions (including 401(k) contributions) will continue to be deducted from your paychecks for the period of time you are eligible for the Supplemental Pay Program unless you timely elect to suspend your benefits coverage.

When you are unpaid (that is, not receiving a paycheck from Dell) or if you only receive Long-Term Disability benefits from Dell's Leave and Disability Administrator, you must pay contributions directly to the benefits administrator. Direct billing for contributions that must be made outside of the Company payroll process will happen automatically, and you will receive a letter notifying you of this at your home address. If you do not make your direct billing payments, your coverage will end retroactively to your last paid-through date. To reinstate coverage while you are on leave, you must contact the Dell Benefits Center. The past due amount must be remitted timely.

Note: After 24 months from the date of leave (except Military Leave) or disability, life insurance will end, and team members will have the option to port or convert coverage to an individual policy with MetLife. When the team member is on Military Leave, life insurance will end after five years of leave, and the team member will have the option to port or convert coverage to an individual policy with MetLife.

Refer to the "Benefits Coverage When Returning From Leave of Absence" section for details on reinstating or continuing coverage after your leave ends.

If you have any questions about contributions while on leave, contact the Dell Benefits Center at 1-888-335-5663.

Benefits Coverage When Returning From Leave of Absence

If you make an affirmative election through the Dell Benefits Center to discontinue coverage at any time during your FMLA leave, or if you elect to suspend coverage within 31 days of the start of your military leave, or if your coverage under this Plan is discontinued during your FMLA or military leave for any reason

other than your premium payments not being made timely, when you return to work your coverage can be restored to the same level of benefits as those you would have had if the leave had not been taken if you contact the Dell Benefits Center within 31 days of your return to elect coverage restoral. In addition, since Dependent Care (Day Care) Flexible Spending Account contributions and HSA contributions (U.S. team members only) are stopped automatically during all leaves of absence, you will need to elect to reinstate your Dependent Care (Day Care) FSA contributions within 31 days of your return from leave if you wish to continue participating. If you are a U.S. team member, you will also need to take action to reinstate your HSA contribution as well but there is no time frame in which this must be done. When you return to work and elect to restore benefits coverage, you will not be required to make up premium payments if you had made such an affirmative election to discontinue coverage. This includes coverage for eligible dependents. You will not be required to meet any initial qualification requirements when returning to work; this includes new or additional waiting periods, waiting for an enrollment period or passing a medical exam to reinstate coverage.

If you do not elect to drop or suspend coverage at the beginning of your leave and your coverage under this Plan is later discontinued during your leave as a result of premium payments not being made timely, when you return to work your coverage may be restored to the same level of benefits only if you contact the Dell Benefits Center within 31 days to request reinstatement. Company payroll will automatically deduct retroactive premium payments from your future paychecks to cover your missed payments and will also begin to deduct your prospective premium payments. If you do not request reinstatement according to the requirements of this reinstatement process, you must wait until the next annual enrollment to enroll in benefits coverage.

If you do not return to work timely according to leave policy, your employment and benefits may be ended. Refer to the “Loss of Plan Eligibility or Termination of Employment” section for additional information on impact to benefits.

Note: To be reinstated to active employment status and avoid any pay implications or system access issues upon your return from a leave, you must contact the Leave and Disability Center at 1-855-857-0325 once you physically return to work and confirm your return. You may also log on to mySedgwick.com/Dell and report your return to work within your claim.

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Short-Term Disability (STD) Program

Overview

The Short-Term Disability (STD) Program provides continuation of your pay for approved disabilities that are due to an illness or injury not covered by workers' compensation benefits. Any time you are absent for a medical reason for more than three consecutive days, you must report your absence to the Leave and Disability Center (Sedgwick) by calling 1-855-857-0325. You may also log on to mySedgwick.com/Dell and initiate your claim. This program is paid 100% by Dell. You do not need to enroll or make a contribution to participate.

If covered under a Dell Medical Program, your medical coverage continues while receiving STD pay benefits, as long as you meet other Plan requirements (for example, enrollment). Any medical premiums and after-tax deductions are deducted from your STD payment, which is considered taxable income.

STD Eligibility and Waiting Period

You are eligible for coverage under the STD Program if you are an eligible team member as described in the “Eligibility” section.

If you are an eligible team member, you must work 30 calendar days from the date you are first eligible before coverage is effective. This is called a waiting period. You are not eligible to receive STD benefits for a disability that begins during this time. You are eligible to receive STD benefits for a disability that begins after the 30-day waiting period as further defined under “Successive Periods of Disability” in the “Short-Term Disability Benefits” section.

Your eligibility for coverage under the STD Program ends on the date you terminate your employment with Dell or recover from your disability, but fail to return to work. There is no conversion option, which means that you cannot continue this coverage as a private insurance policy.

If your employment is terminated and you are later rehired, you must complete a new 30-calendar-day waiting period before coverage is effective unless your termination and rehire occur within the same 12-month period. If rehired within the same 12-month period, prior service is reinstated and you do not need to meet a new 30-calendar-day waiting period requirement.

Definition of Disabled for STD Benefits

You are eligible to receive STD benefits when you are determined to be disabled for at least seven consecutive calendar days by the Leave and Disability Center.

To be disabled, the Leave and Disability Center must determine:

- You are incapable of performing the material duties of your regular occupation or any reasonably related occupation with Dell solely due to:
  - A valid mental and/or behavioral condition;
  - Your status as a resident in either an alcohol or drug abuse treatment program;

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    - Your participation in an outpatient program for the treatment of alcohol or drug abuse that requires attendance at least five calendar days per week for a minimum of six hours each day;
    - A physician, appropriate for your illness or injury and approved by the Leave and Disability Center, has determined that you are unable to perform the material duties of your regular occupation solely because of an injury or illness; or
    - You are ordered not to work by written order from a state or local health officer because you have or are suspected of having a communicable disease;
- Following your elimination period (see the "Short-Term Disability Benefits" section for elimination period information), your current monthly earnings are less than 80% of your pre-disability earnings;
- A disability is substantiated by significant objective findings and the physician provides substantial appropriateness of care documentation that supports you are rendered disabled;
- You are not performing work of any kind for pay or profit, unless the work is performed with the prior approval of the Leave and Disability Center; and
- You have not declined to perform alternative temporary employment generally comparable to your previous occupation that is offered and determined to be within your physical and mental capabilities. The Leave and Disability Center makes this determination on the basis of substantial appropriateness of care, medical evidence and any other information that may be relevant.

You may be required to submit to a physical examination by a physician chosen by the Leave and Disability Center or to provide other evidence or information the Leave and Disability Center deems appropriate.

Conflicts with managers, shifts and/or work place settings will not be factors supporting disability under the Plan.

The Leave and Disability Center will work closely with your health care provider to obtain all required supporting information, however, the responsibility for establishing a disability is yours.

You will not be entitled to receive benefits if your disability is related to or results from any of the following:

- An intentional self-inflicted injury or illness.
- A disabling event that occurs within the first 30 days of your employment.
- Declared or undeclared war or act of war (except when traveling for the Company on approved company business).
- Active duty injury.
- Committing or trying to commit a felony or engagement in an illegal occupation or action.
- Incarceration in any federal, state or municipal penal institution, jail, medical facility or hospital (public or private).
- A work-related illness or injury for which you receive or may be entitled to receive compensation or benefits under any workers' compensation, occupational injury or disability insurance law; provided, however, that if you cease to receive or be eligible for such benefits or compensation, you may then be eligible to receive an STD benefit.
- Illness or injury for which you are not under the continuous care and treatment of a duly qualified health care practitioner.
- Cosmetic surgery (elective surgery), unless such surgery is in connection with an illness or injury and you are deemed disabled. This exclusion will not apply to complications arising from cosmetic (elective) surgery.

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Short-Term Disability Benefits

You must contact the Leave and Disability Center within eight calendar days of your disability to be eligible for Short-Term Disability benefit payments starting on the eighth day of disability, unless the Plan determines that it was not reasonably possible under the circumstances to provide notice of the claim within such time frame. Failure to timely report your claim could result in the denial of your claim. If eligible, STD benefits may begin on the eighth day of your certified disability; STD benefits end after a maximum of 173 continuous calendar days (after the elimination period). STD benefit payments will stop once you have been disabled for 180 calendar days under a continuous disability claim or 180 cumulative days as noted under the "Successive Periods of Disability" subsection below.

The first continuous seven calendar days you are disabled and not performing any work for pay or profit is considered an **elimination period**. During the seven-day elimination period, you are required to take **five** workdays of PWT or Vacation, to be paid for your time off. If you do not have five days of PWT or Vacation to submit to Payroll for payment, those days will go unpaid. The seven-calendar-day elimination period is applied per disability as further defined under "Successive Periods of Disability" in this section.

The Short-Term Disability Program pays benefits as follows:

- STD benefits are calculated based on a seven-day calendar week.
- 100% of your daily benefit-eligible earnings or total target compensation (TTC) for Sales roles for eight weeks of disability after your elimination period;
- 75% of your daily benefit-eligible earnings or total target compensation (TTC) for Sales roles up to a maximum of 180 days per incident (less your elimination period and eight-week period paid at 100%); and
- A maximum of 173 calendar days of benefits are payable per incident, inclusive of both the 100% and 75% benefit payment periods.

Daily Earnings means your annual benefit-eligible earnings or total target compensation (TTC) for Sales roles, which will be determined on the date you are certified as disabled by the Leave and Disability Center, divided by the number of pay periods in the year (26), divided by the number of calendar days in the pay period (14). (This calculation is based on your actual number of pay periods in a year.)

Disability earnings means the earnings which you receive for work performed while you are disabled.

The Leave and Disability Center will determine, in its exclusive discretion, the amount of your Daily Earnings and its determination will be binding on all persons.

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If you work while you are entitled to receive STD Program benefits, your STD Program benefit will be calculated as follows:

1. We will not pay you for any week during which disability earnings exceed 80% of weekly earnings.
2. If you are disabled and your earnings are less than 80% of your weekly earnings, your benefit will be calculated as follows:

    - For each of the first eight weeks following the Elimination Period, 100% of the difference between your pre-disability daily earnings and your earnings while disabled; and
    - After the first eight weeks following the Elimination Period, you will receive payments based on the percentage of income you are losing due to your disability up to a total of 75% of your pre-disability earnings, up to a maximum of 173 calendar days of benefits payable per incident, inclusive of both the 100% and 75% benefit payment periods. This will be calculated as follows:
        - Subtracting your disability earnings from your daily earnings.
        - Dividing the answer in the first bullet above by your pre-disability daily earnings. This is your percentage of lost earnings.
        - Multiplying your STD Program benefit as shown above by the answer in the second bullet above to determine your payment amount.

Benefit Reduction

Any benefit payments you receive under the Short-Term Disability Program will be reduced by benefits you receive from:

- Company-paid sick pay and salary continuation;
- A state or other legislated disability and/or paid leave plan; and
- No-fault automobile insurance or any other third-party benefits that are paid or payable to you for the same period for which the STD benefits are payable (execution of a reimbursement agreement may be required).

If you are entitled to any of these benefits but do not claim them, your benefit will be reduced by the amount you would have received if you had claimed them. If you are eligible for Dell STD Program benefits and claim any of the above, you are eligible for Dell STD Program benefits while waiting to receive the other forms of benefit payment. The Leave and Disability Center will automatically deduct the maximum weekly state benefit to offset your STD benefit unless an Explanation of Benefits is provided confirming the actual state benefit provided.

If benefits are paid in excess of the benefits to which you are entitled, regardless of the cause, it is your obligation and responsibility to repay Dell the amount of the overpayment. If the overpayment is not repaid within a reasonable time, Dell will withhold from any future benefit payments and may withhold from any future compensation to recover such overpayment.

You are required to notify the Leave and Disability Center in writing within 15 calendar days of any increase in the above sources, awards or settlements, which will result in an adjustment to your STD benefits. Failure to provide such notice will reduce the STD benefits payable by the amount of the unreported increase.

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Successive Periods of Disability

Successive periods of disability due to the same or related causes are considered one disability under the Short-Term Disability Program, unless separated by a return to your normal work (full duty) schedule for more than 14 consecutive calendar days. If a relapse happens **within 14 days** after your return to work, benefits will be classified under the original claim and payments will resume at the point your benefits ended. A claim reported **after 14 days** of your return to work will be considered a new claim and a seven-calendar-day elimination period must be met. Then, if approved, the benefit will then pay under a new "eight weeks at 100% of eligible pay" benefit level.

If you continue to be disabled for more than 180 days, your STD claim will be reviewed to determine your eligibility for Long-Term Disability (LTD). **However, to be eligible for LTD claim consideration following an STD claim, you must be enrolled in LTD prior to the beginning of the disability and you must have properly and timely applied for the LTD claim.**

Timing and Form of Disability Payments

After you have submitted all the needed information, your claim will be evaluated. If your claim is approved, the amount of your benefit will be calculated and you will be paid through the regular Dell payroll process. Your subsequent benefit payments will be made according to your normal pay schedule.

When STD Payments End

STD benefit payments will stop:

- Once you have been disabled for 180 calendar days under a continuous disability claim or 180 cumulative days as noted in the "Successive Periods of Disability" subsection under "Short-Term Disability Benefits";
- When you are no longer disabled (as defined by the Plan);
- When you die;
- When you refuse or fail to participate fully in an independent medical examination ordered by the Leave and Disability Center;
- When you are no longer under the regular, continuous care and treatment of a licensed physician, or you refuse to follow the treatment plan prescribed by your health care practitioner that the Leave and Disability Center determines can be expected to restore your functional ability;
- When you fail to furnish information about your disability within 15 calendar days following a written request by the Leave and Disability Center; or
- On the date that your employment with Dell is terminated for misconduct or violation of a written code of conduct.

Benefits may resume once you comply with the above requirements; however, in no event will you be paid benefits for a period when you were not in compliance with the Program.

When your STD payments end, you will receive a direct-billing letter from the Dell Benefits Center to continue your Dell medical, dental and/or vision coverage if you are still an active team member. If you are no longer an active team member, you will receive information about continuing coverage under COBRA. You are responsible for paying the applicable premiums or COBRA costs regardless of whether you are eligible for LTD. If you are not eligible to receive LTD benefits and you have a gap where you were not receiving STD payments before your return to work, you are responsible for paying your portion of any premiums.

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When STD Program Participation Ends

Eligibility continues until any of the following:

- You are no longer employed by the Company;
- You are scheduled to work less than 20 hours per work week;
- Dell changes the Program's eligibility requirement or terminates the Program all together;
- You fail to pay any required contribution; or
- The date you retire.

Note: Your health coverage will end when you are no longer employed by the Company; however, you will be offered COBRA continuation coverage and your STD benefit payments will continue if eligible.

If your date of disability is before any of the above and your STD claim is approved, you will receive payment(s).

There is no conversion or continuation of STD coverage once participation ends.

Filing an STD Claim

You must notify the Leave and Disability Center no later than eight calendar days after you become disabled. Failure to notify the Leave and Disability Center within 30 calendar days of your disability may result in the denial of your claim. You must call 1-855-857-0325 to report your claim. You may also log on to mySedgwick.com/Dell and initiate a claim. For additional information about claims and appeals, see the "Claims and Appeals Procedures" section.

If you have filed a claim for workers' compensation, which is then denied, you must notify the Leave and Disability Center to pursue benefits under the Short-Term Disability Program. These claims will not be considered late filing under the terms of the Short-Term Disability Program.

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Long-Term Disability (LTD) Program

Overview

The Long-Term Disability (LTD) Program provides monthly benefits to qualifying team members who are disabled (according to the definition of disability in the policy document) because of an illness or injury. While you are disabled, if eligible, the LTD Program will pay a portion of your **Annual Eligible Earnings** after you have exhausted the 180-day LTD elimination period. Annual Eligible Earnings will be determined on your initial date of disability.

If you enroll for LTD coverage while you are off work due to a disability, you must return to active work status before the coverage becomes effective.

Important: You must be enrolled in LTD coverage before incurring a disability. If you opted out of coverage, yet have a disability that requires you to be away from work for more than 180 calendar days, you will not be eligible to receive income under this program or any other programs. In addition, if you opt out of coverage within 31 days of your hire date, you will not have another opportunity to enroll until the next annual enrollment, unless you have a qualified status change or special enrollment event during the year. Also, if you waive your option to enroll in LTD coverage at any time, you will be required to provide Evidence of Insurability (EOI) to the insurance company if you wish to enroll at a later date. During enrollment you will complete the EOI process online. Your LTD coverage will go into effect the date EOI is approved.

Transitioning to LTD Benefits

LTD benefits may begin once you have been totally disabled for at least 180 days. If you have LTD coverage, your claim will be evaluated before the exhaustion of your LTD elimination period or upon request for an LTD claim to determine if your condition qualifies for LTD coverage. Generally, by the time you need to apply for LTD benefits, you have already contacted the Leave and Disability Center for STD benefits.

If you have a medical condition that requires you to be absent from work for more than 180 calendar days (such as an injury covered by workers' compensation), the Leave and Disability Center can provide detailed information about how to file a claim; additional claims and appeals information is included in the “Claims and Appeals Procedures” section.

Eligible LTD Program Disabilities

You are disabled when the Leave and Disability Center determines that you:

- Are unable to perform the material and substantial duties of your regular occupation due to your sickness or injury;
- Are under the regular care of a doctor; and
- Have a 20% or more loss in your monthly earnings due to that sickness or injury.

After 24 months of payments, you are disabled when the Leave and Disability Center determines that, due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience, and unable to earn 80% or more of your indexed earnings, and you are under the regular care of a doctor.

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If you have elected and continued to pay for LTD coverage and you have a disability that continues beyond the 180 continuous calendar days, you may be eligible for LTD benefits. The days that you are not disabled will not count toward your 180-day elimination period.

You will automatically be advised of your LTD benefit eligibility by the Leave and Disability Center, unless you are receiving workers' compensation benefits. If you are receiving workers' compensation benefits, please contact the Leave and Disability Center to submit your LTD claim.

You will not be entitled to receive benefits if your disability is related to or results from any of the following:

- Suicide, attempted suicide or self-inflicted injury while sane or insane.
- War or any act of war, whether or not declared.
- Commission of a felony.
- Active participation in a riot.
- The revocation, restriction or non-renewal of an employee's license, permit or certification necessary to perform the duties of his or her occupation unless due solely to injury or sickness otherwise covered by the Plan.

In addition, the plan will not pay disability benefits for any periods of disability during which you are incarcerated in a penal or correction institution.

Pre-Existing Condition

A pre-existing condition is an illness or injury that is diagnosed or treated within three months before the effective date of your LTD coverage and the disability begins in the first 12 months after your effective date of coverage. The LTD claim administrator reviews the medical information submitted by your treating physician(s) and makes the determination of whether there is a pre-existing condition.

Long-Term Disability Benefit

If you are eligible for LTD benefits, you will receive up to 60% of your benefit-eligible earnings from all sources of income, up to a maximum monthly benefit of $10,000. Your net LTD benefit will be reduced by applicable taxes on the portion of your LTD premiums paid for by the Company. Your Daily Earnings are determined exclusively by the Leave and Disability Center.

The LTD claim administrator will issue your LTD payment checks directly to you on a monthly basis.

Your total LTD benefit is payable from several sources. These sources work together to give you a benefit equal to the replacement percentage offered by the LTD Program. You should apply for all disability benefits for which you might be eligible because the LTD Program will assume that you are eligible for other benefits when calculating your LTD benefit.

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Sources of other benefit payments are:

- Loss-of-time benefits under a workers' compensation law, an occupational disease law or any other act or law with similar intent.
- Loss-of-time disability income payments under a state compulsory benefit act or law, automobile liability insurance policy, other insurance or health or welfare plan or group insurance plan where the employer has directly or indirectly paid all or part of the cost or made payroll deductions, or governmental retirement system as the result of a team member's job with his or her employer.
- Loss-of-time disability payments to a team member, spouse and children under the United States Social Security Act, the Railroad Retirement Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act.
- Retirement payments to a team member, spouse and children under the United States Social Security Act, the Railroad Retirement Act, the Canada Pension Plan, the Quebec Pension Plan, or any similar plan or act.
- Retirement benefits, including early retirement benefits, disability retirement benefits and regular retirement benefits—from the employer's retirement plan.
- 50% of Wages portion of benefits received under the maritime doctrine of maintenance, wages and cure.
- Loss-of-time benefits under any salary continuation or accumulated sick leave to the extent the monthly payment and deductible source of income exceed or would exceed 100% of monthly earnings.
- A monetary amount received from a partnership, proprietorship or any similar draws.

If you receive benefits from other sources in a lump sum, adjustments to your LTD benefits will be made as if you received them in monthly installments. Once you provide proof of receipt or denial of other benefits, the Plan will adjust your LTD benefit to reflect the receipt or denial. Your monthly benefit will be reduced by the amount of any other disability income you are eligible to receive from other sources. However, your monthly benefit will not be reduced below $100 or 10% of your gross monthly benefit, whichever is greater. The LTD claim administrator will issue your LTD payment checks directly to you on a monthly basis.

If you work while you are disabled, your LTD benefits may be affected. Contact the Leave and Disability Center for information regarding how your earnings while you are disabled will affect your LTD benefit.

Note: If eligible for COBRA, you may be able to extend your continuation coverage period; refer to "Disability Extension (while on COBRA)" in the "COBRA Continuation Coverage" section.

Periods of Disability

If the periods of disability are due to different causes and you return to work for at least one full day or more, they are considered separate LTD claims. Also, after receiving LTD benefits, if the periods of disability are due to the same cause or causes and you return to work for six months or more, they are considered separate LTD claims.

