HP Inc. U.S. Health and Welfare Benefits

Summary Plan Description

Effective January 1, 2022

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Introduction

This summary plan description (SPD) describes the health and welfare benefits available to eligible employees of HP Inc. (the "Company") and their eligible dependents effective as of January 1, 2022. These health and welfare benefits together compose the HP Inc. Comprehensive Welfare Benefits Plan (the "Plan"). The benefits under the Plan are governed by the certificates of insurance issued by the insurers, this summary plan description, or other governing documents referenced herein. See the "Administrative information" section for plan document information. The Company has established the HP Inc. Cafeteria Plan to permit employees to pay and receive some of these benefits on a pre-tax basis in accordance with Section 125 of the Internal Revenue Code.

This SPD can help you better understand and use your health and welfare benefits, replaces previous SPDs, and is intended to comply with the disclosure requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA). It is to your advantage to read through this SPD, learn how the benefits work, and share this information with your family.

Incorporated documents

This SPD incorporates, by reference, the following documents:

- Aetna (High Deductible Health Plan with Health Savings Account (HDHP w/HSA), Consumer Driven Health Plan with Health Reimbursement Account (CDHP w/HRA), Premium Preferred Provider Organization (PPO), Value PPO, Exclusive Provider Organization (EPO) Group #: 476696 (Medical).
- Aetna (HyperX only) (HMO, PPO) Group #: 169567 (Medical/Prescription Drug/Mental Health/Substance Use)
- Anthem BCBS (HDHP w/HSA, CDHP w/HRA, Premium PPO, Value PPO, EPO, CMPs) Group #: 174000 (Medical)
- Cigna (HDHP w/HSA, CDHP w/HRA, Premium PPO, Value PPO, EPO) Group #: 3171768 (Medical)
- Cigna International Group #: 262 (Medical/Prescription Drug/Mental Health/Substance Use/Dental/Vision)
- Blue Essentials HMO Group #: 099167 (Medical/Prescription Drug/Mental Health/Substance Use)
- ComPsych Group #: HP (Mental Health/Substance Use) for Aetna (Excludes HyperX), Anthem BCBS, and Cigna
- HMSA Group #: 74901 (PPO) (Medical/Prescription Drug/Mental Health/Substance Use)
- Kaiser Colorado Group #: 904 (Medical/Prescription Drug/Mental Health/Substance Use)

- Kaiser Georgia Group #: 8218 (Medical/Prescription Drug/Mental Health/Substance Use)
- Kaiser Hawaii Group #: 1661 (Medical/Prescription Drug/ Mental Health/Substance Use)
- Kaiser Mid-Atlantic States Group #: 4843 (Medical/Prescription Drug/Mental Health/Substance Use)
- Kaiser Northern California Group #: 1501 (HMO) (Medical/Prescription Drug/Mental Health/Substance Use)
- Kaiser Northwest (HMO) Group #: 1400-006-009, 020 (Medical/Prescription Drug/ Mental Health/Substance Use)
- Kaiser Southern California Group #104601 (HMO) (Medical/Prescription Drug/Mental Health/Substance Use)
- MetLife Dental Group #: 312876 (Dental)
- Aetna DMO Group #: 868497 (Dental)
- CVS Caremark Group #: 3663 (Prescription Drug)
- EyeMed Vision Care, Standard Group #: 9756669; Premium Group #: 9756677 (Vision)
- New York Life Group Benefits (formerly Cigna) Policy #: 980026 (Life)
- New York Life Group Benefits (formerly Cigna) Policy #: 980362 (Accidental Death and Dismemberment (AD&D))
- MetLife (Long-Term Disability—Closed to New Participants)
- HP Inc. Long-Term Disability (LTD) Dependent Health Continuation (Long-Term Disability)
- New York Life Group Policy #: FLK-980256 (Long-Term Disability)
- New York Life Hawaii TDI0960538 (Long-Term Disability)
- ReedGroup (Short-Term Disability, Leave Administration)
- John Hancock Policy #: 28982 or 27178-600 (Long-Term Care Insurance—Closed to New Participants)
- MetLife Policy #: 114752 (Long-Term Care Insurance—Closed to New Participants)
- ARAG Group #: 15461 (Prepaid Group Legal Insurance)
- HP Inc. Cafeteria Plan (Health Care FSA /Limited Purpose Health Care FSA/Dependent Care FSA)

- Your Spending Account (Health Reimbursement Account (HRA)/ Health Care FSA/ Limited Purpose Health Care FSA/ Dependent Care FSA)
- HealthEquity (Limited Purpose Health Care FSA/Health Savings Account (HSA))
- ComPsych (Employee Assistance Plan)
- HP Inc. Retiree Welfare Benefits Plan Summary Plan Description

These listed documents are incorporated into this SPD and serve as the source of specific information relating to your health and welfare benefits. This SPD and the listed documents function as one document to summarize your benefits.

While this SPD and the incorporated documents describe your health and welfare benefits, if there is any inconsistency or discrepancy among the provisions of this document and the official plan documents, your rights and benefits will be determined under the official plan documents of the HP Inc. Comprehensive Welfare Benefits Plan.

Please note the word "Plan" or "plan" is used throughout this SPD. When capitalized, "Plan" refers to the HP Inc. Comprehensive Welfare Benefits Plan. When lowercased "plan" refers to any incorporated benefits option plan (e.g., each medical option plan, dental option plan, etc.), official plan documents, another employer's benefits plan, or another plan that is not the HP Inc. Comprehensive Welfare Benefits Plan.