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If a temporary recovery does not exceed six months and it is for the same cause, the subsequent period of disability is considered the same LTD claim. As a result:

- You will not have to complete another 180-day LTD waiting period;
- The pre-disability earnings used to determine your LTD benefit will not change;
- The period of temporary recovery will not count toward your LTD benefit waiting period, maximum benefit period or your own occupation period; and
- You will not be paid LTD benefits for periods of temporary recovery.

If you return to work and become disabled again, your LTD benefits may be affected, depending on the period you were back at work.

Additional Benefits

Survivor Benefit

If your disability benefits had continued for 180 or more consecutive days, your survivor may be eligible to receive a survivor benefit equal to three months of your gross disability payment.

Enhanced Rehabilitation Benefit

If the insurance company determines that you are a suitable candidate for rehabilitation, the insurance company may require you to participate in a rehabilitation plan and assessment at their expense. The insurance company has the sole discretion to approve your participation in a rehabilitation plan and to approve a program as a rehabilitation plan. The insurance company will work with you, Dell and your physician and others, as appropriate, to perform the assessment, develop a rehabilitation plan, and discuss return to work opportunities. The rehabilitation plan may, at the insurance company's discretion, allow for payment of your medical expense, education expense, moving expense, accommodation expense or family care expense while he or she participates in the program.

When LTD Benefit Payments End

Benefits will continue until the earliest of the following dates:

- You are no longer disabled under the terms and conditions of the Plan;
- You die;
- During the first 24 months of payments, when you are able to work in your regular occupation on a part-time basis, but choose not to;
- After the first 24 months of payments, when you are able to work in any gainful occupation on a part-time basis, but choose not to;
- If you are working, the date your current monthly earnings while disabled are greater than 80% of your pre-disability earnings;
- You reach the end of the maximum benefit period. Refer to the chart below to determine your maximum benefit period; or
- The date you fail to submit proof of a continuing disability satisfactory to the Leave and Disability Center.

You will stop receiving payments while you are incarcerated as a result of a conviction.

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In addition to the above, payments will end when you reach your maximum benefit period, which is as follows:

Age When Disability Begins	Maximum Benefit Period
62 or under	Your 65th birthday or 42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

When your LTD payments end, the LTD claim administrator will notify you. If you are on COBRA, your COBRA continuation coverage can continue for the duration of your COBRA eligibility period. If you return to active work with the Company, you will have the option to make elections based on your qualified status change. Contact the Dell Benefits Center for information about how LTD benefits impact your other benefit coverage.

If you continue to be unable to work, you may want to contact the Social Security Administration for information about any disability benefits that may be available.

Note: Your health coverage will end when you are no longer employed by the Company; however, you will be offered COBRA continuation coverage and your LTD benefit payments will continue if eligible.

Mental Illness, Alcohol and Drug Abuse Benefit Restriction

You will no longer be considered as disabled and eligible for LTD monthly benefits after benefits have been payable for 24 months if it is determined that your disability is due in whole or in part to:

- A mental health or psychiatric condition, including physical manifestations of these conditions; or
- Alcohol and/or drug abuse.

There are exceptions that permit payments to continue after 24 months if you are confined in a hospital or institution. Contact the Leave and Disability Center for information on these exceptions. The rules under “Periods of Disability” in the “Long-Term Disability Benefit” section do not apply beyond 24 months to disabilities subject to these benefit restrictions.

Disability That Occurs During an Expatriate Assignment Outside the United States or Canada

If you are on Expatriate assignment outside of the United States and other Home Area Locations, you are enrolled in LTD, and if you otherwise meet the criteria LTD coverage, you remain covered under LTD as long as you return to reside within the Home Area within 12 months of the start date of your disability. Your LTD coverage will not end solely due to living outside of the Home Area Locations for an extended period of time. “Home Area Locations” are defined as the United States, the Dominion of Canada, the Commonwealth of Puerto Rico, Guam and the Virgin Islands of the United States.

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When LTD Program Participation Ends

Your coverage under the LTD Program ends on the earliest of the:

- Date you are eligible for coverage under a plan intended to replace this coverage;
- Date you reach your maximum benefit period;
- Date the LTD Program is cancelled;
- Date you are no longer eligible to participate in the Program;
- Date you have exhausted benefits available under the Program;
- Date benefits end for failure to comply with the terms and conditions of the Plan;
- Last day of the period for which you made any required contributions; or
- Last day you are in active employment except as otherwise provided by the LTD Program.

Taxation of LTD Benefits

Since Dell pays a portion of your LTD premiums, that portion of your LTD benefits will be taxable to you.

The benefit amount is based on your pre-disability earnings and can be reduced if receiving additional income from other employers, self-employment, etc.

For more detailed tax information, contact the Plan Administrator.

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Basic Life and Accidental Death and Dismemberment (AD&D) Insurance Program for Team Members

Overview

Dell provides basic life insurance benefits to your designated beneficiary if you die. Dell also provides AD&D insurance benefits if you die or lose a limb as the result of an accident. AD&D benefits are payable for losses that are the direct result of and occur within 12 months of an accident.

Basic Life Insurance Coverage for Team Members

You automatically have life insurance coverage equal to two times the amount of your benefit-eligible earnings, up to a maximum of $1,500,000. If your benefit-eligible earnings are not an even multiple of $1,000, your benefit-eligible earnings will be rounded up to the next higher multiple of $1,000 before your Basic Life coverage is calculated. To avoid any potential imputed income tax, you may elect a flat $50,000 basic life insurance benefit.

Benefit-eligible earnings are your salary and targeted sales commissions. Benefit-eligible earnings do not include bonuses, overtime pay, shift differential, profit sharing or extra compensation.

If you want to purchase additional life insurance coverage, you may apply for enrollment in the Supplemental Life Insurance Program. See the “Supplemental Life Insurance Coverage” section for more information.

Note: After 24 months from the date of your leave (except Military Leave) or disability, life insurance will end and team members will have the option to port or convert coverage to an individual policy with MetLife. When the team member is on Military Leave, life insurance will end after five years of leave, and the team member will have the option to port or convert coverage to an individual policy with MetLife.

Basic Life Insurance Benefit Payment

If you die, the Life Claims Administrator will pay benefits to your beneficiary.

Living Benefit/Accelerated Benefit Option

If you are diagnosed with a terminal illness which directly results in a life expectancy of 24 months or less, you may request early payment of up to 100% up to a maximum of $1,000,000 of your Basic Life and Supplemental Life Insurance coverage combined. For more information on this accelerated benefit option, contact the Dell Benefits Center at 1-888-335-5663.

Taxation of Basic Life Insurance Coverage for Team Members

Federal law requires you to pay income taxes on the value of any Dell-paid basic life insurance coverage that is over $50,000. This is called imputed income. Your imputed income, if any, will appear on your paycheck stubs and will be reported as income on your W-2 Form.

Note: Imputed income does not apply to AD&D benefits.

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

Basic Life Insurance Coverage Exclusions

Currently, there are no basic life insurance coverage exclusions. Death by suicide may be excluded or limited in some states, please see the Certificate of Coverage for additional detail.

AD&D Coverage for Team Members

Written proof of loss must be furnished to the Company within 90 days after the date of the loss. If the loss is one for which the policy requires continuing eligibility for periodic benefit payments, subsequent written proofs of eligibility must be furnished periodically. Failure to furnish proof within the time required neither invalidates nor reduces any claim if it was not reasonably possible to provide it within the time frame specified, provided the proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the team member, later than one year from the time proof is otherwise required.

AD&D Benefit Payment

Upon receipt of due written proof of death, payment for loss of life of a covered person will be made to the covered person’s beneficiary.

Time of Payment of Claims

Benefits payable under this Plan for any loss other than loss for which this Plan provides any periodic payment will be paid immediately upon the Company’s receipt of due written proof of the loss, but in no event more than 60 days from receipt of proof of loss. Once the Company receives written proof of loss, all accrued benefits for loss for which this Plan provides periodic payment will be paid at the expiration of each month during the continuance of the period for which the Company is liable and any balance remaining unpaid upon termination of liability will be paid immediately upon receipt of the proof of loss.

If the injury results in death within 365 days of the date of the accident that caused the injury, the Company will pay 100% of the principal sum.

Injury means bodily injury: (1) which is sustained as a direct result of an unintended, unanticipated accident that is external to the body and that occurs while the injured person's coverage under the plan is in force, and (2) which directly (independent of sickness, disease, mental incapacity, bodily infirmity or any other cause) causes a covered loss.

Maximum AD&D Coverage Amount

You automatically have AD&D insurance coverage equal to two times your benefit-eligible earnings, subject to a minimum of $50,000 and up to a maximum of $1,500,000. Your coverage amount will be rounded up to the next higher multiple of $1,000, if not already a multiple of $1,000.

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The amount this coverage pays depends on the type of loss, as follows:

Covered Losses	Percentage Covered
Loss of life	100%
Loss of hand completely severed through or above the wrist joint	50%
Loss of foot completely severed through or above the ankle joint	50%
Loss of sight in one eye	50%
Loss of any combination of hand, foot or sight of one eye	100%
Loss of thumb and index finger on same hand	25%
Loss of speech and loss of hearing (in both ears)	100%
Loss of speech or loss of hearing (in both ears)	50%
Quadriplegia	100%
Paraplegia	100%
Hemiplegia	100%
Uniplegia	25%
Coma	1% monthly for 11 months if the covered person remains comatose due to that injury

AD&D Covered Losses

- **Loss of Sight:** Loss of sight means total and irrecoverable loss of the entire sight in that eye.
- **Loss of Thumb and Index Finger on Same Hand:** Loss of thumb and index finger means complete severance through or above the metacarpophalangeal joint of both digits.
- **Loss of Speech:** Loss of speech means total and irrecoverable loss of the entire ability to speak.
- **Loss of Hearing:** Loss of hearing in an ear means total and irrecoverable loss of the entire ability to hear in that ear.
- **Quadriplegia:** Quadriplegia means the complete and irreversible paralysis of both upper and both lower limbs.
- **Paraplegia:** Paraplegia means the complete and irreversible paralysis of both lower limbs.
- **Hemiplegia:** Hemiplegia means the complete and irreversible paralysis of the upper and lower limbs of the same side of the body.
- **Uniplegia:** Uniplegia means the complete and irreversible paralysis of one limb. “Limb” means entire arm or entire leg.
- **Coma:** Coma means a profound state of unconsciousness from which the covered person cannot be aroused to consciousness, even by powerful stimulation, as determined by a physician.

Limitation on Multiple Benefits

If a covered person suffers one or more losses from the same accident for which amounts are payable under more than one of the following benefits provided under the policy, the maximum amount payable under all of the benefits combined will not exceed the amount payable for one of those losses, the largest: accidental death benefit, accidental dismemberment benefit, paralysis benefit and coma benefit.

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Exposure and Disappearance

If by reason of an accident occurring while a covered person's coverage is in force under the Plan, the covered person is unavoidably exposed to the elements and as a result of that exposure suffers a loss for which a benefit is otherwise payable under the Plan, the loss will be covered under the terms of the Plan.

If the body of a covered person has not been found within one year of the disappearance, forced landing, stranding, sinking or wrecking of a conveyance in which the person was an occupant while covered under the Plan, then it will be deemed, subject to all other terms and provisions of the Plan, that the covered person has suffered accidental death within the meaning of the Plan.

AD&D Seatbelt Use Benefit

The Company will pay a benefit when the covered person suffers accidental death such that an accidental death benefit is payable under the Plan and the accident causing death occurs while the covered person is operating, or riding as a passenger in, an automobile and wearing a properly fastened, original, factory-installed seatbelt or, if the covered person is a child, a properly installed and fastened child restraint device as defined by state law. The amount payable is the lesser of:

- $50,000; or
- 10% of the covered person's principal sum.

Verification of the actual use of the seatbelt, at the time of the accident must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s).

AD&D Airbag Benefit

The Company will pay an additional benefit if a seatbelt benefit is payable under this Plan and if the covered person is positioned in a seat protected by a properly functioning, original, factory-installed supplemental restraint system that inflates on impact. The additional amount payable is the lesser of:

- $50,000; or
- 10% of the covered person's principal sum.

Verification of the actual use of the seatbelt, at the time of the accident, and that the supplemental restraint system inflated properly upon impact must be a part of an official report of the accident or be certified, in writing, by the investigating officer(s).

Emergency Evacuation Benefit

The Company will pay for covered emergency evacuation expenses reasonably incurred if you suffer an injury or emergency sickness that warrants your emergency evacuation while you are outside a 100-mile radius from your current place of primary residence.

The physician ordering the emergency evacuation must certify that the severity of your injury or emergency sickness warrants your emergency evacuation. All transportation arrangements made for the emergency evacuation must be by the most direct and economical conveyance and route possible.

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Texas Department of Human Services Reimbursement (Applicable to Texas Residents)

Benefits paid on behalf of a covered person must be paid to the Texas Department of Human Services, if such covered person is eligible for benefits under this benefit and is also entitled for benefits for the same expense from the Texas Department of Human Services.

Family Travel Benefit

Following an emergency evacuation for which an emergency evacuation benefit is payable under the Plan, the Company will pay for expenses reasonably incurred to:

- Return to your current place of primary residence, with an attendant if necessary, any of your children who were accompanying you when the injury or emergency sickness occurred; but not to exceed the cost of a single one-way economy airfare ticket less the value of applied credit from any unused return travel tickets per child; and
- Bring one person chosen by you to and from the hospital or other medical facility where you are confined if you are alone and if the place of confinement is outside a 100-mile radius from your place of primary residence; but not to exceed the cost of one round-trip economy airfare ticket.

Travel Guard Group, Inc. must make all arrangements and must authorize all expenses in advance for any benefits to be payable. The Company reserves the right to determine the benefit payable, including reductions, if it is not reasonably possible to contact Travel Guard Group, Inc. in advance.

Rehabilitation Benefit

If you suffer an accidental dismemberment or an accidental paralysis for which an accidental dismemberment or paralysis benefit is payable, the Company will reimburse you for covered rehabilitative expenses that are due to the injury causing the dismemberment or paralysis. The covered rehabilitative expenses must be incurred within two years after the date of the accident causing that injury, up to a maximum of $25,000 for all injuries caused by the same accident.

Hospital

As used in this section, means a facility that:

- Is operated according to law for the care and treatment of injured people;
- Has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis;
- Has 24-hour nursing service by registered nurses (R.N.s); and
- Is supervised by one or more physicians.

A hospital does not include:

- A nursing, convalescent or geriatric unit of a hospital when a patient is confined mainly to receive nursing care;
- A facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged; nor does it include any ward, room, wing or other section of the hospital that is used for such purposes; or
- Any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or government agency for the treatment of members or ex-members of the armed forces.

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Medically Necessary Rehabilitative Training Service

As used in this section, means any medical service, medical supply, medical treatment or hospital confinement (or part of a hospital confinement) that:

- Is essential for physical rehabilitative training due to the injury for which it is prescribed or performed;
- Meets generally accepted standards of medical practice; and
- Is ordered by a physician.

Covered Rehabilitative Expense(s)

As used in this section, means an expense that:

- Is charged for a medically necessary rehabilitative training service performed under the care, supervision or order of a physician;
- Does not exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred (for a hospital room and board charge, does not exceed the most common charge for hospital semi-private room and board in the hospital where the expense is incurred); and
- Does not include charges that would not have been made if no insurance existed.

Covered rehabilitative expenses do not include any expenses for or resulting from an injury for which you are entitled to benefits paid or payable by workers' compensation or other similar law.

Texas Department of Human Services Reimbursement (Applicable to Texas Residents)

Benefits paid on behalf of a covered person must be paid to the Texas Department of Human Services, if such covered person is eligible for benefits under this benefit and is also entitled for benefits for the same expense from the Texas Department of Human Services.

Repatriation of Remains Benefit

If you die due to injury or emergency sickness while outside a 100-mile radius from your current place of primary residence, the Company will pay for covered expenses reasonably incurred to return your body to your current place of primary residence.

Covered expenses include, but are not limited to, expenses for:

- Embalming or cremation;
- The most economical coffins or receptacles adequate for transportation of the remains; and
- Transportation of the remains by the most direct and economical conveyance and route possible.

Travel Guard Group, Inc. must make all arrangements and must authorize all expenses in advance for this benefit to be payable. The Company reserves the right to determine the benefit payable, including any reductions, if it was not reasonably possible to contact Travel Guard Group, Inc. in advance.

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Emergency Sickness

As used in this section, means an illness or disease, diagnosed by a physician, which meets all of the following criteria:

- There is a present severe or acute symptom requiring immediate care and the failure to obtain such care could reasonably result in serious deterioration of your condition or place your life in jeopardy;
- The severe or acute symptom occurs suddenly and unexpectedly; and
- The severe or acute symptom occurs while the Policy is in force as to your suffering the symptom.

Repatriation of remains benefits are not payable if loss of life is caused in whole or in part by, or results in whole or in part from, any condition for which you are entitled to benefits under any Workers' Compensation Act or similar law.

AD&D Insurance Coverage Exclusions

The Plan does not cover and no payment shall be made for any loss resulting in whole or in part from, or contributed to by, or as a natural and probable consequence of any of the following excluded risks even if the proximate or precipitating cause of the loss is an accidental bodily injury:

- Suicide or any attempt at suicide or intentionally self-inflicted injury or any attempt at intentionally self-inflicted injury or auto-eroticism.
- Sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from any of these.
- Travel or flight in or on (including getting in or out of, or on or off of) any vehicle used for aerial navigation, if you are:
  - Riding as a passenger in any aircraft not intended or licensed for the transportation of passengers;
  - Performing, learning to perform or instructing others to perform as a pilot or crew member of any aircraft unless, with respect to performing or instructing others to perform as a licensed pilot of a Dell aircraft, the covered person has a current and valid medical certificate and pilot certificate with appropriate ratings for such aircraft and a minimum of 1,000 military, private or professional pilot hours logged, separately or combined; or
- Declared or undeclared war, or any act of declared or undeclared war, unless outside of the United States of America or outside the covered person's country of permanent residence.
- Infections of any kind regardless of how contracted, except bacterial infections that are directly caused by botulism, ptomaine poisoning or an accidental cut or wound independent and in the absence of any underlying sickness, disease or condition including but not limited to diabetes.
- Full-time active duty in the armed forces, National Guard or organized reserve corps of any country or international authority. (Unearned premium for any period for which you are not covered due to your active duty status will be refunded.) (Loss caused while on short-term National Guard or reserve duty for regularly scheduled training purposes is not excluded.)
- If you're under the influence of intoxicants while operating any vehicle or means of transportation or conveyance.
- If you're under the influence of drugs unless taken under the advice of and as specified by a physician.
- Your commission of or attempt to commit a felony.
- The medical or surgical treatment of sickness, disease, mental incapacity or bodily infirmity whether the loss results directly or indirectly from the treatment.
- Stroke or cerebrovascular accident or event; cardiovascular accident or event; myocardial infarction or heart attack; coronary thrombosis; aneurysm.

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Life and AD&D Beneficiary Designation

You should designate your beneficiary when you first become an eligible team member and review your designation periodically. You may do this by going to My Well at Dell. If you have difficulties designating your beneficiary online, you may call a Benefits Representative at 1-888-335-5663.

You should make sure you have the correct beneficiary designated if you experience a significant event in your life such as marriage, divorce or birth of a child.

If you do not have a valid beneficiary designation on file, your life and AD&D benefits, if any, will be paid in the following order to your:

- Lawful spouse;
- Natural or legally adopted child or child(ren);
- Mother or father;
- Brothers or sisters; or
- The executors or administrators of your estate.

Actively at Work Requirement for Life and AD&D Coverage

You must be actively at work for your coverage to go into effect; refer to the “Glossary” section for a definition of actively at work as it relates to this coverage. If you are not actively at work on the date your coverage would normally go into effect, coverage will be delayed until you return to active at work status. The actively at work requirement applies to all coverages described in this section.

Assignment of Life and AD&D Coverage

You may assign ownership of your life insurance coverage. Once you make an absolute assignment, you cannot change your coverage options or beneficiaries. You are responsible for paying any required premiums. For more information about absolute assignment, contact your tax or estate planning advisor. To make an absolute assignment, contact the Dell Benefits Center at 1-888-335-5663 for a form with instructions.

Portability or Conversion of Basic Life Insurance Coverage

If your employment with Dell ends or you are working less than the minimum number of hours (described in the “Eligibility” section), you may elect to take your coverage with you without Evidence of Insurability (EOI) by applying for portability for yourself within 31 days of when your coverage ends. If you do not apply within 31 days, you will not be eligible to apply at a later date.

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The minimum and maximum amounts that may be ported are noted in the chart below:

Portable Coverage	Minimum Amount	Maximum Amount
Team Member Basic and Supplemental Life Insurance Coverage Combined	$10,000	$1,500,000

Note: The maximum amount is limited to the amount of coverage in place when coverage ended.

Certain other restrictions may apply to your portability options. Please contact MetLife at 1-888-252-3607 for more information on these restrictions.

You may also port supplemental coverage. See the “Supplemental Life Insurance Coverage” section for details.

Conversion of AD&D Insurance Coverage

You can convert your AD&D coverage to an individual policy without Evidence of Insurability (EOI). You must apply for conversion within 31 days of when your coverage ends. If you do not apply within this time frame, you will not be allowed to convert your coverage. This conversion privilege applies to the AD&D benefits only.

Age Reductions for Life Coverage

Basic life insurance benefits are reduced for any covered person age 70 or older to 65%. If you are age 70 or older on the effective date of your insurance, the amount of your basic life insurance on your effective date of insurance will be limited to 65% of such insurance. If you are under the age of 70 on the effective date of your insurance, the amount of your Basic Life Insurance on and after age 70 will be 65% of such insurance in effect on the day before your 70th birthday.

This is a brief description of the AD&D coverage available under policy series C11656(REV 3-99)DBG-TX(ER-EE). The policy contains reductions, limitations, exclusions, definitions and termination provisions. Full details of the coverage are contained in the policy. If there are any conflicts between this document and the policy, the policy shall govern. Insurance underwritten by National Union Fire Insurance Company of Pittsburgh, Pa. (“the Company”), a Pennsylvania insurance company, with its principal place of business at 175 Water Street, 15th Floor, New York, NY 10038. It is currently authorized to transact business in all states and the District of Columbia. NAIC No. 19445.

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Supplemental Life Insurance Coverage

Overview

Supplemental Life Insurance coverage offers you an opportunity to purchase additional life insurance beyond the basic life insurance in which Dell automatically enrolls you. Since most experts agree that individuals with dependents need life insurance coverage at least equal to four times (and often more) their annual earnings, applying for Supplemental Life Insurance is an important financial consideration you should explore to protect you and your family. Once your coverage becomes effective, your Supplemental Life Insurance coverage will be paid to your designated beneficiary if you die from any cause (other than suicide) while covered under the Program. You may also purchase coverage for your spouse or domestic partner and your eligible children. You pay the full cost of all Supplemental Life Insurance in which you enroll. If you, whether sane or insane, commit suicide within two years from the effective date of any contributory life insurance, our liability with respect to that coverage will be limited to an amount equal to the premiums paid for the coverage. If there has been an increase in your amount of contributory life insurance for which you were required to apply or for which we required Evidence of Insurability (EOI), and if you die by suicide within two years of the effective date of the increase, our liability with respect to that increase will be limited to the premiums paid and attributable to such increase.

For information on changing your Supplemental Life Insurance election for yourself, your spouse or domestic partner or your child, see the “Changing Your Election” section. For information on claims and appeals see the “Claims and Appeals Procedures” section.

Team Member Supplemental Life Insurance Coverage

You may choose Supplemental Life Insurance coverage in addition to your Dell provided basic life insurance in amounts equal to 1, 2, 3, 4, 5, 6, 7 or 8 times your benefit-eligible earnings. If your benefit-eligible earnings are not an even multiple of $1,000, your benefit-eligible earnings will be rounded up to the next higher multiple of $1,000 before your supplemental coverage is calculated. The maximum amount of Supplemental Life Insurance coverage is $3,000,000.

Full-time team members whose basic annual earnings are greater than $167,000 may elect to become covered for an amount of Supplemental Life Insurance equal to $500,000. If you make this election, you cannot make an election based on the above.

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New Hire—Additional Requirements for Team Member Supplemental Life

You may elect up to three times your benefit-eligible earnings or $500,000 (the lesser of these two amounts) without needing to complete and submit Evidence of Insurability (EOI) provided you make your election within 31 days of your date of hire. This coverage amount will go into effect on your date of election of Supplemental Life Insurance. If you enroll for more than three times your benefit-eligible earnings or over $500,000, you will have to provide EOI to MetLife. This coverage amount will go into effect on the date MetLife approves your EOI. If this EOI requirement applies to you, you will need to click on the link provided in the enrollment site to complete the process. If you enroll more than 31 days after your date of hire, all amounts elected require EOI. Not all applicants who must submit EOI will be approved; certain health conditions and other facts may prevent eligibility. If you are not sure if you have been approved for Supplemental Life Insurance coverage or have other questions regarding the status of a submitted Statement of Health, you should contact the Dell Benefits Center at 1-888-335-5663. If you are not eligible for the level of coverage for which you applied, you should decide if you need to make your own arrangements for additional coverage outside of Dell's benefit plans.

Spouse/Domestic Partner Supplemental Life Insurance Coverage

If you enroll in Supplemental Life Insurance for yourself, you can also enroll your spouse or domestic partner for Supplemental Life Insurance coverage. You may choose coverage in increments of $25,000. The maximum coverage is the lesser of $500,000 or an amount equal to the basic and supplemental combined coverage you elected. The minimum coverage is $25,000. If your spouse is employed by Dell, you may not elect supplemental life coverage on your spouse.

Newly Eligible—Additional Requirements for Spouse/Domestic Partner Supplemental Life

You may elect up to $50,000 without Evidence of Insurability (EOI) (Statement of Health), provided you elect within 31 days of your spouse's/domestic partner's eligibility date. This coverage amount will go into effect on the date of eligibility. If you enroll for more than one-half your benefit-eligible earnings or $50,000, you will have to submit a Statement of Health on your spouse/domestic partner to MetLife. This coverage amount will go into effect on the date MetLife approves your spouse's/domestic partner's EOI.

If you are not sure if your spouse/domestic partner has been approved for Supplemental Life Insurance coverage or you have other questions regarding the status of a submitted Statement of Health, you can contact the Dell Benefits Center at 1-888-335-5663.

Actively at Work Requirement for All Life Insurance Coverage

You must be actively at work for your coverage to go into effect; refer to the "Glossary" section for a definition of actively at work as it relates to this coverage. If you are not actively at work on the date your coverage would normally go into effect, coverage will be delayed until you return to active at work status. The actively at work requirement applies to all of your coverages described in this section.

As long as the employee is insured under the Supplemental Life insurance plan, MetLife does require the employee to be actively at work in order to add or increase dependent coverage. Coverage is effective for a dependent when the dependent meets all eligibility requirements under the policy which include: application is made, Evidence of Insurability (EOI) is approved (if required), MetLife receives the required premium and the dependent is not medically confined, refer to "Hospitalization and Confinement Requirement for Dependent Life" in this section for more information.

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The following chart outlines, by coverage, type and leave type how long coverage can be continued during a leave absence.

	Insurance Coverage Type and Length of Time Coverage Is Continued for the Type of Leave		
Type of Leave	**Basic Life Insurance**	**Basic AD&D Insurance**	**Supplemental Life Insurance (including dependent coverage)**
FMLA Leaves	Basic Life coverage remains in effect and is not affected by an employment status change, subject to a maximum of 12 weeks.	Basic AD&D coverage remains in effect and is not affected by an employment status change, subject to a maximum of 12 weeks.	Up to 12 weeks. To care for a covered service member with a serious injury or illness (up to 26 weeks). FMLA leaves can extend indefinitely into non-FMLA leaves as long as eligibility criteria are met. You are responsible for ensuring any required insurance premium/contribution costs are paid timely during the leave.
Company Discretionary Leave	Basic Life coverage remains in effect and is not affected by an employment status change, subject to a maximum of six months.	Basic AD&D coverage remains in effect and is not affected by an employment status change, subject to a maximum of six months.	You are responsible for ensuring any required insurance premium/contribution costs are paid timely during the leave, subject to a maximum of six months.
Non-FMLA Medical Leaves of Absence, including Disability	Basic Life coverage remains in effect and is not affected by an employment status change, subject to a maximum of 24 months.	Basic AD&D coverage remains in effect and is not affected by an employment status change, subject to a maximum of 24 months.	You are responsible for ensuring any required insurance premium/contribution costs are paid timely during the leave, subject to a maximum of 24 months (six months for spouse/dependent).

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Type of Leave	Insurance Coverage Type and Length of Time Coverage Is Continued for the Type of Leave		
	Basic Life Insurance	**Basic AD&D Insurance**	**Supplemental Life Insurance (including dependent coverage)**
Military Leaves	Basic Life coverage remains in effect and is not affected by an employment status change, except when the military leave extends beyond five years and/or the Company takes action to terminate the team member. The maximum length of benefits coverage extension is five years.	Basic AD&D coverage remains in effect and is not affected by an employment status change, except when the military leave extends beyond five years and/or the Company takes action to terminate the team member. The maximum length of benefits coverage extension is five years.	Coverage can continue for up to five years. However, coverage will end earlier if a required premium payment is not made within the required time. Your coverage will end if you do not notify the Company of your intent to return to work within the required period following completion of your military service by either reporting to work (if your military service was less than 31 days) or applying for reemployment (if your military service was for more than 30 days). You are responsible for ensuring any required insurance premium/contribution costs are paid timely during the leave. The maximum length of benefits coverage extension is five years.
Layoff	Basic Life coverage remains in effect and is not affected by an employment status change, subject to a maximum six months.	Basic AD&D coverage remains in effect and is not affected by an employment status change, subject to a maximum of six months.	You are responsible for ensuring any required insurance premium/contribution costs are paid timely during the leave, subject to a maximum of six months.
Leave of Absence	Basic Life coverage remains in effect and is not affected by an employment status change, subject to a maximum of 24 months.	Basic AD&D coverage remains in effect and is not affected by an employment status change, subject to a maximum of 24 months.	You are responsible for ensuring any required insurance premium/contribution costs are paid timely during the leave, subject to a maximum of 24 months (six months for spouse/dependent).

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Type of Leave	Insurance Coverage Type and Length of Time Coverage Is Continued for the Type of Leave		
	Basic Life Insurance	**Basic AD&D Insurance**	**Supplemental Life Insurance (including dependent coverage)**
Leave due to illness or injury	Basic Life coverage remains in effect and is not affected by an employment status change, subject to a maximum of 24 months.	Basic AD&D coverage remains in effect and is not affected by an employment status change, subject to a maximum of 24 months.	You are responsible for ensuring any required insurance premium/contribution costs are paid timely during the leave. The insurance cannot be continued beyond 24 months (12 months for spouse/dependent).

Hospitalization and Confinement Requirement for Dependent Life

If a dependent is hospitalized or confined because of illness or disease on the date his or her insurance would otherwise become effective, his or her effective date shall be delayed until he or she is released from such hospitalization or confinement. This does not apply to a newborn child. However, in no event will insurance on a dependent be effective before the insured employee's insurance under the group policy is effective.

Child Supplemental Life Insurance Coverage

If you enroll yourself for Supplemental Life Insurance coverage, you may enroll your children in Supplemental Life Insurance at initial eligibility, at annual enrollment or at a qualified status change without having to submit Evidence of Insurability (EOI). An eligible child includes your natural born child, stepchild, adopted child (including a child placed with you for adoption), and who, in each case is under age 26 and unmarried. In addition, eligible unmarried children include:

- Your domestic partner's children.
- Your grandchildren who are under age 26, and who can be claimed by you as a dependent for federal income tax purposes at the time you applied for coverage.
- Your children (any age) who are incapable of self-sustaining employment because of a mental or physical handicap. If you have children of any age who are incapable of self-sustaining employment because of a mental or physical handicap, contact the Dell Benefits Center at 1-888-335-5663 for information on disabled child certification.

You may choose $5,000, $10,000 or $15,000 per eligible child up to age 26. It is your responsibility to terminate your children's supplemental coverage once they are over age 26 or no longer eligible. To cancel this coverage when your child(ren) reach age 26, you may use My Well at Dell or call a Benefits Representative at 1-888-335-5663.

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If you and your spouse or domestic partner work at Dell, your life insurance coverage for dependents must be coordinated. $5,000 coverage is automatic from the date of live birth. Likewise, if your child is employed by Dell, you may not elect supplemental life coverage on that child. Please call 1-888-335-5663 and speak with a Dell Benefits Representative for more information.

Exclusions for Supplemental Life Insurance

If you or an insured dependent whether sane or insane, commit suicide within two years from the effective date of any contributory life insurance, our liability with respect to that coverage will be limited to an amount equal to the premiums paid for the coverage. If there has been an increase in your amount of contributory life insurance for which you were required to apply or for which we required Evidence of Insurability (EOI), and if you die by suicide within two years of the effective date of the increase, our liability with respect to that increase will be limited to the premiums paid and attributable to such increase.

Evidence of Insurability (EOI or Statement of Health) for Supplemental Life Insurance Coverage

Evidence of Insurability is generally a statement of your medical history. In certain cases, team members may be required to undergo a medical examination. EOI is requested for certain amounts of Supplemental Life Insurance coverage for team members and each team member's spouse or domestic partner. Payroll deductions for new or increased coverage amounts will begin once the insurance company approves your EOI and your coverage is effective. EOI is determined by completion of a Statement of Health form. Questions regarding the status of a submitted Statement of Health form may be directed to MetLife at 1-800-638-6420. For enrollment or other questions related to Supplemental Life Insurance, contact the Dell Benefits Center at 1-888-335-5663.

Cost of Supplemental Life Insurance Coverage

Your cost is based on age as of January 1, nicotine user status and the amount of coverage you elect. The cost of this coverage is on an after-tax basis and, therefore, all Supplemental Life Insurance benefits are paid without taxation.

Special Rules for Nicotine Users

If you are a nicotine user and you declare that you are a non-nicotine user, any life insurance benefits paid under this Program will be reduced by the additional premium you would have paid as a nicotine user. See the "Glossary" section for the definition of "nicotine user."

Supplemental Life Living Benefit/Accelerated Benefit Option

If you are diagnosed with a terminal illness which directly results in a life expectancy of 24 months or less, you may request early payment of up to 100% of your Supplemental Life Insurance coverage up to a maximum of $1,000,000 of your Basic Life and Supplemental Life Insurance coverage combined. If your spouse/domestic partner is diagnosed with a terminal illness which directly results in a life expectancy of 24 months or less, you may request early payment of up to 100% of his/her supplemental coverage on their behalf up to a maximum of $500,000. For more information on this accelerated benefit option, contact the Dell Benefits Center at 1-888-335-5663.

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Supplemental Life Insurance Beneficiary Designation

Your beneficiary for Supplemental Life Insurance will be the same beneficiary you designate for basic life and AD&D insurance. You also have the option to designate a different beneficiary for Supplemental Life Insurance. You may go to My Well at Dell to change your beneficiary designations or call a Benefits Representative at 1-888-335-5663. If you do not have a valid beneficiary designation on file, see the “Life and AD&D Beneficiary Designation” section for how your supplemental life benefits, if any, will be paid.

You are automatically the beneficiary for the Supplemental Life Insurance for your spouse/domestic partner and child.

Assignment of Supplemental Life Insurance Coverage

You may assign ownership of your Supplemental Life Insurance coverage. Once you make an absolute assignment, you cannot change your coverage options or beneficiaries. You are responsible for paying any required premiums. For more information about absolute assignment, contact your tax or estate planning advisor. To make an absolute assignment, contact the Dell Benefits Center at 1-888-335-5663 for a form with instructions.

When Supplemental Life Insurance Coverage Ends

For information about when Supplemental Life Insurance coverage ends, see the “When Coverage Ends” section.

You may be able to continue coverage through the portability or conversion options discussed below.

Portability of Supplemental Life Insurance Coverage

If your employment with Dell ends (including retirement) or you are working less than the minimum number of hours (described in the “Eligibility” section), you may elect to take your coverage with you without Evidence of Insurability (EOI) by applying for portability for yourself and your dependents within 31 days of when your coverage ends. If you do not apply within 31 days, you will not be eligible to apply at a later date. While the premium rates you will be offered by MetLife will still be competitive, once you port your coverage, your rates will change and will likely be higher than the rates you were paying for Supplemental Life Insurance through Dell.

If you elect ported coverage for yourself, you may also elect portable coverage for your covered dependents.

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The minimum and maximum amounts that may be ported are noted in the chart below.

Portable Coverage	Minimum Amount	Maximum Amount Under Age 65	Maximum Amount Age 70
Team Member Basic Life Insurance Coverage	$10,000	$1,000,000	65% of the amount in force on portability date to a maximum of $650,000
Spouse or Domestic Partner Supplemental Life Insurance Coverage	$10,000	$500,000	
Child Supplemental Life Insurance Coverage	$5,000	$15,000	

Note: The maximum amount is limited to the amount of coverage in place when coverage ended.

Certain other state restrictions may apply to your portability options. Please contact MetLife at 1-888-252-3607 for more information on these restrictions.

Generally, child coverage terminates at the end of the month of the child's 26th birthday.

Conversion of Supplemental Life Insurance Coverage

Another option in lieu of portability is the option to convert. You and your dependents can convert your coverages to individual life policies without Evidence of Insurability (EOI). You must apply for conversion within 31 days of when your coverage ends. If you do not apply within this time frame, you will not be allowed to convert your coverage.

Age Reductions for Supplemental Life Insurance Coverage

Age reductions do not apply to Dell's Supplemental Life Insurance benefits.

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Business Travel Accident Program

Overview

The Business Travel Accident (BTA) Program provides 24-hour coverage while on a required business trip traveling away from your place of business (where you are permanently assigned to work). Coverage is provided during business travel, including while riding as a passenger (not a pilot or crewmember) on a scheduled or Corporate-owned/leased aircraft. BTA coverage may include payment for accidental loss of life, loss of limb(s), paralysis, coma, and loss of sight, hearing and speech. There is no cost to you for this coverage. Dell pays 100% of the cost.

Business Travel Accident coverage is provided by Chubb. For information about eligibility and enrollment see the “Plan Participation” section.

Note: Throughout this section “you” refers to you or your covered dependent who is eligible for this coverage, unless specifically noted otherwise.

BTA Benefits

The BTA benefit is three times your annual benefit eligible earnings rounded to the next higher $1,000 (subject to a $300,000 minimum), up to a maximum benefit of:

- $1,500,000 for you;
- $100,000 for your eligible spouse or domestic partner; and
- $50,000 for your eligible dependent children.

Benefit-eligible earnings defined under the policy means (1) Base Salary (including the employee’s base compensation for the year, before any salary reduction for before-tax contributions to the savings plan, spending accounts and other health and insurance plans); and (2) targeted commissions for the year. For Sales Employees, Annual Salary means Total Target Compensation (TTC) which includes both base pay and incentive pay.

There is a combined maximum of $37,500,000 for all covered losses and injuries due to any one covered accident. There is a combined maximum of $15,000,000 per covered accident due to travel on corporate-owned, leased or controlled aircraft. There is a combined maximum of $100,000,000 per covered accident due to travel in a commercial aircraft. The same applies for a series or combination of covered accidents directly caused by one or more associated events. If the total amount claimed by all insured persons is greater than this amount, then the amount that will be paid to each insured person will be reduced in the same proportion, so that the total amount paid does not exceed this combined maximum.

No more than the benefit maximum will be paid for all losses per covered accident. If, in the absence of this provision, the benefit payment would be more than this benefit maximum for all losses from one covered accident, then the benefits payable to each person with a valid claim will be reduced proportionately, so the total paid is the benefit maximum.

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Benefits	Amount per Covered Accident or Associated Event	Maximum per Covered Accident
Alternative Commuting Coverage	Up to eligible, individual Principal Sum Amount	Aggregate Limit: $37,500,000
Bereavement and Trauma	Amount per session: $100 Maximum number of sessions: 10	$1,000
Carjacking	10% of the covered person's principal sum up to the maximum	$50,000
Coma	1% of the covered person's principal sum per month up to 11 months; 100% of principal sum thereafter	
Cosmetic Disfigurement From Burns	A percentage of the covered person's principal sum based on the standard burn chart indicated in the policy	
Emergency Medical Benefit	Covered expenses up to the maximum	$10,000
Emergency Medical Evacuation	100% of covered expenses	
Family Reunion Benefit	Up to $5,000	Up to $5,000
Felonious Assault Benefit	10% of the covered person's principal sum up to the maximum	$50,000
Home Alteration and Vehicle Modification	10% of the covered person's principal sum up to the maximum	$50,000
Political Evacuation	Up to $250,000	$250,000
Rehabilitation	10% of the covered person's principal sum up to the maximum	$50,000
Repatriation of Remains	100% of covered expenses	
Seatbelt and Airbag	10% of the covered person's principal sum up to the maximum	$50,000
Special Education Benefit	5% of the covered person's principal sum up to the maximum	$5,000
War Risk Coverage	Up to eligible, individual Principal Sum Amount	Aggregate Limit: $37,500,000

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BTA Benefit Features

This Program includes the following additional benefits when related to required business travel away from your place of business:

- **Accidental Death and Dismemberment Benefits** if you are injured in a covered accident and, within 365 days of that accident, suffer one of the losses shown below (if multiple losses occur, only one benefit amount—the largest—will be paid for all losses due to the same accident):

Covered Loss	Benefit Amount
Life	100% of principal sum
Two or More Members	100% of principal sum
Quadriplegia	100% of principal sum
Hemiplegia	100% of principal sum
Paraplegia	100% of principal sum
One Member	50% of principal sum
Thumb and Index Finger on Same Hand	25% of principal sum
Uniplegia	100% of principal sum

- **Bereavement and Trauma Counseling Benefits** if you are injured as the direct result of a covered accident and you or an immediate family member requires bereavement and trauma counseling. To be covered, counseling must meet all of the following conditions:
  - Expenses must be incurred within one year from the date of the covered accident;
  - Expenses must be for the covered person or one or more of his or her immediate family members;
  - Counseling is provided under the care, supervision or order of a physician; and
  - A charge would have been made if no insurance existed.

  Covered bereavement and trauma counseling benefits do not include any expense for which you are entitled under any workers' compensation act or similar law.

- **Carjacking Benefit** if you are injured during a carjacking of an automobile that you were operating, getting into or out of, or riding in as a passenger. Verification of the carjacking must be made part of an official police report or certified in writing by the investigating officer within 24 hours of the carjacking or as soon as reasonably possible.
- **Coma Benefits** if you become comatose within 31 days of a covered accident and remain in a coma for at least 31 days. Benefits will be paid for each month you remain in a coma, for up to 11 months. If you die while in a coma or remain in a coma for more than 12 straight months, a lump-sum benefit equal to the principal sum will be paid. This lump-sum payment will end your insurance and no further benefits will be paid.
- **Cosmetic Disfigurement from Burns Benefit** if you suffer third or fourth degree burns in one or more areas of the body subject to the Cosmetic Burn Chart in the policy.

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- **Emergency Medical Benefits** if you are traveling 100 miles or more from your place of permanent residence and suffer a medical emergency while on a covered trip and incur expenses for guarantee of payment* to a medical provider, hospital or treatment facility. Benefits will not be paid unless the charges incurred are medically necessary and do not exceed the charges for similar treatment, services or supplies in the area in which they were incurred or include charges that would not have been made if there was no insurance. Benefits will not be payable unless Chubb or the Policyholder's assistance provider (International SOS) authorizes in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Chubb's assistance provider or the Policyholder's assistance provider (ISOS).
- **Family Reunion Benefit** if, during the course of business travel, you are confined to a hospital for at least five consecutive days or if you are medically evacuated to another hospital in another location, reasonable and customary lodging and transportation expenses shall be payable for an Immediate Family Member to join you. Benefits will not be payable unless Chubb or the Policyholder's assistance provider (International SOS) authorize in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Chubb's assistance provider.
- **Emergency Medical Evacuation Benefits** if you suffer a medical emergency while traveling 100 miles or more away from your place or permanent residence and must be medically evacuated, as ordered by a physician. Benefits will not be payable unless:
    - The physician ordering the emergency medical evacuation certifies that the severity of the medical emergency requires an emergency evacuation;
    - All transportation arrangements made for the emergency medical evacuation are by the most direct and economical conveyance and route possible;
    - The charges incurred are medically necessary and do not exceed the usual level of the charges for similar transportation, treatment, services or supplies in the locality where the expense is incurred; and
    - Expenses do not include charges that would not have been made if there were no insurance.
    - Coverage also includes medical treatment, medical services and medical supplies necessarily received in connection with the emergency medical evacuation.

  Benefits will not be payable unless Chubb (or their authorized assistance provider) authorizes in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Chubb's assistance provider or the Policyholder's assistance provider (ISOS).

- **Felonious Assault Benefit** if you die as the result of an injury that occurs as a direct result of a Felonious Assault. A person other than another person covered by the policy, a covered person's Immediate Family Member or household member must inflict the assault. "Felonious Assault" means an act of physical violence against you. "Immediate Family Member" means your parent, sister, brother, husband, wife or children.

This benefit is specifically intended to pay a Hospital Admission or Medical Provider "Guarantee of Payment" if demanded by the medical facility as a condition for admission or access to services; it is not intended to cover medical and hospital expenses following admission. Contact ISOS immediately if a medical provider is requesting a medical expense guarantee.

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- **Home Alteration and Vehicle Modification Benefit** if you are injured as a direct result of a covered accident and require home alteration or vehicle modification within one year of the covered accident to maintain an independent lifestyle. You must not have required the use of any adaptive devices or adaption of residence and/or vehicle before the date of the covered accident.
- **Security Evacuation Benefit** if, due to political or military events in a host country, a formal recommendation from the appropriate authorities is issued for you to leave the host country, or if you are expelled or declared persona non-grata by the host country—this benefit will pay 100% of the reasonable and customary charges incurred for transportation to the nearest place of safety or for repatriation to your home country/country of residence, up to the benefit maximum shown at the beginning of this section. Evacuation and repatriation must occur within 10 days of any such event. Coverage will apply to the most appropriate and economical means consistent under the circumstances with your health and safety. Evacuation and repatriation costs will be paid once per covered person, per occurrence. Security Evacuation includes Natural Disaster Evacuation occurring within seven days of the event.
- **Limitations:** This benefit is not paid for losses:
    - Recoverable under any other insurance or through an employer.
    - Arising from or attributable to:
        - Alleged violation of the laws of the host country, unless the allegations are determined to be fraudulent; or
        - Failure to maintain required documents and visas.

  Benefits will not be paid unless authorized in writing or by an authorized electronic or telephonic means in advance.

- **Rehabilitation Benefits** if you are participating in a rehabilitation program due to an accidental dismemberment covered loss that resulted directly from a covered accident or if a physician has prescribed a rehabilitation program.
    - Benefits are payable for:
        1. The facility providing the rehabilitation program in which the covered person is participating; and
        2. Immediate family members who incur expenses for travel to and from the location at which you are participating in a rehabilitation program provided that actual receipts are submitted with the claim.

  “Immediate family member” means your parent, grandparent, spouse, child, brother, sister or in-law.

  “Rehabilitation Program” means a specialized, intensive program for rehabilitation or assimilation at an accredited medical facility specializing in research, surgery and training of person with Accidental Dismemberment Covered Losses as outlined in the Schedule of Covered Losses (above).

- **Repatriation of Remains Benefit** if you die while traveling 100 miles or more from your home. Covered expenses include:
    - Expenses for embalming or cremation;
    - The least costly coffin or receptacle adequate for transporting the remains;
    - Transporting the remains by the most direct and least costly conveyance and route possible; and
    - Escort service expenses for an immediate family member or companion who is traveling with the covered person to join the covered person’s body during the repatriation.

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Benefits will not be payable unless Chubb or the Policyholder's assistance provider (International SOS) authorizes in writing, or by an authorized electronic or telephonic means, all expenses in advance, and services are rendered by Chubb's assistance provider or the Policyholder's assistance provider (ISOS).

- **Seatbelt and Airbag Benefit** if you die or are dismembered directly and independently of injuries sustained while wearing a seatbelt and operating or riding as a passenger in an Automobile (as defined in the Policy). An additional benefit will be paid if you were also positioned in a seat protected by a properly functioning and properly deployed Supplemental Restraint System (airbag) as defined in the Policy:
    - Verification of proper use of the seatbelt and that the airbag properly inflated at the time of the covered accident must be part of an official police report or be certified in writing by the investigating officer(s) and submitted with your claim. If this certification or police report is not available or it is unclear whether you were wearing a seatbelt or were protected by a properly functioning and properly deployed airbag, a default benefit will be paid to your beneficiary.
    - In the case of a child, seatbelt means a child restraint, as required by state law and approved by the National Highway Traffic Safety Administration, that was properly secured and being used as recommended by its manufacturer for children of like age and weight at the time of the covered accident.
- **Special Education Benefit** for each qualifying Dependent child and a surviving spouse under your certificate on the date he or she dies. Your death must result, directly and independently of all other causes, from a covered accident. This benefit is subject to the conditions set forth in the policy.

BTA Covered Activities

- **Exposure and Disappearance:** Benefits will be paid for an injury due to exposure to the elements after a forced landing, stranding, sinking or wrecking of a vehicle. A covered person is presumed dead if he or she is in a vehicle that disappears, sinks or is stranded or wrecked on a covered trip, or if his or her body is not found within one year of a covered accident.
- **Business Travel:** Benefits will be paid for an injury while traveling on an authorized business trip. However, coverage does not include commuting between the covered person's home and place of work. Coverage will begin at the actual start of a trip, regardless of location. Coverage will end when the covered person returns to his or her home, place of work or when his or her personal deviation lasts more than 14 days. "Personal deviation" means an activity that is not reasonably related to your business and is not incidental to the purpose of the trip.
- **Owned, Leased or Controlled Aircraft:** The Covered Accident must take place while:
    - The Covered Person is riding in, or getting on or off of, a covered Owned, Leased or Controlled Aircraft as defined by the Policy;
    - As a result a Covered Person being struck by a covered Owned, Leased or Controlled Aircraft as defined by the Policy;
    - Away from the Policyholder's premises in the Covered Person's city of permanent assignment;
    - On business of the Policyholder; and
    - In the course of the Policyholder's business.

Coverage will begin at the actual start of a trip, regardless of location. Coverage will end when the covered person returns to his or her home, place of work or when his or her personal deviation lasts more than 14 days. "Personal deviation" means an activity that is not reasonably related to your business and is not incidental to the purpose of the trip.

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- **Relocation:** Benefits will be paid if a covered person is injured while traveling on a relocation trip at Dell's expense and direction. Coverage will begin at the actual start of a trip, regardless of location. Coverage will end when the covered person returns to his or her home, place of work or when his or her personal deviation lasts beyond 14 days. "Personal deviation" means an activity that is not reasonably related to business and is not incidental to the purpose of the trip.

  "Relocation Trip" means a trip in connection with your transfer or proposed transfer by the Policyholder to a new worksite.

- **War Risk:** Benefits will be paid for covered losses resulting from a Covered Accident caused by war or acts of war that occur anywhere in the world except in the following countries:
  - The United States; or
  - The covered person's Home Country as defined in the Policy.

  No more than $37,500,000 per occurrence will be paid for war risk benefits for all injuries sustained from acts of war. The insurer reserves the right to audit and charge an additional premium if the war risk exposure changes. This coverage may be cancelled provided written notice is provided within 30 days of the termination date.

- **Alternative Commuting:** Benefits will be paid as a result of injury arising while a covered person is commuting between his or her home and place of work using an alternative means of transportation as a result of a discontinuation of service, strike or major breakdown of one or more public transportation systems that the covered person uses regularly in commuting. Benefits will not be payable for covered accidents that occur more than two hours after the covered person leaves his or her home or place of work, unless it can be conclusively established that the delay was caused by conditions beyond his or her control and that more time was needed for normal direct commuting.

BTA Exclusions

Benefits will not be paid for any loss or injury that is caused by, or results from:

- Intentionally self-inflicted injury (applicable to Accidental Death and Dismemberment benefit only).
- Suicide or attempted suicide (applicable to Accidental Death and Dismemberment benefit only).
- A covered accident that occurs on active duty service in the military, naval or air force of any country or international organization. Upon receipt of proof of service, any premium paid for the time will be refunded. Reserve or national guard active duty training is not excluded unless it extends beyond 31 days.
- Sickness, disease, bodily or mental infirmity, bacterial or viral infection or medical or surgical treatment thereof, except for any bacterial infection resulting from an accidental external cut or wound or accidental ingestion of contaminated food.
- Piloting or serving as a crewmember in any aircraft (except as provide by this coverage).
- Commission of, or attempt to commit, a felony.

This coverage does not apply to the extent that trade or economic sanctions or regulations prohibit the insurer from providing insurance, including, but not limited to, the payment of claims.

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International SOS

Overview

International SOS provides you with medical and security advice and assistance while abroad. Global services include medical and security risk planning, in-country expertise and emergency response for travelers.

Prior to international travel, you can view the online country information and download the International SOS App. If you need more in-depth information or have questions specific to your personal health and safety, call any one of the 26 International SOS Assistance Centers before you travel. International SOS Assistance Centers are 24/7/365 operations centers staffed by doctors and nurses, security experts, multi-lingual coordinators and logistics support personnel.

Some examples of services available to you while away from home include:

- Medical advice on vaccinations for your group and travel safety tips before traveling overseas.
- You or your colleagues have a medical condition that you wish to discuss with a doctor.
- If you become unwell with a cold and are unsure where to find a doctor or pharmacy.
- On-call medical and emergency advice, referral to doctors and specialists as well as coordination of treatment with the treating practitioner.
- Guaranteed payment of medical expenses provided for in your health insurance contract (if International SOS is contacted prior to or during treatment).
- On-call security information and emergency advice.
- Assistance in the event a passport or other official document is lost or stolen.
- Referral to vetted security service providers.
- Emergency medical evacuation/repatriation.
- Compassionate visit and family travel assistance.
- Transportation in the event of death and assistance with legal aspects of repatriation of mortal remains.
- Recommendations in the event of an emergency or critical event.

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Cigna Medical Benefits Abroad (MBA) Travel Medical Insurance

Overview

Cigna provides medical coverage for all Dell team members and their spouses/domestic partners and dependent children who are under age 26 traveling on business outside of their home country. Leisure/personal travel is also covered for Dell team members and their spouses/domestic partners and dependent children who are under age 26, while traveling outside of their home country of residence or permanent assignment with the Dell team member. Dependents are not eligible for AD&D coverage.

Coverage includes the following:

Cigna Medical Benefits Abroad (MBA) Travel Medical Insurance Coverage	
Calendar Year Medical Benefit Maximum	$1 million
Calendar Year Deductible	$0
Coinsurance (paid by Cigna)	100%
Out-of-Pocket Coinsurance Maximum	None
Prescription Drug	100% of covered expenses, when medically necessary while on an approved international business trip. This benefit includes replacement medicine for lost prescriptions that are medically necessary during an international trip.
Emergency Dental (includes dental accident & alleviation of sudden unexpected pain)	$1,000 calendar year maximum
Personal Deviation (Sojurn)	7 days, when taken in conjunction with an approved business trip.
Personal Travel	Covered
Room and Board Inside the U.S.	Average Semi-Private Room Rate
Room and Board Outside the U.S.	Average Semi-Private Room Rate
Pre-Existing Condition	None. Subject to the calendar year maximum
Medical Evacuation & Repatriation	$250,000
War Risk	Covered
Accidental Death and Dismemberment (AD&D)	Not covered. Please refer to the AD&D schedule for benefit information.

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Exclusions — Medical Illness and Injury

In addition to any benefit-specific exclusion, benefits will not be paid for any covered medical illness or injury which directly or indirectly, in whole or in part, is caused by or results from any of the following:

- Injury or sickness which results from or in the course of an Insured's regular occupation for wage or profit. (This does not apply to a corporate officer, partner or sole proprietor who is not insured under Workers' Compensation, Employer's Liability Law or similar law).
- Flight in, boarding or alighting from an aircraft or any craft designed to fly above the Earth's surface:
  - Except as a fare-paying passenger on a regularly scheduled commercial or charter airline;
  - Being flown by the covered person or in which the covered person is a member of the crew;
  - Being used for:
    - Crop dusting, spraying or seeding, giving and receiving flying instruction, firefighting, sky writing, sky diving or hang-gliding, pipeline or power line inspection, aerial photography or exploration, racing, endurance tests, stunt or acrobatic flying; or
    - Any operation that requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on);
  - Designed for flight above or beyond the earth's atmosphere;
  - An ultra-light or glider;
  - Being used by any military authority, except an aircraft used by the Air Mobility Command or its foreign equivalent;
  - Being used for the purpose of parachuting or skydiving;
- Injury or sickness for which an Insured is entitled to benefits under Workers' Compensation Law, Employer's Liability Law or similar law.
- Travel in or on any off-road motorized vehicle not requiring licensing as a motor vehicle;
- Participation in any motorized race or contest of speed;
- An accident if the covered person is the operator of a motor vehicle and does not possess a valid motor vehicle operator's license; except while participating in a Driver's Education Program;
- Travel in any aircraft owned, leased or controlled by Dell, or any of its subsidiaries or affiliates. An aircraft will be deemed to be "controlled" by Dell if the aircraft may be used as Dell wishes for more than 10 straight days, or more than 15 days in any year;
- Sickness occurring while the Insured is serving on full-time active duty in the Armed Forces of any country or international authority;
- Hospital confinement, surgery, treatment, service or supply for which:
  - The charge is payable or reimbursable by or through a plan or program of any governmental agency; or
  - Charges which would not have been made if the person had no insurance.
- To the extent that payment is unlawful where the person resides when the expenses are incurred.
- To the extent that they are more than the Maximum Reimbursable Charges.
- Injury as a result of a commission of a felony.
- Attempted suicide or intentionally self-inflicted Injury, while sane or insane.
- Eyeglasses, contact lenses, hearing aids or examinations for prescription or fitting thereof.
- Cosmetic or plastic surgery except:
  - When necessary as a result of an injury or sickness occurring while insured; or
  - Reconstructive surgery when such service is incidental to or follows surgery resulting from injury or sickness.
- Hospital confinement, care or treatment which is not recommended and approved by a physician.
- Treatment or care of a person by a physician or nurse, if the physician or nurse is a member of the Insured's immediate family or ordinarily resides with the Insured.
- Private Duty Nursing.

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- Obesity/Bariatric surgery.
- Physical examinations unless required because of injury or sickness.
- Dental expenses unless the result of an accident to sound natural teeth or alleviation of sudden unexpected dental pain, then the benefit is unlimited per calendar year up to the medical maximum.
- Expenses related to alcoholism, chemical dependency or drug addiction.
- Operating any type of vehicle while under the influence of alcohol or any drug, narcotic or other intoxicant including any prescribed drug for which the covered person has been provided a written warning against operating a vehicle while taking it. Under the influence of alcohol, for purposes of this exclusion, means intoxicated, as defined by the law of the state and or country in which the covered accident occurred.
- Expenses incurred during vacation travel when not in conjunction with a business trip unless specified on the Insurance Schedule.
- Claim payments which are illegal under applicable law.
- Medical treatments or procedures deemed not Medically Necessary as determined by the Company.
- The covered persons being Intoxicated. “Intoxicated” means having a blood alcohol level of .08 or higher.
- Any and all expenses incurred for medical services or treatment in the Insured’s country of permanent residence.
- Expenses incurred if the original or ancillary purpose of your trip is to obtain medical treatment.
- Injury or sickness caused by war, or an act of war, whether declared or undeclared, riot, civil commotion or police action.
- Routine maternity treatment.

For a complete list of benefits covered and exclusions under Cigna MBA Travel Medical Insurance Coverage, see the Cigna Global Certificate of Coverage.

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Work/Life Benefits

Overview

Only you know what you need to achieve balance in your life. While Dell cannot make those decisions for you, we offer a variety of work/life benefits you can use to help you achieve your own balance. This section provides a brief description of the various programs offered. **The benefits described in this section are not subject to ERISA, the federal law governing employee benefits.**

Adoption and Surrogacy Assistance Programs

U.S. and Puerto Rico team members working at least 20 hours per week are eligible for the adoption and surrogacy assistance programs. You must be employed by Dell at the time the adoption and surrogacy are final.

Adoption Assistance

Dell's Adoption Assistance Program can support all paths to parenthood. Recognizing the unique challenges associated with adoption, Progyny assists in reviewing and administering the Adoption Assistance Program. Dell reimburses up to $10,000 (per child) of eligible adoption expenses with a $20,000 lifetime maximum reimbursement. You also have unlimited access to a dedicated Patient Care Advocate (PCA), who provides you with information, resources and emotional support throughout your adoption journey.

Who's Eligible
U.S. and Puerto Rico-paid team members working at least 20 hours per week. You must be employed by Dell at the time the adoption is final.

Eligible Expenses
Any of the following expenses are eligible for reimbursement up to the maximum amount:

- Legal and court fees;
- Placement and home study fees;
- Public, private and foreign adoption agency fees;
- Temporary foster care charges; and
- Transportation, immigration and translation costs.

The following expenses are not eligible for reimbursement:

- Professional counseling for parent or child;
- Costs related to adoption of a blood relative, stepchild or child of a domestic partner;
- Expenses for adopting children related to either adopting parent, including, but not limited to nephews, nieces, cousins, brothers and sisters; and
- Costs for personal items such as food and clothing for the parents and the child.

Reimbursement Process

Dell will reimburse up to $10,000 per child toward eligible adoption expenses for finalized adoptions. The maximum lifetime reimbursement is $20,000.

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If both partners work for Dell, the benefit is not doubled, and only one parent may submit expenses for reimbursement.

Here are the steps:

- Contact your Progyny Patient Care Advocate (PCA) at 1-833-278-1676 to initiate the process.
- Your PCA will provide you with a Progyny Attestation Form, and you will submit all relevant itemized invoices for eligible expenses, appropriate proofs of payment and any supporting legal documents to Progyny for review.
- Once all documents are reviewed and approved, reimbursement will be issued to you via Dell Technologies payroll within two to three pay periods.
- A copy of the final adoption decree is to be provided. If the adoption took place in another country, you must also provide a copy of the translated version of the final adoption decree. (The adoption must be successful in order to get reimbursed.)
- A copy of eligible expense receipts must be provided.

Planning for a New Child? Here's Step-by-Step Benefits Guidance

Plan your next steps with help. Check out an online checklist and eGuide that will help you stay on top of important actions and connect to support available through your Dell benefits. That way, you can focus on what matters most — your growing family.

- See a printable PDF eGuide with the checklist details, an example of how leave works and more.

Is the Reimbursement Taxable?

For U.S. and Puerto Rico team members:

Dell Payroll will withhold Social Security, Medicare and federal unemployment taxes from your reimbursement. Expenses are not subject to federal or state tax withholding. However, based on your family adjusted gross income, you may owe federal and state income tax on this reimbursement income when you file your tax returns.

A few things to know:

- Your W-2 form will report your reimbursement amount.
- You will then compute any federal income tax owed on IRS Form 8839 when you file your return.
- For more information about taxability, go to the IRS Forms and Publications website and enter the form or publication number in the Search Forms and Publications box.
  - IRS Form 8839**,** Qualified Adoption Expenses: Compute your tax liability and attach to your federal tax return.
  - IRS Form W-7A**,** Application for Taxpayer Identification Number for Pending U.S. Adoptions: Use until you're able to obtain a Social Security number for your adopted child.

You may be eligible for a tax benefit when you file your personal income tax return. Please consult your tax advisor for additional information.

Surrogacy Assistance

Dell's Surrogacy Assistance Program can support all paths to parenthood. Recognizing the unique challenges associated with surrogacy, Progyny assists in reviewing and administering Dell's Surrogacy Assistance Program. Dell reimburses up to $20,000 (per attempt) of eligible surrogacy expenses. You also have unlimited access to a dedicated PCA, who provides you with information, resources and emotional support throughout your surrogacy journey.

Who's Eligible

U.S. and Puerto Rico-paid team members working at least 20 hours per week. You must be employed by Dell at the time the surrogacy attempt is complete.

Eligible and Ineligible Expenses

- Any of the following expenses are eligible for reimbursement up to the maximum amount: Donor fertility costs and fees not covered by another source
- Egg or sperm donation shipping and transport fees
- Egg or sperm retrieval fees, IVF and medical costs (if not covered by Progyny or another source)
- Egg/sperm donation agency fees
- Gestational carrier, egg or sperm donor compensation
- Gestational carrier, egg or sperm donor screening costs
- Legal and attorney fees
- Pregnancy medical expenses related to surrogacy
- Surrogacy agency fees
- Travel expenses for the intended parents
- Other costs associated with surrogacy or donor tissue

The following expenses are not eligible for reimbursement:

- Corrective surgeries like laparoscopies and myomectomies

Reimbursement Process

Dell will reimburse up to $10,000 per attempt toward eligible surrogacy expenses. The maximum lifetime reimbursement is $20,000.

If both partners work for Dell, the benefit is not doubled, and only one parent may submit expenses for reimbursement.

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Here are the steps:

- Contact your Progyny PCA at 1-833-278-1676 and request assistance with the Surrogacy Reimbursement application.
- Once your surrogacy process is complete or you have incurred $10,000 in eligible expenses, contact your Progyny PCA for a Progyny Attestation Form.
- You will submit all relevant itemized invoices for eligible expenses, appropriate proofs of payment and any supporting legal documents to Progyny for review.
- Once all documents are reviewed and approved, a reimbursement will be issued to you via Dell Technologies payroll within two to three pay periods.
- A copy of eligible expense receipts must be provided.

Planning for a New Child? Here's Step-by-Step Benefits Guidance

Plan your next steps with help. Check out an online checklist and eGuide that will help you stay on top of important actions and connect to support available through your Dell benefits. That way, you can focus on what matters most — your growing family.

- See a printable PDF eGuide with the checklist details, an example of how leave works and more.

Is the Reimbursement Taxable?

For U.S. team members:

Dell Payroll will withhold all payroll taxes from your reimbursement, as surrogacy reimbursements are fully taxable. Your W-2 form will report your reimbursement amount.

For Puerto Rico team members:

Social Security, Medicare and applicable state income taxes (SIT) will be withheld.

Commuter Benefits Program

The voluntary Commuter Benefits Program sponsored by Dell is provided through Alight Smart-Choice Accounts (in partnership with Wire Commute), in accordance with IRS Code 132(f). This program lets you pay for eligible commuting costs through automatic, before-tax payroll deductions; it is convenient and easy to use with online ordering and home delivery **plus** direct-payment—you do not have to wait for reimbursement.

In addition, you can save money on payroll taxes. Your fare and parking still cost the same, but because the money to pay for them comes out of your paycheck before taxes are deducted, your tax withholding is where you see your savings. You can save on federal income tax, FICA (Social Security) tax and state income tax (except in MS, NJ and PA).

Exactly how much you save will vary depending on your commuting expenses, your tax situation and IRS limits. Generally, however, for every $100 of eligible commuting expenses, you can save from $30 to $40 each month. That’s as much as a 40% savings!

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You pay no fees and you can start, change or stop your participation at any time. However, you must enroll by the 10th of the month to take advantage of the Program for the following month. This monthly cutoff date is the same deadline for making changes and cancellations.

If you are on any type of extended leave, you are not eligible to participate; however, your eligibility for the program will be reinstated upon return to active status.

2022 Contribution Limits

The IRS establishes maximum monthly limits for qualified transportation expenses (which are subject to change). If your expenses exceed these limits, you can elect to have your total monthly commuting costs withheld from your pay, using before-tax contributions up to the IRS maximum and then deducting the balance on an after-tax basis. That way, you can still enjoy the convenience of home delivery and automatic payments.

For 2022, the IRS allows up to $280 per month for transit/vanpool expenses and up to $280 per month for parking expenses. These limits apply monthly; remaining Commuter Card balances can roll over from month to month (see “Transit/Vanpool and Parking Options” in this section for information on the Alight Smart-Choice Accounts Commuter Card. Any unused funds on the card will remain available for future use and roll over from month to month up to the $1,500 maximum balance on the Commuter Card. The Commuter Benefits Program is designed for you to use commuter products to get to and from work. It’s important to understand how the plan works.

You will not be refunded for any credits or lost pass claims. Your account will be closed as soon as administratively possible following your date of separation. If your employment is terminated, you will forfeit the balance in your account.

The total cost of your election will be deducted from your pay each month.

Enrolling for the Benefit

There is no annual enrollment period, so you can sign up or make changes whenever you choose—online or by phone. Any change will be implemented as soon as administratively possible.

You can enroll online at My Well at Dell and select the Smart-Choice Accounts tab or portal icon. Click on the **Commuter Account** tab on the main benefits page.

Any order placed by the 10th of the month will become effective the following month (please note the deadline is the 4th of the month for Metro-North Railroad and Long Island Rail Road). Do not forget to enter your email address to receive confirmations electronically. Note that it is up to you to make changes through Alight Smart-Choice Accounts—your transit or parking provider cannot notify us if you stop parking or riding.

If you do not have easy internet access or need assistance with your ordering process, you can call Alight Smart-Choice Accounts and they can help you through the process. You can call Alight Smart-Choice Accounts at 1-888-335-5663.

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Making Changes

You can start, change or stop your participation at any time. You do not need to enroll each month; you may elect to have deductions made on a continuing basis. However, if you choose to make a change or cancel deductions, the deadline for changes or cancellations is always the 10th of the month for the following benefit month (please note the deadline is the 4th of the month for Metro-North Railroad and Long Island Rail Road), the same as the monthly cutoff date for placing an order.

Choose *Modify or Cancel Commuter Order* from the menu:

- Click **Cancel** to cancel your order or change to a different type of pass or parking provider and start over with a new order.
- To change the dollar amount, frequency or mailing address, follow the instructions and place your order.

Besides making changes, you can also log in to My Well at Dell and select the Smart-Choice Accounts tab or portal icon to review your order history, update your contact information, change your user name and password, change your email address, and even set up direct deposit of reimbursements into your bank account.

Eligible Expenses

It is important to make sure you spend your Commuter Benefits Program dollars only on expenses deemed eligible by the IRS. The following list identifies common eligible expenses you incur to commute to and from work:

- Bus, train, streetcar, trolley, subway or ferry.
- Vanpool.
- Parking at or near work.
- Parking at or near public transportation for your commute.

Ineligible Expenses

Expenses that are reimbursed not related to commuting are not eligible for this program. In addition, some expenses that are not eligible include:

- Parking costs that are not work-related.
- Expenses for other family members.
- Gas, mileage and tolls.
- Taxis and limousines.
- Parking at an airport for air travel.

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Transit/Vanpool and Parking Options

You can pay for your commuting expenses in different ways:

- **Transit Options:**
  - ***Buy My Pass:*** Order your transit passes or ticket books through Alight Smart-Choice Accounts and have them mailed to your home every month, in time for the month they are valid. Alight Smart-Choice Accounts will mail your pass in a plain business envelope, so be careful not to mistake it for junk mail. The exact date of delivery may vary depending on your transit agency and the U.S. Mail.
  - Alight Smart-Choice Accounts ***Commuter Card (Transit):*** The Alight Smart-Choice Accounts Commuter Card is a reusable stored-value card. The Transit Card is used to buy your transit pass or ticket book at ticket windows or vending machines that accept credit/debit cards. Funds automatically become available the 20th day of the month before each benefit month. Any unused funds automatically roll over and remain on the card for future expenses as long as you remain eligible for commuter benefits.
- **Parking Options:**
  - ***Pay My Parking:*** If you have a monthly parking arrangement, Alight Smart-Choice Accounts can automatically pay your parking facility. You just need to register with Alight Smart-Choice Accounts to tell them where and how much you pay to park.
  - Alight Smart-Choice Accounts ***Commuter Card (Parking):*** The Parking Card is used to pay for parking at or near your workplace, public transportation or park-and-ride facilities that accept credit/debit cards. Funds will automatically become available the first day of the benefit month. Any unused funds automatically roll over and remain on the card for future expenses.
  - ***Parking Pay Me Back:*** If your parking expenses vary each month or you use metered parking, you can submit claims for reimbursement by check or direct deposit. You must submit claims within 180 days after you pay your expenses. If you miss the deadline, your funds are no longer available for expenses submitted more than 180 days from the date of service.

If You Leave the Company

Commuter benefits are a “use-it-or-lose-it” plan, and if you leave the Company, you will not be refunded for any credits or lost pass claims. Any remaining credits would be forfeited once you leave Dell.

If your employment is terminated, your payroll deductions will stop and your account will be closed as of your termination or transfer date. You will forfeit any balance in your account. You may, however, still be able to get reimbursed for expenses incurred before your participation ended.

Back-Up Child, Adult and Elder Care Benefits

The Back-Up Care Benefit is a nationwide program through Bright Horizons designed for you to get to work when you experience a disruption in normal dependent care (child and/or adult/elder care) arrangements and are in need of temporary care services. The Bright Horizons Back-Up Care Program includes:

- Center based back-up child care (bringing your child to a center location);
- Back-up child care in your home (arranging for a nanny to go to your home);
- Mildly ill child care in your home (arranging for a nanny to go to your home); and

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- Adult/elder care in your adult loved one's home (arranging for a caregiver to go to your adult's/elder's home).

You have access to up to **100** hours of back-up care per calendar year.

All eligible team members may participate in this program; however, you must register with Bright Horizons to schedule care. To register, visit backup.brighthorizons.com (if prompted, enter the username "Dell" and password "Benefits4You") or call 1-855-500-8881. Bright Horizons' phone lines are open 24 hours a day to assist with your care needs. There is no cost to register for the program. You are encouraged to register in advance, before you have an unexpected child or adult/elder care need.

Dell pays for the majority of the costs for the Back-Up Care Program. You are responsible for your copay portion (for which Bright Horizons will direct bill you). The copay is $4 per hour per child for center-based care and $8 per hour for home-based care (rate applies for up to three of your dependents). These rates are subject to change annually based on provider-contracted rates and standard cost of living increases or times when the copays are waived during certain promotion periods. Please confirm rates with Bright Horizons at the time of scheduling backup care.

Taxation of Dependent Care Programs

The IRS limits the amount of dependent care benefits you may receive on a tax-free basis. Dependent care benefits you receive in excess of $5,000 are taxable to you as income. Amounts you contribute to your Dependent Care (Day Care) FSA count against the $5,000 limit. For example, if you elect to contribute $4,000 to your Dependent Care (Day Care) FSA, you may only receive up to $1,000 in emergency backup care benefits on a tax-free basis. Dell will withhold income taxes from your compensation for any dependent care benefits you receive in excess of $5,000. Please consult IRS Publication 503 for more information on taxation of dependent care benefits.

Financially Well at Dell

All team members have access to Financially Well at Dell, which helps you take charge of your financial situation by offering tools and support to manage your day-to-day expenses, navigate uncertain markets and plan for the long term.

If you want one-on-one assistance, a Financial Wellness Coach can help you:

- Better understand your current financial status.
- Plan your next steps.
- Delve deeper into basic financial habits.
- Offer retirement support.
- Keep you on track with your financial wellness journey.

To get started with an online assessment, customized recommendations, access on-demand webinars and find more Dell programs that can help improve your financial health, visit **MyWellatDell.com > Financially Well at Dell**.

Tuition Assistance Benefit

This benefit is designed to encourage professional growth for active U.S. and Canada Dell team members working 20 or more hours per week. Eligibility begins on the first day of employment. The team member must be employed before, during and upon completion of the course for which assistance is being paid. Dell may reimburse up to $5,250 per calendar year in eligible expenses incurred for academic coursework when the courses meet the eligibility requirements listed in the program policy. Employees are responsible for reading and following all policy requirements. Please visit the “Access Education Support” section at clients.brighthorizons.com/Dell (enter the username “Dell” and password “Benefits4You”) for more information.

All reimbursements are made through payroll and are treated as “taxable” or “non-taxable” as outlined in the “Taxation of Tuition Reimbursement” section. The tuition reimbursement policy may be revised or revoked at any time, with no advance notice.

Taxation of Tuition Reimbursement
The determination of whether tuition reimbursement or direct payment is treated as taxable compensation is made by Dell in accord with tax regulations. Dell does not provide any assistance to team members with individual tax liability resulting from reimbursements that are considered taxable income.

Current U.S. tax law exempts from a team member’s taxable income the reimbursement of up to $5,250 a year of a team member’s tuition expenses under Dell’s Tuition Assistance Plan. Some states may not follow federal guidelines for taxation. In such cases, reimbursement excluded from federal taxable income may be subject to state income tax. Thus, even if federal taxes are not withheld, some states may require the withholding of state taxes.

Some, or all, of the amount paid on behalf of the team member may be subject to reporting as federal or state taxable income and be subject to tax withholding.

Taxation for Canada: Any payments made to a team member for employment-related education are excludable from income.

Tuition Assistance Coaching
With this benefit, you have access to free one-on-one coaching throughout your academic journey. Whether you’re currently enrolled in a program or trying to figure out next steps for going back to school, the team of education experts will help provide personalized strategies and the best course of action to save time and money on your education.

Please visit the “Let an Education Coach Help You” section at clients.brighthorizons.com/Dell (enter the username “Dell” and password “Benefits4You”) for more information and to schedule an appointment.

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.

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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 PPO, Health Fund or Indemnity medical plan to access Sword Health. This service is offered in addition to traditional physical therapy coverage through your plan.

Additional Benefits to Help You Manage Your Life

Program	Description	Contact Information
Back-Up Child and Adult/Elder Care	Temporary care for your children and adult loved ones when there is a breakdown in your regular care, so you don't have to miss work. Access your 100 hours of care per year for your children, spouse or parents (anywhere in the U.S., and they don't have to live with you or even in the same state) for $4/hour for center-based care or $8/hour for in-home care. Reimbursable care is available for mildly ill children.	backup.brighthorizons.com First-time registrants click **Don't Have a Bright Horizons Login – Sign Up?** If prompted, enter the following employer credentials: Employer username: Dell Employer password: Benefits4You Registered users can use their created username and password or click **Forgot your username/password?** 1-855-500-8881 Available 24/7
Bicycle Voucher	Dell will pay for bike vouchers, up to $20 per month for eligible bicycle expenses. This benefit is taxable. These vouchers are purchased through the Smart-Choice Commuter Account once you are logged in to My Well at Dell if you bike to work. Eligible expenses may include bike purchase, improvement, maintenance and/or storage costs.	1-888-335-5663 My Well at Dell
Child Care Discounts & Tutoring Discounts	For full-time child care options, receive preferred waitlist placement at Bright Horizons centers and a registration discount up to $250. Or enroll at a partner center for up to 10% off tuition. There are also a number of different tutoring, camp and before/after school	To see all your Bright Horizons benefits, visit: clients.brighthorizons.com/Dell Look for "Secure Full-Time Care in a Quality Child Care Center"

Program	Description	Contact Information
	provider discounts offered through your Bright Horizons program.	Access Discounted Nanny Placement Services: collegenanniesandtutors.com/bh In addition to child care discounts, visit **clients.brighthorizons.com/Dell** to find all the self-serve/self-pay resources available to Dell team members. You can either reference them separately as below or refer to **clients.brighthorizons.com/Dell** to get started. Access babysitters, nannies, elder companions, pet sitters, housekeepers, help creating learning pods, virtual sitters at sittercity.com/Dell Elder Care support and resources, sittercity.com/dell?site=years_ahead Before- and after-school care with Right At School: **rightatschool.com/partners/Bright-Horizons** Summer Day Camp: **join.steveandkatescamp.com/efs** Tutoring & Test Prep Discounts with Varsity Tutors: varsitytutors.com/brighthorizons Tutoring & Test Prep Discounts with Revolution Prep: revolutionprep.com/your-benefits/bright-horizons Tutoring & Test Prep Discounts with Sylvan Learning: **sylvanlearning.com/partners/brighthorizons** Brooklyn Robot Foundry virtual offerings: **brooklynrobotfoundry.com/bright-horizons-efs** Code Ninjas program: **forms.codeninjas.com/bh** Get the Marco Polo Learning App for Preschoolers:

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Program	Description	Contact Information
		marcopololearning.com/special-offer/BRIGHT?transaction_id=7a4297ef2d2046a09f78dcde73c5683d&affiliate_id=34
College Coach	Helping your child navigate educational challenges can be a stressful and time-consuming process. College Coach will guide families through important educational challenges, including how to keep your child academically motivated, college selection, application preparation, essay review, saving and paying for college. You have access to live webinar events, personalized one-on-one assistance with former College Admissions and Finance Counselors, customized college lists and the online Learning Center. These resources are available and completely free to all active team members and their dependents, age newborn through grade 12.	passport.getintocollege.com Employer username: Dell Employer password: Benefits4You 1-855-500-8881 or dell@getintocollege.com
Dell Benefits Marketplace	Dell Benefits Marketplace is a new discount portal available for Dell team members to find valuable discounts on thousands of brands. This new platform is designed to help you spend smarter and save more, with savings and discounts at over 200,000 vendors. You can find savings on everything from fitness to personal finance, travel, dining and more. You can earn cash back on purchases, find great deals exclusive to Dell team members, get the convenience of payroll deduction for auto, home and pet insurance.	**DellBenefitsMarketplace.com** 1-866-664-4621
Dell Merit Scholarship Program	Competitive scholarships are awarded annually to dependents of active, regular, U.S. Dell team members (dependents must be high school seniors or college freshmen, sophomores or juniors to apply).	My Well at Dell Benefits > Work/Life > Family and Education Benefits > Dell merit scholarships

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Program	Description	Contact Information
Family Central	Family Central has resources to help you care for family at any age and stage. Find nanny and sitter services, virtual learning pods and tutoring, back-up child care, college coaching and more.	**MyWellatDell.com > Work/Life menu > Family Central**
Tuition Assistance	Reimbursement for expenses related to formal education at accredited schools, colleges and universities in support of your career path at Dell.	clients.brighthorizons.com/Dell clients.brighthorizons.com/dell#Education-Assistance-for-Your-Career 1-855-500-8881
Group Auto and Home Program	This program can connect you to representatives from three of the nation's leading home insurance carriers to get free, no-obligation premium quotes for auto and home insurance.	My Well at Dell 1-844-317-4474
Health Savings Account (U.S. team members only)	You and Dell may contribute to your Health Savings Account on a before-tax basis through payroll deduction.	1-888-335-5663 My Well at Dell
Fitness Reimbursement	All U.S. team members can get up to $500 back each year on eligible expenses such as activity trackers, home gym equipment, personal training and workout classes.	**MyWellatDell > Wellness menu > Fitness reimbursement and discounts**
Discounted memberships at national fitness centers	You have access to discounts on enrollment fees and monthly dues through the Dell Benefits Marketplace.	**DellBenefitsMarketplace.com** 1-866-664-4621
Wellbeats virtual fitness classes	Wellbeats, through the Dell Wellness Hub, provides access to more than 700 virtual fitness classes (up to 60 minutes in length), including something for every age and ability. In addition to over 30 channels and hundreds of virtual classes geared toward all fitness levels, Wellbeats also offers short sessions to help boost your mood and relieve stress and improve eating habits.	WellatDellFitness.com **DellBenefitsMarketplace.com** 1-866-664-4621
Virtual fitness center through Premise Health	Access virtual fitness coaches to provide personal guidance and exercise program plans. 50+ weekly LIVE virtual fitness classes available from Strength, Cardio, Yoga, Barre,	WellatDellFitness.com VirtualFitness@dell.com

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Program	Description	Contact Information
	Zumba, Tai Chi and more! Connect with co-workers through virtual fitness social groups on Microsoft Teams. Virtual fitness center is free of charge and available to all U.S. team members.	
Pet Insurance	This pet insurance program offers coverage for the other members of your family through Nationwide. You can cover dogs, cats, birds, rabbits and even exotic pets, and choose the coverage level that best meets your needs, including coverage for surgeries, lab fees and X-rays.	**DellBenefitsMarketplace.com** Or **benefits.petinsurance.com/Dell** 1-877-738-7874
Torchlight	Torchlight helps families with different types of caregiving challenges—from supporting children who are struggling with developmental, academic, social and other challenges to navigating the complexities of elder care.	Contact: 1-844-693-3477 or Dell.torchlight.care
Mother's Rooms	You have access to private rooms on Dell campuses for nursing mothers; these rooms are supplied with a small refrigerator for storing breast milk during the day.	intranet.dell.com/facilities/global/Pages/global/mothers_rooms.htm
Milk Stork	When you're traveling on Dell-approved business within the U.S., Milk Stork provides no-fuss, refrigerated, express FedEx shipping or easy toting of breast milk home to your baby. If you are traveling internationally, you can use the Pump & Check option to bring your refrigerated breast milk as luggage back to the U.S.	**milkstork.com/Dell** 1-510-356-0221 Monday through Saturday, 6 a.m. – 8 p.m. CT.

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Program	Description	Contact Information
Legal Services	Ceridian provides active and retired employees, and their spouses and dependent children, a place to turn for support when faced with legal questions or issues on any topic. The services include unlimited telephonic general legal information and a free 30-minute consultation with a local attorney for each unique legal issue. Participating attorneys are selected by Ceridian but are independent providers of legal services. Discounts are available for retention of an attorney beyond the free 30-minute consultation.	LifeWorks.com User name: lfg Password: resources 1-877-849-6034
Legacy Planning Services	Active and retired employees, and their spouses and dependent children, can access resources designed to help individuals and families work through end-of-life issues when dealing with the loss of a loved one or planning for their own passing.	LegacyPlanningServices.com
Personal Travel Assistance	RedpointWTP LLC provides travel assistance services to all active U.S. employees covered under the group life insurance program and their spouses and dependents. The services are available 24/7/365 for emergency assistance and transport services when traveling 100 or more miles away from home. Pre-trip resources are also available.	LifeBenefits.com/travel 1-855-516-5433 (U.S. and Canada) +1-415-484-4677 (Other locations)

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Life Events

Overview

During your employment at Dell, you may experience life events such as birth of a child, marriage or divorce. 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):

- Adding an eligible dependent;
- Child loses Plan eligibility;
- COBRA coverage from another plan ends;
- Death of dependent;
- Death of team member;
- Divorce or termination of domestic partnership;
- Family member coverage costs significantly change;
- Family member gets new coverage;
- Family member makes new annual enrollment election;
- Gain eligibility in another plan;
- Go on or return from a leave of absence;
- You become disabled;
- You leave Dell and are rehired;
- Loss of eligibility in another plan;
- Loss of government or educational institution plan coverage;
- Loss of Plan eligibility or termination of employment;
- Loss of subsidy from another employer;
- Medicare or Medicaid eligibility;
- Move or worksite change;
- New hire or newly eligible; and
- Repatriating to the U.S.

Note: This list is not all-inclusive and other qualified status changes may apply. Contact the Dell Benefits Center at 1-888-335-5663 for more information.

For more information on what happens to your benefits when on a leave, refer to the “Leaves of Absence” 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.

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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 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. Any change will be implemented as soon as administratively possible.

Adding an Eligible Dependent

The following chart summarizes the changes allowed and some considerations if you gain a dependent, either through birth, adoption, placement for adoption, foster child, marriage or domestic partnership, that is eligible for any Dell benefit. Any change you make must be consistent with gaining a new dependent, unless it is a special enrollment right. See the “Special Enrollment” section for additional information.

Benefit Plan	**Allowed Changes and Considerations**
Medical, Dental and Vision	▪ Enroll yourself, add your spouse or domestic partner, add eligible children, drop coverage for you and/or your spouse/domestic partner or children, or change Medical Program option. ▪ Revoke or decrease coverage when you gain or increase coverage under your spouse’s or domestic partner’s plan.
Working Spouse Contribution	▪ If you enroll your spouse or domestic partner and he or she is employed and eligible for benefits through his or her employer, you will be required to pay an additional fee for Dell medical benefits.
Health Care Flexible Spending Account	▪ Enroll, increase or stop participation. ▪ Decrease election if you or your dependents become eligible under a new spouse’s health plan.
Dependent Care (Day Care) Flexible Spending Account	▪ Enroll, increase or stop participation. ▪ Decrease or terminate coverage if new spouse is not employed or makes a dependent care flexible spending account coverage election under the spouse’s plan.

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Benefit Plan	Allowed Changes and Considerations
Long-Term Disability	▪ Enroll or drop coverage. (Subject to Evidence of Insurability (EOI) requirements after 31 days from initial eligibility.)
Supplemental Life Insurance—Team Member, Spouse or Domestic Partner and Child	▪ Enroll, increase, decrease or drop coverage. Increases in coverage are subject to EOI requirements. You may increase coverage with EOI. If EOI is denied, you will keep your current level of coverage. Legally marrying your domestic partner who is already covered for life insurance under this plan does not qualify as a life event with a guaranteed issue opportunity.
Other Benefit Considerations	▪ Apply for a Social Security card for your child, if the hospital does not do it for you automatically. ▪ Consider adding your child as a beneficiary on any 401(k), life insurance or investment accounts you maintain, including those outside Dell's benefit plans. ▪ Contact your attorney to create or revise your will and living will. ▪ Learn about 529 plan accounts to start saving for your child's college expenses. ▪ Review your savings plan contributions. ▪ Contact the EAP for private and confidential counseling. Visit My Well at Dell to learn more about these considerations.

All changes must be made within 31 days of gaining the dependent, except that you have 60 days to add a newborn to coverage.

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. If you report this change after the 31-day window, the domestic partner status will not be changed retroactively, and any imputed income cannot be corrected.

Child Loses Plan Eligibility

The following chart summarizes the changes you must make and some considerations if your child loses eligibility under the Plan (for example, the child reaches age 26).

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Benefit Plan	Allowed Changes and Considerations
Medical, Dental and Vision	▪ You must drop coverage for the affected child.
Health Care Flexible Spending Account	▪ Decrease or stop participation (only if child is no longer a tax dependent and cannot have expenses reimbursed from the Health Care Flexible Spending Account).
Dependent Care (Day Care) Flexible Spending Account	▪ Decrease or stop participation.*
Long-Term Disability	▪ Enroll or stop coverage. (Subject to Evidence of Insurability [EOI] requirements.)
Supplemental Life Insurance—Team Member, Spouse or Domestic Partner	▪ Enroll, increase, decrease or stop coverage. Increases in coverage are subject to EOI requirements. You may increase coverage with EOI. If EOI is denied, you will keep your current level of coverage.
Supplemental Life Insurance—Child	▪ You must drop coverage for the child.

*A child turning age 13 is not considered a “loss” of eligibility and therefore not an event that allows you to change your participation in a Dependent Care (Day Care) Flexible Spending Account. If you know that your child will be turning age 13 during a plan year, you should consider this when determining your contribution amount for the plan year.

All changes, with the exception of newborn and adoption, must be made within 31 days of the event. You have 60 days to add a child due to birth or adoption. Children who lose health coverage because they are no longer eligible may continue coverage under COBRA. For more information about COBRA, see the “COBRA Continuation Coverage” section.

Note: Coverage for children turning age 26 will continue through the end of the month in which they turn age 26.

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COBRA Coverage From Another Plan Ends

The following chart summarizes the changes allowed and some considerations if your continuation of coverage under COBRA with another employer expires or a family member's COBRA coverage ends.

Benefit Plan	Allowed Changes and Considerations
Medical, Dental and Vision	▪ You may enroll yourself and your eligible dependents in the Medical, Dental and Vision Programs. ▪ If you are already enrolled in medical, you may change your Medical Program option.
Health Care Flexible Spending Account	▪ Enroll or increase participation.

All changes must be made within 31 days of the loss of COBRA coverage.

Death of Dependent

The following chart summarizes the changes allowed and some considerations if you experience the loss of a dependent due to death, including the death of a spouse, domestic partner or child.

Benefit Plan	Allowed Changes and Considerations for the Death of a Spouse or Domestic Partner	Allowed Changes and Considerations for the Death of a Dependent Child
Medical, Dental and Vision	▪ You may enroll yourself and your eligible children if you lose coverage under your spouse's or domestic partner's plan. ▪ You must drop your spouse's or domestic partner's coverage. ▪ You must drop coverage for your domestic partner's children if they lose eligibility. ▪ Your coverage tier may be adjusted based on number of dependents. ▪ You may change your Medical Program option.	▪ You must drop coverage for the child who has died. ▪ Your coverage tier may be adjusted due to the number of your covered dependents.

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Benefit Plan	Allowed Changes and Considerations for the Death of a Spouse or Domestic Partner	Allowed Changes and Considerations for the Death of a Dependent Child
Health Care Flexible Spending Account	▪ Enroll, increase, decrease or stop participation.	▪ Decrease or stop participation.
Dependent Care (Day Care) Flexible Spending Account	▪ Enroll, increase, decrease or stop participation.	▪ Decrease or stop participation.
Long-Term Disability	▪ Enroll or drop coverage. (Subject to Evidence of Insurability [EOI] requirements.)	▪ Enroll or drop coverage. (Subject to EOI requirements.)
Supplemental Life Insurance—Team Member, Spouse, Domestic Partner and Child Life	▪ You may enroll, increase, decrease or drop team member or child coverage. Increases in coverage are subject to EOI requirements. You may increase coverage with EOI. If EOI is denied, you will keep your current level of coverage. You must drop your spouse's or domestic partner's coverage.	▪ You may enroll, increase, decrease or drop team member, spouse/domestic partner or child coverage. Increases in coverage are subject to EOI requirements. You may increase coverage with EOI. If EOI is denied, you will keep your current level of coverage.
Other Benefit Considerations	▪ Consider changing your beneficiary on any 401(k), life insurance or investment accounts, including those you maintain outside Dell's benefit plans. ▪ Contact your attorney to create or revise your will and living will. ▪ Contact the EAP for private and confidential counseling. Visit My Well at Dell to learn more about these considerations.	

You must make all changes within 31 days of the loss of your dependent.

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Death of Team Member

The following chart summarizes the changes that will occur, some considerations and your surviving dependents' options if you die while actively employed at Dell.

Benefit Plan	Changes and Considerations
Medical, Dental and Vision	▪ All coverage will stop at the end of the day that you die. Your covered dependents are eligible for continuation of coverage under COBRA; see the "COBRA Continuation Coverage" section for more information. ▪ Any dependent covered under the Plan at the time of your death will automatically be enrolled in COBRA continuation coverage, and the first 60 days of coverage will be paid by Dell.
Health Care Flexible Spending Account	▪ If you were participating, participation will end, but your estate has the opportunity to submit eligible expenses incurred before your death.
Dependent Care (Day Care) Flexible Spending Account	▪ If you were participating, participation will end, but your estate has the opportunity to submit eligible expenses incurred before your death.
Long-Term Disability	▪ Coverage will stop.
Supplemental Life Insurance—Team Member, Spouse or Domestic Partner and Child	▪ All coverage will stop (any applicable death benefit that you were eligible for will be paid). Your dependents may be able to convert any supplemental spouse/domestic partner or child life insurance coverage that you had under the Plan; see the "Conversion of Supplemental Life Insurance Coverage" section for more information.
Other Benefit Considerations	▪ The EAP remains available to your dependents. The EAP can provide resources like grief counseling. ▪ When the Dell Benefits Center is notified of your death, an instructional letter will automatically be sent to your estate with instructions for 401(k), life insurance and other benefits.

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Benefit Plan	Changes and Considerations
	Visit My Well at Dell to learn more about these considerations.

Divorce, Legal Separation, Annulment or Termination of Domestic Partnership

The following chart summarizes the changes allowed and some considerations if you divorce or terminate a domestic partnership, or have a legal separation or annulment.

Benefit Plan	Allowed Changes and Considerations
Medical, Dental and Vision	▪ If you or your children lose coverage under your ex-spouse's or domestic partner's plan, you may enroll yourself and your children. ▪ You must drop your spouse's or domestic partner's coverage. ▪ You may drop coverage for your dependent children if they become covered under an ex-spouse's plan. ▪ You may change your Medical Program option.
Health Care Flexible Spending Account	▪ Enroll, increase, decrease or stop participation.
Dependent Care (Day Care) Flexible Spending Account	▪ Enroll, increase, decrease or stop participation.
Long-Term Disability	▪ Enroll or drop coverage. (Subject to Evidence of Insurability [EOI] requirements.)
Supplemental Life Insurance—Team Member, Spouse, Domestic Partner	▪ Enroll, increase, decrease or drop team member coverage or elect child coverage. Increases in coverage are subject to EOI requirements. You may increase coverage with EOI. If EOI is denied, you will keep your current level of coverage. Spouse/domestic partner must be dropped.
Other Benefit Considerations	▪ If your banking information is changing, consider if you need to change your direct deposit information for your paychecks. You can change your direct deposit information using the online paystub tool or by calling the Dell Service Center at 1-888-335-5663, option 3. ▪ If your banking information is changing, you should also consider if you need to change your financial institutions information. ▪ Contact your attorney to create or revise your will and living will. ▪ Consider revising your beneficiary designations on any 401(k), life insurance or investment accounts, including those you maintain outside Dell's benefit plans. ▪ Review your savings plan contributions.

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Benefit Plan	Allowed Changes and Considerations
	Visit My Well at Dell to learn more about these considerations.

All changes must be made within 31 days of your divorce or termination of domestic partnership.

Family Member's Coverage Costs Significantly Change

The following chart summarizes the changes allowed and some considerations if there is a significant change in your family member's cost of coverage for coverage provided outside the Dell plan, as defined by COBRA.

Benefit Plan	Allowed Change and Considerations for Increased Cost	Allowed Change and Considerations for Decreased Cost
Medical, Dental and Vision	▪ Enroll yourself. ▪ Add your spouse or domestic partner and affected children. ▪ Change Medical Program option.	▪ Drop your coverage. ▪ Drop your spouse's or domestic partner's coverage. ▪ Drop your affected children's coverage.
Employed Spouse Contribution	▪ If you enroll your spouse or domestic partner and he or she is employed and eligible for benefits through his or her employer, you will be required to pay an additional fee for Dell medical benefits.	▪ If you drop Dell medical benefits for your spouse or domestic partner, the additional fee for medical coverage is no longer required.
Dependent Care (Day Care) Flexible Spending Account	▪ Enroll, increase, decrease or stop participation (allowed only if the dependent care provider is not a relative).	▪ Enroll, increase, decrease or stop participation.
Long-Term Disability	▪ Enroll for coverage. (Subject to Evidence of Insurability [EOI] requirements.)	▪ Drop coverage.
Supplemental Life Insurance—Team Member, Spouse, Domestic Partner and Child	▪ Enroll, increase, decrease or stop participation. Increases in coverage are subject to EOI	▪ N/A

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Benefit Plan	Allowed Change and Considerations for Increased Cost	Allowed Change and Considerations for Decreased Cost
	requirements. This event permits a 1-level increase (subject to dollar maximums) to existing team member and spouse/domestic partner coverage with no EOI required, including first-time enrollment.	

All changes must be made within 31 days of the change in your family member's cost.

Family Member Gets New Coverage

The following chart summarizes the changes allowed and some considerations if your family member becomes eligible for a new benefit option under his or her employer's plan.

Benefit Plan	Allowed Changes and Considerations
Medical, Dental and Vision	▪ Drop your coverage. ▪ Drop your spouse's or domestic partner's coverage. ▪ Drop your affected children's coverage.
Employed Spouse Contribution	▪ If your spouse or domestic partner is enrolled and he or she is employed and eligible for medical benefits through his or her employer, you will be required to pay an additional fee for Dell medical benefits. ▪ If you drop Dell medical benefits for your spouse or domestic partner, the additional fee for medical coverage is no longer required.
Dependent Care (Day Care) Flexible Spending Account	▪ Enroll, increase, decrease or stop participation.
Long-Term Disability	▪ Decrease or drop coverage.
Supplemental Life—Team Member, Spouse, Domestic Partner or Child	▪ Decrease or drop coverage.

All changes must be made within 31 days of your family member gaining eligibility for the new benefit option.

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Family Member Makes New Annual Enrollment Election

The following chart summarizes the changes allowed and some considerations if your family member makes new benefit elections during his or her employer's annual enrollment.

Benefit Plan	Allowed Changes and Considerations
Medical, Dental and Vision	▪ Enroll yourself. ▪ Add your spouse or domestic partner. ▪ Add your affected children. ▪ Drop coverage for yourself if you become covered under your spouse's or domestic partner's plan. ▪ Drop coverage for your spouse or domestic partner and your eligible children if they become covered under spouse's plan.
Employed Spouse Contribution	▪ If your spouse or domestic partner is enrolled and he or she is employed and eligible for medical benefits through his or her employer, you will be required to pay an additional fee for Dell medical benefits. ▪ If you drop Dell medical benefits for your spouse or domestic partner, the additional fee for medical coverage is no longer required.
Dependent Care (Day Care) Flexible Spending Account	▪ Enroll, increase, decrease or stop participation.
Long-Term Disability	▪ Enroll or drop coverage. (Subject to Evidence of Insurability [EOI] requirements.)
Supplemental Life—Team Member, Spouse, Domestic Partner or Child	▪ Enroll, increase, decrease or drop coverage. Increases in coverage are subject to EOI requirements. This event permits a 1-level increase (subject to dollar maximums) to existing team member and spouse/domestic partner coverage with no EOI required, including first-time enrollment.

All changes must be made within 31 days of your family member's annual enrollment change effective date.

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Gain Eligibility in Another Plan

The following chart summarizes the changes allowed and some considerations if you or a family member gains eligibility for benefits through another employer because you have a second job or your spouse or domestic partner has had a qualified status change with his or her employer.

Benefit Plan	Allowed Changes and Considerations When You Gain Eligibility	Allowed Changes and Considerations When a Family Member Gains Eligibility
Medical, Dental and Vision	▪ Drop coverage for yourself.	▪ Drop coverage for you, your spouse or domestic partner and any affected children.
Health Care Flexible Spending Account	▪ No changes are allowed.	▪ Decrease or stop participation if your spouse is returning from strike, lockout or an unpaid leave of absence.
Dependent Care (Day Care) Flexible Spending Account	▪ Enroll, increase, decrease or stop participation.	▪ Decrease or stop participation if your spouse is returning from strike, lockout or an unpaid leave of absence.
Long-Term Disability	▪ Enroll, increase, decrease or drop coverage. (Subject to Evidence of Insurability [EOI] requirements.)	▪ Enroll or drop coverage. (Subject to EOI requirements.)
Supplemental Life Insurance—Team Member, Spouse, Domestic Partner and Child	▪ Decrease or drop coverage.	▪ Decrease or drop coverage.

All changes must be made within 31 days of the gain or loss of eligibility.

Go on or Return From a Leave of Absence

For information on what happens to your benefits and your options for managing your benefits when beginning and returning from leave, refer to the “Leaves of Absence” section.

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If You Become Disabled

Eligibility for STD or LTD benefits does not make you eligible to elect benefits coverage changes. However, if you are approved for an FMLA leave, you are eligible to make certain changes within the first 31 days of your FMLA leave. Refer to the “Leaves of Absence” section for more information on changes allowed or required during various leaves, including FMLA.

If You Leave Dell and Are Rehired

The following chart summarizes the changes allowed and some considerations if you leave Dell and are rehired within 30 days of your termination date as a benefits-eligible team member. **Note:** If you are rehired at a different location or at a different job grade, there may be differences in your medical plan and/or contributions.

Benefit Plan	**Allowed Changes and Considerations**
Medical, Dental and Vision	▪ You automatically receive the same coverage you had when your employment ended.
Health Care Flexible Spending Account	▪ You automatically receive the same coverage you had when your employment ended. ▪ Contributions will be recalculated based on the remaining pay periods.
Dependent Care (Day Care) Flexible Spending Account	▪ You automatically receive the same coverage you had when your employment ended. ▪ Contributions will be recalculated based on the remaining pay periods.
Short-Term Disability	▪ You automatically receive the same coverage you had when your employment ended.
Long-Term Disability	▪ You automatically receive the same coverage you had when your employment ended.
Basic Employee Life and AD&D Insurance	▪ You automatically receive the same coverage you had when your employment ended.
Supplemental Life—Team Member, Spouse, Domestic Partner or Child	▪ You automatically receive the same coverage you had when your employment ended.

If you return in a different calendar year or more than 30 days from your termination of employment, you must follow the same enrollment guidelines as a new hire.

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Loss of Eligibility in Another Plan

The following chart summarizes the changes allowed and some considerations if you or a family member loses eligibility for benefits in another plan.

Benefit Plan	Allowed Changes and Considerations When You Lose Eligibility	Allowed Changes and Considerations When Family Member Loses Eligibility
Medical, Dental and Vision	▪ Enroll yourself. ▪ Add your spouse or domestic partner. ▪ Add eligible children ▪ Change Medical Program option.	▪ Enroll yourself. ▪ Add your spouse or domestic partner. ▪ Add eligible children.
Employed Spouse Contribution	▪ If you enroll your spouse or domestic partner and he or she is employed and eligible for benefits through his or her employer, you will be required to pay an additional fee for Dell medical benefits.	▪ If you drop Dell medical benefits for your spouse or domestic partner, the additional fee for medical coverage is no longer required.
Health Care Flexible Spending Account	▪ No changes allowed.	▪ If family member is beginning an unpaid leave of absence, you can increase, decrease or stop participation. ▪ If family member is on strike or lockout or has a change in work schedule or work status, you can increase or start contributions.
Dependent Care (Day Care) Flexible Spending Account	▪ Enroll or increase participation.	▪ If family member is beginning an unpaid leave of absence, you can increase, decrease or stop participation. ▪ If family member is beginning a change in work schedule or work status, you can enroll or increase participation.

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Benefit Plan	Allowed Changes and Considerations When You Lose Eligibility	Allowed Changes and Considerations When Family Member Loses Eligibility
		▪ If family member transferred to a different worksite, you can enroll, increase, decrease or stop participation.
Long-Term Disability	▪ Enroll or drop coverage. (Subject to Evidence of Insurability [EOI] requirements.)	▪ Enroll or drop coverage. (Subject to EOI requirements.)
Supplemental Life Insurance—Spouse, Domestic Partner and Child	▪ Enroll, increase, decrease or drop coverage. Increases in coverage are subject to EOI requirements. This event permits a 1-level increase (subject to dollar maximums) to existing team member and spouse/domestic partner coverage with no EOI required, including first-time enrollment.	▪ Enroll, increase, decrease or drop coverage. Increases in coverage are subject to EOI requirements. This event permits a 1-level increase (subject to dollar maximums) to existing team member and spouse/domestic partner coverage with no EOI required, including first-time enrollment.

All changes must be made within 31 days of the gain or loss of eligibility.

Loss of Government or Educational Institution Plan Coverage

The following chart summarizes the changes allowed and some considerations if you, your spouse, domestic partner or eligible children lose coverage under another employer plan that is a government or educational institution plan.

Benefit Plan	Allowed Changes
Medical, Dental and Vision	▪ Enroll yourself. ▪ Add coverage for your spouse or domestic partner. ▪ Add coverage for your eligible children.
Employed Spouse Contribution	▪ If you enroll your spouse or domestic partner and he or she is employed and eligible for benefits through his or her employer, you will be required to pay an additional fee for Dell medical benefits.

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All changes must be made within 31 days of the loss of coverage.

Loss of Plan Eligibility or Termination of Employment

The following chart summarizes the changes that will occur and some considerations if you have a status change, such as a reduction in regularly scheduled time from full-time to part-time, that causes you to lose eligibility for benefits or if you terminate employment.

Benefit Plan	**Changes**
Medical, Dental and Vision	▪ All coverage will end. ▪ You and/or your covered dependents may be eligible for continuation of coverage (including EAP) under COBRA; see the “COBRA Continuation Coverage” section for more information.
Health Care Flexible Spending Account	▪ If you were participating, participation will end; you may submit eligible expenses incurred before the event. ▪ You may be eligible for continuation of coverage under COBRA; see the “COBRA Continuation Coverage” section for more information.
Dependent Care (Day Care) Flexible Spending Account	▪ If you were participating, participation will end; you may be eligible to submit eligible expenses incurred before the event.
Short-Term and Long-Term Disability	▪ All coverage will end.
Basic Employee Life and AD&D Insurance	▪ All coverage will end. ▪ You may be able to port or convert coverage that you had under the Plan; see the “Portability or Conversion of Basic Life Insurance Coverage” and “Conversion of AD&D Insurance Coverage” sections for more information.
Supplemental Life Insurance—Team Member, Spouse or Domestic Partner and Child	▪ All coverage will end. ▪ You and/or your dependents may be able to port or convert any supplemental spouse/domestic partner or child life insurance coverage that you had under the Plan; see the “Portability of Supplemental Life Insurance Coverage” and “Conversion of Supplemental Life Insurance Coverage” sections for more information.

For more information, see the “When Coverage Ends” section.

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Loss of Subsidy From Another Employer

The following chart summarizes the changes allowed and some considerations if you lose subsidy from another employer during the plan year; for example, if you received subsidized coverage from a prior employer in a severance package and your severance package expires.

Benefit Plan	Allowed Changes and Considerations
Medical, Dental and Vision	▪ Enroll yourself. ▪ Add coverage for your spouse or domestic partner. ▪ Add coverage for your affected children. ▪ Change your Medical Program option.
Employed Spouse Contribution	▪ If you enroll your spouse or domestic partner and he or she is employed and eligible for benefits through his or her employer, you will be required to pay an additional fee for Dell medical benefits.
Health Care Flexible Spending Account	▪ Enroll or increase your contribution.

All changes must be made within 31 days of the loss of subsidy.

Medicare or Medicaid Eligibility

The following chart summarizes the changes allowed and some considerations if you or a family member become Medicare- or Medicaid-eligible or lose eligibility for Medicare or Medicaid.

Benefit Plan	Allowed Changes and Considerations When Become Eligible	Allowed Changes and Considerations When Eligibility Is Lost
Medical, Dental and Vision	▪ You may drop medical, dental or vision coverage only for the person who is eligible for Medicare or Medicaid.	▪ You may enroll yourself and add coverage for the eligible family member who loses Medicare or Medicaid. ▪ You may change your Medical Program option.
Health Care Flexible Spending Account	▪ Decrease or stop participation.	▪ Enroll or increase participation.
Other Benefit Considerations	▪ Change beneficiary designation for life and/or 401(k).	▪ Use Will Preparation Service, if eligible.

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Dell's programs comply with the rules of the Social Security Act of 1965, as amended. 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. Therefore, it is important that if you or a dependent is eligible for Medicare, you enroll for Medicare coverage. See the "Coordination of Benefits" section for more information.

Most changes must be made within 31 days of your gain or loss of eligibility for Medicare or Medicaid. However, if you are eligible to make changes to your benefits due to loss of Medicaid eligibility, you have 60 days from your loss of coverage to enroll.

Move or Worksite Change

The following chart summarizes the changes allowed and some considerations if you change your home address or your worksite address.

Benefit Plan	Allowed Changes and Considerations
Medical	▪ Change your Medical Program option (if your home address ZIP code changes to one not covered under your current Medical Program option). ▪ You may enroll eligible dependents if you need to change your Medical Program option or if new options become available.

Any new election must be made within 31 days of the change.

New Hire or Newly Eligible

The following chart summarizes the elections/changes allowed and considerations if you are a new hire at Dell and you are a benefits-eligible team member or you have had a change in employment status through which you became an eligible team member (such as increasing your work hours to 20 or more per week).

Benefit Plan	Allowed Elections/Changes
Medical, Dental and Vision	▪ Enroll yourself, your spouse or domestic partner and/or your eligible children.
Health Care Flexible Spending Account	▪ Enroll.
Dependent Care (Day Care) Flexible Spending Account	▪ Enroll.
Long-Term Disability	▪ Enroll or drop coverage.
Supplemental Life Insurance—Team Member, Spouse or Domestic Partner and Child	▪ Enroll or increase coverage for yourself, your spouse or domestic partner and/or eligible children.

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You must enroll within 31 days of your new hire or eligibility date.

Repatriating to the U.S.

The following chart summarizes the elections/changes allowed and considerations if you have previously been on a Dell Expatriate assignment, your home country is the U.S. and are repatriating.

Benefit Plan	Allowed Elections/Changes
Medical, Dental and Vision	▪ Enroll, change or drop your Medical and Dental Program options. ▪ You may enroll eligible dependents if you need to change your Medical Program option.
Health Care Flexible Spending Account	▪ Enroll, increase, decrease or stop participation.
Dependent Care (Day Care) Flexible Spending Account	▪ Enroll, increase, decrease or stop participation.
Voluntary Benefits	▪ Enroll yourself and your eligible dependents when you repatriate to the U.S.

You must submit changes within 31 days of the effective date of your new status.

Note: If you are a U.S. team member and you take no action, you will default into the PPO Plan and regional dental option, based on your home address.

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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.

Eligibility Claims and Appeals Procedures

Eligibility claims and appeals are related to participation in a program (including Health Rewards) 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.

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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. Comprehensive Welfare Benefits 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 team member 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, prescription drug, dental, vision, EAP, Critical Illness and Accidental Injury Insurance, Health Care Flexible Spending Account and Dependent Care (Day Care) Flexible Spending Account 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.

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The following information provides an overview of the claims and appeals process for health care benefit claims listed above. Health care claims are divided into:

- ***Urgent Claims***, which are requests for verification or approval of medical, dental or vision 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, 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 (U.S. Team Members)" section and how to file for reimbursement of eligible expenses under a medical reimbursement or flexible spending account is included in the "Health Care Flexible Spending Account Program" and "Dependent Care (Day Care) Flexible Spending Account Program" sections.

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.

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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.

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Health Care and Dependent Care (Day Care) Flexible Spending Account Program Claims and Appeals

If you feel your claim was denied in error, you must file a written appeal that explains why you believe the claim should be approved. Your written appeal must be mailed to:

Alight Smart-Choice Accounts
P.O. Box 64009
The Woodlands, TX 77387-4009

The appeal must be received within 180 days of the date you receive notice that your claim was denied. If your claim was never received, your appeal, with proof of timely claims submission, must be received by the claim-it-by date for the program. You may submit additional information related to your claim along with your appeal, such as written comments, documents, records, a letter from your health care provider indicating medical necessity of the denied product or service or any other information you feel will support your claim. In addition, you can request copies of all documents and information related to your denied claim, which will be provided at no charge.

Your appeal will be reviewed by a person who was not involved with the initial claim denial and who is not a subordinate of any person who was. The review will be a new look at your claim appeal without deference to the initial denial and will take into account all information submitted with your claim and/or appeal. You will be notified of the decision regarding your appeal in writing by Alight Smart-Choice Accounts within 30 days of receipt of your written appeal.

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 Aetna International Customer Resolution Team P.O. Box 14463 Lexington, KY 40512

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Type of Appeal	Send Written Appeals to:
	BCBSIL Claim Review Section P.O. Box 2401 Chicago, IL 60690-1364 Kaiser Permanente California Contact: Member Services at 1-800-464-4000 Kaiser Permanente Hawaii Hawaii Claims Administration P.O. Box 378021 Denver, CO 80237 Customer Service Tel: 1-808-432-5955 Customer Service Toll-Free: 1-800-966-5955 Customer Service Toll-Free TTY: 1-877-447-5990
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 Aetna International Customer Resolution Team P.O. Box 14463 Lexington, KY 40512 BCBSIL Claim Review Section P.O. Box 2401 Chicago, IL 60690-1364
Mental Health and Substance Abuse	Kaiser Foundation Health Plan, Inc. Attn: Regional Appeals Office 711 Kapiolani Blvd. Honolulu, HI 96816 Fax: 808-432-5667 KPHawaii.Appeals@kp.org Customer Service Tel: 1-808-432-5955 Customer Service Toll-Free: 1-800-966-5955 Customer Service Toll-Free TTY: 1-877-447-5990 Kaiser Permanente California DHMO: Kaiser Foundation Health Plan, Inc. Contact: Member Services at 1-800-464-4000

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Type of Appeal	Send Written Appeals to:
Employee Assistance Program	Lyra Health, Attn: Billing Operations 287 Lorton Avenue Burlingame, CA 94010 Email: care@lyrahealth.com Care Team: 1-877-222-4258
Prescription Drug Program. See the "Prescription Drug Program (U.S. Team Members)" 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 Aetna International Customer Resolution Team P.O. Box 14463 Lexington, KY 40512 Administrative Review Requests: CVS Caremark Attn: Prescription Claim Appeals MC 109 P.O. Box 52084 Phoenix, AZ 85072 Fax: 1-866-443-1172 Kaiser Permanente California DHMO: Kaiser Foundation Health Plan, Inc. Contact: Member Services at 1-800-464-4000 Kaiser Permanente Hawaii 711 Kapiolani Blvd Honolulu, HI 96813 Customer Service Tel: 1-808-432-5955 Customer Service Toll-Free: 1-800-966-5955 Customer Service Toll-Free TTY: 1-877-447-5990
Dental Program	U.S. team members Delta Dental P.O. Box 1809 Alpharetta, GA 30023-1809

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Type of Appeal	Send Written Appeals to:
	Hawaii team members and Expatriates Depending on your medical option enrollment: If enrolled in Aetna International: Aetna International Customer Resolution Team P.O. Box 14463 Lexington, KY 40512 If enrolled in Kaiser Permanente: Delta Dental P.O. Box 1809 Alpharetta, GA 30023-1809
Vision Program (U.S. Team Members)	Vision Service Plan P.O. Box 997105 Sacramento, CA 95899-7105
Health Care Flexible Spending Account Program	Alight Smart-Choice Accounts P.O. Box 64009 The Woodlands, TX 77387-4009
Dependent Care (Day Care) Flexible Spending Account Program	Alight Smart-Choice Accounts P.O. Box 64009 The Woodlands, TX 77387-4009
Critical Illness Insurance (U.S. Team Members)	Cigna Group Insurance P.O. Box 55290 Phoenix, AZ 85078
Accidental Injury Insurance (U.S. Team Members)	Cigna Group Insurance P.O. Box 55290 Phoenix, AZ 85078
Cigna Travel Medical Insurance	Cigna Global Health Benefits Attn: Appeals Department P.O. Box 15800 Wilmington, Delaware 19850

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. If you're a U.S. team member, for certain Claims Administrators, including National coverage option medical carriers, 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.

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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.

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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) (U.S. team members 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.

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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 (U.S. team members only)—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.

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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.

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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.

Regional Medical Plans (U.S. team members only)

For a complete description of Member claims and appeals processes under the Regional Medical Plan coverage options, contact the following:

- Kaiser Permanente California DHMO: Contact Kaiser Member Services at 1-800-464-4000 or refer to the Evidence of Coverage (EOC) brochure located at my.kp.org/Dell.
- Kaiser Permanente POS Program Hawaii: Contact Kaiser Member Services at 1-800-966-5955 or refer to the Evidence of Coverage (EOC) brochure located at my.kp.org/Dell.

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Critical Illness and Accidental Injury Insurance Claims and Appeals

If you are a U.S. team member, the following information explains the claims and appeals process for Critical Illness and Accidental Injury Insurance benefit claims.

Claims for Disability Benefits Under Critical Illness and Accidental Injury Insurance

A disability "claim" is any claim which requires a determination of disability by Cigna regardless of the type of plan under which it arises (for example, short-/long-term disability, waiver of premium, etc.). A disability claim is "filed" as of the date Cigna first receives notice that a claimant is seeking disability benefits under the Plan.

Cigna has 45 days from the date it receives a claim for disability benefits to determine whether or not benefits are payable. Cigna may require more time to review the claim if necessary due to matters beyond its control. The review period may be extended for up to two additional 30-day periods. If this should happen, Cigna must provide its extension notice in writing before expiration of the current decision period, explaining the circumstances requiring extension and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information, and the time for Cigna's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date Cigna receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

During the review period, Cigna may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If additional information is required, Cigna will notify the claimant, in writing, stating what information is needed and why it is needed.

If the claim is approved, Cigna will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, Cigna will provide written or electronic notice which will include the following information:

- The specific reason(s) for the decision;
- Specific reference to the Plan provision(s) on which the decision was based;
- A description of any additional information required to perfect the claim, and the reason this information is necessary;
- A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by the claimant to Cigna of the health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - The views of medical or vocational experts whose advice was obtained on behalf of Cigna in connection with the claimant's adverse benefit decision, without regard to whether the advice was relied upon in making the benefit decision; and
    - A disability decision regarding the claimant presented by the claimant to Cigna made by the SSA;
- Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria Cigna relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;

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- If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits; and
- A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Appeal of Denied Disability Claims

Whenever a claim decision is fully or partially adverse, unless ERISA provides otherwise, the claimant must appeal once to Cigna. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records and other information relevant to the claim for benefits, and the claimant may submit to Cigna written comments, documents, records and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by Cigna, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by Cigna within 180 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. Cigna has 45 days from the date it receives a request for appeal to provide its decision. Under special circumstances, Cigna may require more time to review the claim and can extend the time for decision, once, by an additional 45 days. If this should happen, Cigna must provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected. If the extension is made because additional information must be furnished, the claimant has 45 days within which to provide the requested information, and the time for Cigna's decision shall be tolled (stopped) from the date on which the notification of the extension was sent until the date Cigna receives the claimant's response or upon the date the requested information is required to be furnished expires, whichever is sooner.

The review will give no deference to the original claim decision. The review will not be made by the person who made the initial claim decision, or a subordinate of that person. When deciding an appeal based in whole or in part upon medical judgment, Cigna will consult with a medical professional having the appropriate training and experience in the field of medicine involved in the medical judgment. Any medical or vocational experts consulted by Cigna for the review will be identified and will not be the expert who was consulted during the initial claim decision or a subordinate of that expert.

During the appeal, Cigna may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If additional information is required, Cigna will notify the claimant, in writing, stating what information is needed and why it is needed.

Before Cigna issues an adverse benefit decision on appeal, if Cigna considered, relied upon, or generated any new or additional evidence in connection with the claim, and/or if Cigna intends to rely on any new or additional rationale in connection with that review, then such evidence and/or rationale will be provided to the claimant, free of charge, as soon as possible and sufficiently in advance of the date that the decision on appeal is required to be made, giving the claimant a reasonable opportunity to respond.

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If the claim is approved, Cigna will pay the appropriate benefit. If the claim decision on appeal is adverse, in whole or in part, Cigna will provide written or electronic notice that includes:

- The specific reason(s) for the decision;
- Specific reference to the Plan provision(s) on which the decision was based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits;
- A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures;
- A statement of claimant's right to bring a civil action under section 502(a) of ERISA, including a description of any applicable contractual limitations period that applies to the claimant's right to bring such an action, and the calendar date on which the contractual limitations period expires for the claim;
- A discussion of the decision, including an explanation of the basis for disagreeing with or not following:
    - The views presented by the claimant to Cigna of the health care professionals treating the claimant and vocational professionals who evaluated the claimant;
    - The views of medical or vocational experts whose advice was obtained on behalf of Cigna in connection with the adverse decision, without regard to whether the advice was relied upon in making the adverse decision; and
    - A disability decision regarding the claimant presented by the claimant to Cigna made by the SSA;
- Either the specific internal rules, guidelines, protocols, standards or other similar plan criteria Cigna relied upon in making the decision, or, alternatively, a statement that such rules, guidelines, protocols, standards or other similar plan criteria do not exist;
- If the adverse decision is based upon medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the decision, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- A notice provided in a culturally and linguistically appropriate manner, to the extent required by ERISA.

Claims for Non-Disability Benefits

A non-disability "claim" is any claim which does not require a determination of disability by Cigna regardless of the type of policy under which it arises (for example, a death claim, an accident claim, etc.). A non-disability claim is "filed" as of the date Cigna first receives notice that a claimant is seeking benefits under the Plan.

Cigna has 90 days from the date the claim is filed to determine whether or not benefits are payable. Cigna may require more time to review the claim if special circumstances exist. The review period may be extended for up to one additional 90-day period. If this should happen, Cigna will provide the extension notice in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

During the review period, Cigna may require a medical examination of the claimant, at its own expense, or additional information regarding the claim. If additional information is required, Cigna must notify the claimant, in writing, stating what information is needed and why it is needed.

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If the claim is approved, Cigna will pay the appropriate benefit. If the claim decision is adverse, in whole or in part, Cigna will provide written or electronic notice which will include the following information:

- The specific reason(s) for the claim decision;
- Specific reference to the Plan provision(s) on which the decision was based;
- A description of any additional information required to perfect the claim, and the reason this information is necessary; and
- A description of the review procedures and the time limits applicable to those procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of ERISA after the claimant appeals and after the claimant receives an adverse decision on appeal.

Appeal of Denied Non-Disability Claims

Whenever a claim decision is fully or partially adverse, the claimant must appeal once to Cigna. As part of the claimant's appeal, the claimant may receive, upon request, free of charge, copies of all documents, records and other information relevant to the claim for benefits, and the claimant may submit to Cigna written comments, documents, records and other information relating to the claim. The review will take into account all comments, documents, records and other information the claimant submits related to the claim, without regard to whether such information was submitted or considered in the initial claim decision. Once an appeal request has been received by Cigna, a full and fair review of the claim appeal will take place.

A written request for appeal must be received by Cigna within 60 days from the date the claimant received the adverse decision. If an appeal request is not received within that time, the right to appeal will have been waived. Cigna has 60 days from the date it receives a request for appeal to provide its decision. Under special circumstances, Cigna may require more time to review the claim and extend the time for decision, once, by an additional 60 days. If this should happen, Cigna will provide the extension notice, in writing, before expiration of the initial decision period, indicating the special circumstances and the date a decision is expected.

If the appeal decision is adverse, in whole or in part, Cigna will provide written or electronic notice that includes:

The specific reason(s) for the claim decision;

- Specific reference to the Plan provision(s) on which the decision was based;
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits;
- A statement describing any voluntary appeal procedures offered, and the claimant's right to obtain the information about those procedures, and
- A statement of the claimant's right to bring a civil action under section 502(a) of ERISA.

Disability Benefit Claims and Appeals

The following information explains the claims and appeals process for disability benefit claims, which include claims for Short-Term Disability (STD) and Long-Term Disability (LTD) benefits.

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Filing a Disability Benefit Claim

For STD: You must notify the Leave and Disability Center no later than eight calendar days after you become disabled. Failure to notify the Leave and Disability Center within 30 calendar days of your disability may result in the denial of your claim.

For LTD: You must notify the Leave and Disability Center within 30 calendar days of your disability to be eligible for Long-Term Disability benefits. You must also send the Leave and Disability Center written proof of your claim no later than 90 days after the 180-day elimination period ends. If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required except in the absence of legal capacity.

You can contact the Leave and Disability Center at 1-855-857-0325.

If you have filed a claim for workers' compensation, which is then denied, you must notify the Leave and Disability Center to pursue benefits under the Short-Term Disability Plan. These claims will not be considered late filing under the terms of the Short-Term Disability Plan.

Claims can be filed by you, your dependent, or someone authorized to act on your or their behalf. Claims should be submitted as soon as possible, but no later than one year after the disability begins. If a claim is not submitted within this period or within an earlier period specified above, it may be denied.

Disability Benefit Claim Determinations

After you have submitted your claim, your disability claim will be evaluated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. If your claim is approved, the amount of your benefit will be calculated and Short-Term Disability benefits will be paid through the regular Dell payroll process. Long-Term Disability benefits will be paid in accordance with the Long-Term Disability program.

If the claim is denied, you will receive a written explanation.

Notification of Disability Benefit Claim Decision

Once your claim is reviewed, the Claims Administrator will notify you in writing of the determination. If the claim is denied, the written denial notice will include:

- 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;
- A discussion of the decision and any reasons for disagreeing with or not following:

    - The views you presented to the Plan of health care professionals treating you and vocational professionals who evaluated you;
    - The views of medical or vocational experts consulted by the Plan in connection with your claim denial (regardless of whether the advice was relied upon in making the benefit determination); and
    - An SSA disability determination you presented to the Plan;

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- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following a denial of the final appeal; and
- 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.

In addition, the notice may include:

- Any internal rule, guideline, protocol or other similar criterion that was relied on in making the determination or a statement that such rule, guideline, protocol or similar criterion do not exist; and
- 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 or applying the terms of the Plan to your medical circumstances, if the determination was based on medical necessity, experimental treatment or a similar exclusion or limit in the assessment or treatment of the condition on which the disability benefit claim is based.

If You Disagree With a Disability Benefit Claim Decision

If a benefit is denied or limited and you disagree with that denial, you or your authorized representative must request a review of the denied claim (appeal). An appointment of representation (authorizing a representative) in a form approved by the Plan may be required if an appeal is filed on behalf of the member.

Disability Benefit Claim Appeal Determination

The Disability Program includes a two-level appeal process for both STD and LTD benefit claims. The review of your claim on appeal will be conducted by an impartial and independent party who did not make, and who is not a subordinate of someone who made, the initial denial, and will not afford deference to the initial benefit determination. If your claim involves medical judgment, the Claims Administrator will consult with an appropriate health care professional who was not consulted, and who is not a subordinate of someone who was consulted, in the initial denial. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents and information relevant to your claim for benefits, and the identification of any medical or vocational experts whose advice was obtained in connection with the denial of your claim.

STD Benefit First Level Claim Appeal Determination

If you disagree with your STD determination, you or your authorized representative must appeal by submitting a written request for review of your denied claim within 180 days after your receipt of the denial letter. When requesting the review of the claim denial, please state the reason(s) you believe your claim was improperly denied. You may also submit additional medical or vocational information, and any facts, data, questions or comments you deem appropriate.

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Information to consider when requesting an appeal:

- Is there new medical documentation to submit with your appeal?
- Does the new medical documentation cover the time frame that has been denied?
- Has medical documentation been submitted from all of your treating providers?

The National Appeals Unit will consider all documents, records and other information submitted, even if this information was not previously provided.

The National Appeals Unit will provide the appeal decision within 45 days after receipt of the request for appeal. You will receive a notice of this decision in writing. If an extension is required, you will receive a notice explaining why the extension is needed and the new decision date.

If you need additional time to provide medical records, documentation or other information, "tolling" may be available upon request. Tolling (additional time) will temporarily pause the National Appeals Unit's 45-day decision period while you provide additional information.

Requests for STD appeal review and supporting documentation should be faxed to 1-855-673-2488 or submitted to:

National Appeals Unit (NAU)
P.O. Box 14748
Lexington, KY 40512-4748

Prior to an appeal denial, you will be provided as soon as possible before the appeal denial notification with any new or additional evidence considered, relied upon, or generated by the Plan, insurer or other person making the benefit determination.

If your appeal is **denied**, in whole or in part, you will be notified, in writing, of:

- The specific reason(s) for denial;
- The Plan provisions on which the denial was based;
- A discussion of the decision and any reasons for disagreeing with or not following:
    - The views you presented to the Plan of health care professionals treating you and vocational professionals who evaluated you;
    - The views of medical or vocational experts consulted by the Plan in connection with your claim denial (regardless of whether the advice was relied upon in making the benefit determination); and
    - An SSA disability determination you presented to the Plan;
- 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 benefit claim;
- If an internal rule, guideline, protocol or other similar criterion was relied on in making the determination, you will receive either a copy of this information or a statement that this information does not exist;
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

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- A description of any further Plan review procedures and the time limits applicable to such procedures, and a statement of your right to bring a civil action under section 502(a) of ERISA following a denial of the final appeal and any applicable contractual limitations period that applies to your right to bring such an action.

STD Benefit Second-Level Claim Appeal Determination

If you disagree with your first level STD appeal determination, you or your authorized representative must appeal by submitting a written request for review of your denied claim within 180 days after your receipt of the denial letter for the first level appeal. When requesting the review of the claim denial, please state the reason(s) you believe your claim was improperly denied. You may also submit additional medical or vocational information, and any facts, data, questions or comments you deem appropriate for us to give your appeal proper consideration. Requests for STD appeal review and supporting documentation should be faxed to 1-855-673-2488 or submitted to:

National Appeals Unit (NAU)
P.O. Box 14748
Lexington, KY 40512-4748

The process for second level appeals follows the same guidelines as noted above in the “STD Benefit First Level Claim Appeal Determination” section.

The decision on a second level appeal is final. As a result, once final, the Claims Administrator will not review your matter again. Once a final decision has been made you have exhausted the Plan’s claims and appeals process.

LTD Benefit First-Level Claim Appeal Determination

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate time frame (in which case the claim for benefits is deemed to have been denied) and you disagree with the denial, you or your representative must appeal your denied claim in writing to New York Life within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. You may submit with your appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by New York Life, utilizing individuals not involved in the initial benefit determination. This review will not afford any deference to the initial benefit determination.

New York Life shall make a determination on your claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if New York Life determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date that New York Life expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled (i.e., suspended) from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information or the deadline to provide the information has passed.

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Prior to an appeal denial, you will be provided as soon as possible before the appeal denial notification with any new or additional evidence considered, relied upon, or generated by the Plan, insurer or other person making the benefit determination.

If the claim on appeal is denied in whole or in part, you will receive a written notification from New York Life of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include:

- The specific reason(s) for the adverse determination;
- References to the specific plan provisions on which the determination was based;
- A discussion of the decision and any reasons for disagreeing with or not following:
    - The views you presented to the Plan of health care professionals treating you and vocational professionals who evaluated you;
    - The views of medical or vocational experts consulted by the Plan in connection with your claim denial (regardless of whether the advice was relied upon in making the benefit determination); and
    - An SSA disability determination you presented to the Plan;
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request;
- A statement describing any further appeal procedures offered by the Plan and your right to obtain the information about such procedures, and a statement of your right to bring an action under Section 502(a) of ERISA, and any applicable contractual limitations period that applies to your right to bring such an action;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in making the denial, either the specific rule, guideline, protocol, or other similar criterion or a statement that such rule, guideline, protocol or other similar criterion was relied upon in making the denial and that a copy of the rule, guideline, protocol or other similar criterion does not exist; and
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

LTD Benefit Second-Level Claim Appeal Determination

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate time frame (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal of your denial in writing to New York Life within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied. New York Life will accept your second appeal only if new information for the time period under review is submitted. You may submit with your second appeal any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

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New York Life shall make a determination on your second claim appeal within 45 days of the receipt of your appeal request. This period may be extended by up to an additional 45 days if New York Life determines that special circumstances require an extension of time. A written notice of the extension, the reason for the extension and the date by which New York Life expects to render a decision shall be furnished to you within the initial 45-day period. However, if the period of time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information or the deadline to provide the information has passed.

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this Plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the Plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the Plan agrees that any statute of limitations or other defense based on timeliness is tolled during the time that the appeal is pending.

If your second level appeal is denied in whole or in part, you will receive a written notification from New York Life of the denial. The notice will be written in a manner calculated to be understood by the applicant and shall include the same type of information that was included in the first level appeal denial letter. If a decision on appeal is not furnished to you within the time frames mentioned above, the claim shall be deemed denied on appeal.

Requests for LTD appeal review and supporting documentation should be mailed or faxed to:

New York Life
P.O. Box 22325
Pittsburgh, PA 15222
Fax: 1-866-517-9874

The Plan Administrator has appointed the Insurance Company as the named fiduciary for adjudicating claims for benefits under the Plan, and for deciding any appeals of denied claims. The Insurance Company shall have the authority, in its discretion, to interpret the terms of the Plan, to decide questions of eligibility for coverage or benefits under the Plan, and to make any related findings of fact. All decisions made by the Insurance Company shall be final and binding on participants and beneficiaries to the full extent permitted by law.

Death or Dismemberment Benefit Claims and Appeals

The following information explains the claims and appeals process for death or dismemberment benefit claims, which are claims for benefits under the Basic Life Insurance, AD&D Insurance and Supplemental Life Insurance Programs.

Filing a Death Benefit Claim

Claims can be filed by you (for a dependent), your dependent, your beneficiary or someone authorized to act on your or their behalf. Claims should be submitted as soon as possible, but no later than one year after the date of death. If a claim is not submitted within this period, it may be denied.

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To file a claim, request a Claim Initiation Form from the Dell Benefits Center. You must complete this form and include a description of the death or dismemberment benefits for which you are applying and any relevant documentation, such as a death certificate in the case of a death benefit claim (you will be notified of what you need to provide when you contact the Dell Benefits Center).

For Basic and Supplemental Life Insurance, return the form to:

MetLife Group Life Claims
P.O. Box 6100
Scranton, PA 18505-6100
Fax: 1-570-558-8645

For AD&D Insurance, return the form to:

AIG Accident & Health Claims Department
PO BOX 25987
Shawnee Mission, KS 66225

Death or Dismemberment Benefit Claim Determinations

You or your beneficiary will receive a determination notice as soon as possible. If the claim is denied, you will receive a written explanation within 60 days after the claim is filed. This period may be extended once by 90 days for special circumstances. You will be notified of the circumstances requiring the extension and the date by which the Plan expects to render a decision within the original 90-day response period.

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.

Notification of Death or Dismemberment Benefit Claim Decision

Once your claim is reviewed, the Claims Administrator will notify you in writing of the determination. If the claim is denied, the written denial notice will include:

- 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; and
- A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action under section 502(a) of ERISA following a denial of the final appeal.

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.

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If You Disagree With a Death or Dismemberment Benefit Claim Decision

If a benefit is denied or limited and you disagree with that denial, you, your beneficiary or your representative must request a review of the denied claim (appeal). An appointment of representation (authorizing a representative) is required if an appeal is filed on behalf of the member. 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 Dell Benefits Center.

As part of the review process, you may review pertinent documents and submit written issues. You or your representative, with proper consent, may make a written request for a full and fair review of the claim denial. The written request must be received by the Plan 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.

For Basic and Supplemental Life Insurance, send the request to:

MetLife
Appeals
P.O. Box 6100
Scranton, PA 18505

For AD&D insurance, send the request to:

AIG Accident & Health Claims Department
PO BOX 25987
Shawnee Mission, KS 66225

Death or Dismemberment Benefit Claim Appeal Determination

The Plan includes a one-level appeal process for death benefit claims. However, the review of your claim on appeal will be conducted by an impartial and independent party from the initial claim review.

You will receive written notice no later than 60 days after your request for review. If special circumstances require an extension, the period may be extended by an additional 60 days (120 days in total). You will be notified in writing if an additional 60-day extension is needed.

If your appeal is **denied**, in whole or in part, you will be notified, in writing, of:

- The specific reason(s) for denial;
- The Plan provisions on which the denial was 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 benefit claim; and
- A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures, and a statement of your right to bring an action under section 502(a) of ERISA and the time frame within which you must bring such action.

The decision on appeal is final. As a result, once final, the Claims Administrator will not review your matter again.

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Business Travel Accident Insurance Claims

To submit a claim for benefits under the Business Travel Accident Insurance program, send a written request to:

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

If Your MetLife Legal Plans Benefits Are Denied

Denials of Eligibility

MetLife Legal Plans verify eligibility using information provided by Dell. When you call for services, you will be advised if you are ineligible, and MetLife Legal Plans will contact Dell for assistance. If you are not satisfied with the final determination of eligibility, you have the right to a formal review and appeal.

Denials of Coverage

If you are denied coverage by MetLife Legal Plans or by any Plan Attorney, you may appeal by sending a letter to:

MetLife Legal Plans, Inc. Director Administration
1111 Superior Avenue, Suite 800
Cleveland, OH 44114-2507

The Director will issue MetLife Legal Plans' final determination within 30 days of receiving your letter. This determination will include the reasons for the denial with reference to the specific Plan provisions on which the denial is based and a description of any additional information that might cause MetLife Legal Plans to reconsider the decision, and an explanation of the review procedure. In general, your claim for benefits is paid as soon as reasonably possible. However, your claim may not be paid simply because you have not provided sufficient information. If more information is needed, you will need to submit the required information in writing in order to have the claim processed.

Your Right to Appeal

If your claim is denied, in whole or in part, you have two possible ways of appealing the denial:

- By using the Legal Plan Provider’s grievance procedure; or
- By using the Plan’s ERISA claims procedure. You may do both if you wish (including appealing a grievance procedure denial by using the Plan’s ERISA claims appeal procedure).

Identity Theft Protection Claims Process

To report a claim to Allstate Identity Protection, all claims must be filed by phone with an AIP Restoration Specialist to ensure privacy, expedited payment, quick resolution and proper filing procedures. AIP's Restoration Specialists work very closely with victims through every step of the process. As of January 1, 2023, participants will also be able to track their claims through the Resolution Tracker within the portal.

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In order to initiate a claim, the victim's dedicated Restoration Specialist will gather all necessary details based on the victim's circumstances. If a claim is needed, the dedicated Restoration Specialist will serve as the internal point of contact for all interactions during the claim process.

Time limit for filing a claim: 90 days from becoming aware of the ID Theft event (Stolen Funds) / 60 days from becoming aware of the ID Theft event (General Reimbursement).

Allstate Identity Protection will pay any covered loss within 30 days after:

- Allstate Identity Protection reaches agreement with the member; or
- The entry of final judgment.

Allstate Identity Protection will pay all covered claims within 90 days from the date acceptable proof of loss is received.

For additional information about the Allstate Identity Protection reimbursement policy, log on to infoarmor.com/identity-fraud-financial-reimbursement.

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.

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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. Comprehensive Welfare Benefits 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.

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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.

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.

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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.

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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.

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- **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.

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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.

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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. Comprehensive Welfare Benefits 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

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- 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.

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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.

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- **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.

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- **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. Comprehensive Welfare Benefits 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 is not a guarantee of continued employment nor does it 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 team members, 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. Comprehensive Welfare Benefits Plan
- **Employer Identification Number:** 74-2487834
- **Plan Number:** 501
- **Plan Funding:** Except as noted otherwise, the Medical Program, Health Rewards, Fertility & Family Building, Prescription Drug Program, Dental Program through Delta Dental, Vision Program, Health Care Flexible Spending Account Program, Dependent Care (Day Care) Flexible Spending Account Program, Short-Term Disability Program and Adoption Assistance Program are self-funded programs, which means Dell pays benefits from its general assets. The Kaiser Permanente California DHMO Medical Program, the Kaiser Permanente Medical Program, Aetna International Expatriates Medical Plan, Employee Assistance Program, Long-Term Disability Program, Basic Employee Life and Accidental Death and Dismemberment Program, Supplemental Life Insurance Program, Business Travel Accident Program, Critical Illness Insurance, Accidental Injury Insurance, MetLife Legal Plans and Identity Theft Protection are fully insured programs, which means insurance companies pay benefits under the terms of an insurance policy or contract.
- **Type of Administration:** Dell Inc. through its Benefits Administration Committee
- **Plan Year:** January 1 – December 31

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- **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, 2022
- **Benefits:** The Plan is a comprehensive welfare plan providing Medical Program, Prescription Drug Program, Health Rewards, Employee Assistance Program, Dental Program, Vision Program, Health Care Flexible Spending Account, Dependent Care (Day Care) Flexible Spending Account, Short-Term Disability, Long-Term Disability, Life Insurance (Basic and Supplemental), AD&D and Business Travel Accident Insurance benefits, Critical Illness Insurance, Accidental Injury Insurance, Legal Plan Services and Identity Theft Protection.

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 team members 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.

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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.

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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.

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Glossary

Disclaimer

The terms below are commonly used terms but are not intended to be specific to every benefit described in this SPD only. Medical terms described here, apply principally to the National medical plan options. You should always check with your health plan if you have a specific question about a defined term.

Terms

Actively at Work means, for long-term disability, life and accidental death and dismemberment insurance coverage, that you are performing all of the usual and customary duties of your job on a full-time basis. This must be done at:

- A Dell place of business;
- An alternate place approved by Dell; or
- A place to which Dell's business requires you to travel.

You will be considered to be actively at work during weekends or Dell-approved vacations, holidays or business closures if you were actively at work on the last scheduled work day preceding this time off.

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.

Annual Eligible Earnings: Your annual base salary (including your standard wage, excluding commissions, bonuses, overtime pay or any other extra compensation). Sales team members' monthly earnings will include total target compensation but not actual commissions or other sales-related earnings.

Applicable Charges for professional services (applies to Kaiser Permanente POS option [Hawaii only])—Applicable Charges mean:

- When Medical Group or Health Plan Hospital provides medical services to a Member, then Member Rates are used.
- When a contracted non-Medical Group practitioner or a contracted non-Health Plan facility provides medical services to a Member, the Applicable Charge is the negotiated rate.

For other medical services or items, Applicable Charges mean:

- When Kaiser Permanente provides medical services or items to a Member, then Member Rates are used.
- When medical services or items are not provided by Kaiser Permanente, then Applicable Charges mean the negotiated rate, or the actual billed charge.

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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.

Associated Events, as this relates to the Business Travel Accident Program, means events that have a common cause or are a chain of events forming part of a larger or broader event, even if the individual events themselves are separate in time and place.

Autism Spectrum Disorders as defined in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* of the American Psychiatric Association.

Base Monthly Earnings: Your Daily Earnings multiplied by 365 (366 for a leap year), then divided by 12.

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.

Benefit-Eligible Earnings is the amount used to calculate compensation-based benefits under the Dell Welfare Plan. It includes:

- Base salary (including your base compensation for the year, before any salary reduction for before-tax contributions to the savings plan, spending accounts and other health and insurance plans); and
- Targeted compensation for the year. (For Life Insurance, the “year” is the 12 months before the team member’s date of loss.)

Benefit-eligible earnings does not include:

- Bonuses;
- Overtime pay; or
- Extra compensation, profit sharing (for Life Insurance), including shift differentials.

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.

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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.

- **Accidental Injury Insurance Administrator:** Cigna Group Insurance (U.S. team members).
- **Business Travel Accident Claims Administrator:** Chubb.
- **Critical Illness Insurance Administrator:** Cigna Group Insurance (U.S. team members).
- **Dental Claims Administrator:** Delta Dental (U.S. team members). Aetna International (Expatriates) depending on enrollment.
- **Eligibility Claims Administrator:** Dell Benefits Administration Committee.
- **Fertility & Family Building Administrator:** Progyny, Inc. (U.S. team members)
- **Identity Theft Protection Administrator:** Allstate Identity Protection (U.S. team members).
- **Leave and Disability Claims Administrator:** Sedgwick.
- **Legal Plan Services Administrator:** MetLife Legal Plans (U.S. team members).
- **Life Insurance Claims Administrator:** MetLife.
- **Medical Claims Administrators:** Aetna, BCBSIL, Kaiser Permanente California (California team members), Kaiser Permanente (Hawaii team members) or Aetna International (Expatriates) depending on enrollment.
- **Prescription Drug Claims Administrator:** CVS Caremark for claims and their Independent Review Organization (IRO) for appeals for Aetna or BCBSIL (U.S. team members). Kaiser Permanente California (California team members), Kaiser Permanente (Hawaii team members) or Aetna International (Expatriates) depending on enrollment.
- **Reimbursement and Flexible Spending Account Claims Administrator:** Alight Smart-Choice Accounts.
- **Vision Claims Administrator:** VSP (U.S. team members).

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.

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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.

Country of Permanent Assignment, as it relates to the Business Travel Accident Program, means a country, other than a covered person's home country in which a covered person is required to work for a period that exceeds 180 days.

Covered Charge (applies to U.S. team members) 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.

Daily Earnings means your annual benefit-eligible earnings on the date you are certified as disabled by the Leave and Disability Center, divided by 365 (366 for a leap year). If you receive sales commissions as part of your total compensation, your Daily Earnings will include your total targeted compensation, not actual commissions or other sales-related earnings.

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.

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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 (does not apply to Life Insurance);
- 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.

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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 (applies to U.S. team members) 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.

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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.

Evidence of Insurability or EOI means documentation of good health of an individual before certain life insurance and long-term disability coverage is approved by the insurer. This may include proof of health through the completion of a form (such as a Statement of Health) or through a medical examination.

Expatriate means a team member working abroad on an approved international assignment. If U.S. outbound, the minimum length of assignment is six months.

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) (applies to U.S. team members) 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.

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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.

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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 Country, as it relates to the Business Travel Accident Program, means a country from which a covered person holds a passport. If the covered person holds passports from more than one country, his or her home country will be the country that he or she has declared to the insurer in writing is his or her home country.

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.

Imputed Income means the value of a benefit or service that is considered as income for the purposes of calculating your federal taxes.

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Illness means a sickness, disease or pregnancy.

In-Network means covered services provided by network or participating providers.

Indexed Earnings for disability means for the first 12 months monthly benefits are payable, indexed earnings will be equal to covered earnings. After 12 monthly benefits are payable, indexed earnings will be your covered earnings plus an increase applied on each anniversary of the date monthly benefits become payable. The amount of each increase will be the lesser of:

- 10% of your indexed earnings during the preceding year of disability; or
- The rate of increase in the Consumer Price Index (CPI-W) during the preceding calendar year.

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 (except for AD&D) 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.

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Maximum Allowable Charge (MAC) (Kaiser Hawaii) means, as determined by Kaiser Permanente as the Medical Claims Administrator, the amount of an out-of-network provider's charge that is eligible for coverage. This refers to the maximum charge that Kaiser Permanente will consider for a covered service you receive from contracted or noncontracted health care providers. For non-emergency services, the MAC is determined by Kaiser Permanente Insurance Company (KPIC) as the lesser of the:

- Usual and customary charge for services or supplies generally made or made within a local area;
- Rate KPIC has negotiated in advance with the provider for covered services; or
- Actual billed charges for the covered services. You can find a more detailed description of the MAC in your Certificate of Insurance.

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.

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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. You do not have to enroll in Part B if you are an active team member or the dependent of an active team member.

Mental Health and Substance Use Disorder Services (applies to U.S. team members) 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.

Mental Health and Substance Use Disorder Services (applies to Expatriates) means services for mental illness and substance use disorder that are classified in the International Classification of Diseases.

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 combined ID card for medical, prescription, dental and vision 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.

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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. Comprehensive Welfare Benefits 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.

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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.

Private passenger car means a validly registered four-wheeled private passenger car or policyholder-owned car, jeep, pickup truck or van, including a sport utility vehicle (SUV), that is not licensed commercially or being used for racing, or acrobatic or stunt driving.

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 team members enrolled in the 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.

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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.

Recognized Charge (applies to Expatriates) 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. You are responsible for all amounts above what is eligible for coverage. The recognized charge depends on the geographic area where you receive the service or supply. Contact Aetna for more information regarding recognized charges.

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.

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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.

Statement of Health means the form used by MetLife to provide Evidence of Insurability before life insurance coverage is approved.

Substance Abuse means the abuse of or psychological or physical dependence on or addiction to alcohol or a controlled substance.

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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.

Supplemental restraint system means an air bag which inflates for added protection to the head and chest areas.

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.

Team Member means you are an employee employed by Dell Inc.

Tobacco User means the smoking, chewing, inhaling or snuffing of tobacco or tobacco-related products.

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.

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Note: If you are a U.S. team member, 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.

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Neither an emergency room nor the outpatient department of a hospital shall be considered a Walk-in Clinic.

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