Plan contacts

For additional information about your health and welfare benefits, you may contact the following:

Contacts
Plan administrator • Eligibility claims and appeals • Plan document requests HP Inc. Plan Committee Welfare Plan Claims 3800 Quick Hill Road, Bldg. 2-150 Austin, TX 78728-1343
Third party administrator • Verify your eligibility • Review your benefits • Get answers to most questions • Get information about premiums **HP Benefits Center** www.myhpbenefits.com 1-800-890-3100 1-847-883-0465 (outside the US, Puerto Rico, or Canada) Representatives are available Monday through Friday from 6 a.m. to 6 p.m. Pacific Time (8 a.m. to 8 p.m. Central Time)

Contacts

Claims administrators

- Review your benefits
- Locate a participating provider
- Obtain a predetermination
- Review your rights as a patient
- Speak with a claims service representative
- Request or download a claim form
- Claims and appeals process

Aetna Life Insurance Company
Attn: National Account CRT
PO Box 981106
El Paso, TX 79998-1106
aetna.com
1-800-545-5810
(self-insured medical)

Anthem BCBS Life and Health Insurance Company
Attn: Appeals
PO Box 54159
Los Angeles, CA 90054
anthem.com/ca
1-800-364-3301
(self-insured medical)

Cigna
4616 South US Hwy 75
Denison, TX 75020
cigna.com
1-800-244-6224
(self-insured medical)

Cigna International
PO Box 15800
Wilmington, DE 19850
cignaenvoy.com
1-800-441-2668
(fully insured medical)

Blue Essentials HMO
P.O. Box 660044
Dallas, TX 75266-0044
bcbstx.com
1-877-299-2377
(self-insured medical/prescription drug/mental health/substance use)

Contacts
ComPsych PO Box 8379 Chicago, IL 60680 guidanceresources.com 1-844-819-4773 (fully insured mental health/substance use/EAP) HMSA PO Box 860 Honolulu, Hawaii 96808-0860 hmsa.com 1-808-948-6111, option 5 (fully insured medical/prescription drug/mental health/substance use) Kaiser Permanente Northern California: Kaiser Permanente Health Plan, Inc. Claims Department PO Box 12923 Oakland, CA 94604-2923 kp.org 1-800-464-4000 (fully insured medical/prescription drug/mental health/substance use/vision/dental) Kaiser Permanente Southern California: Kaiser Permanente Health Plan, Inc. Claims Department PO Box 7004 Downey, CA 90242-7004 kp.org 1-800-464-4000 (fully insured medical/prescription drug/mental health/substance use/vision/dental) Kaiser Mid-Atlantic Region PO Box 6831 2101 East Jefferson Street Rockville, MD 20852-4908 kp.org 1-800-777-7902 (fully insured medical/prescription drug/mental health/substance use) Kaiser NW Region 500 NE Multnomah Street, KPB-14

Contacts
Portland, OR, 97232 kp.org 1-800-813-2000 or 1-503-813-4480 (fully insured medical/prescription drug/mental health/substance use) Kaiser Colorado 2500 S Havana Street Aurora, CO 80014-1622 kp.org 1-800-632-9700 (fully insured medical/prescription drug/mental health/substance use) Kaiser Hawaii 711 Kapiolani Blvd Honolulu, HI 96813 kp.org 1-800-966-5955 (fully insured medical/prescription drug/mental health/substance use) Kaiser Georgia Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736 kp.org 1-888-865-5813 (fully insured medical/prescription drug/mental health/substance use/vision/dental) HealthEquity 15 West Scenic Point Drive Draper, UT 84020 myhealthequity.com 1-866-346-5800 (Limited Purpose Health Care FSA, HSA) CVS Caremark PO Box 52136 Phoenix, AZ 85072-2136 caremark.com 1-844-740-0599 (self-insured prescription drug) MetLife Dental PO Box 981282 El Paso, TX 79998-1282

Contacts
metlife.com/dental 1-888-878-6388 (self-insured dental) Aetna Member Services—dental PO Box 14094 Lexington, KY 40512 aetna.com 1-877-238-6200 (fully insured dental) EyeMed Vision Care Attention: Quality Assurance 4000 Luxottica Place Mason, OH 45040 eyemed.com 1-866-504-9021 (fully insured vision) New York Life Group Benefits Solutions PO Box 22328 Pittsburgh, PA 15222-0328 newyorklife.com 1-800-362-4462 (fully insured life, AD&D) New York Life Group Benefits Solutions PO Box 709015 Dallas, TX 75370-9015 myNYLGBS.com 1-888-842-4462 (fully insured Long-Term Disability) ReedGroup PO Box 6278 10355 Westmoor Drive Westminster, CO 80021 1-866-218-4647 (self-insured Short-Term Disability) HP Inc. Welfare Plan Claims 3800 Quick Hill Road, Bldg. 2-150 Austin, TX 78728-1343

Contacts
1-800-890-3100 (self-insured LTD Dependent Health Continuation) John Hancock Life Insurance Company Group Long-Term Care Insurance PO Box 111 X-3 Boston, MA 02117 1-800-482-0022 (fully insured Long-Term Care Insurance—closed policy) MetLife Insurance Company Long-Term Care Group PO Box 14407 Lexington, KY 40512-4407 1-800-438-6388 (fully insured long term care, closed policy) Your Savings Account (YSA) HP Benefits Center 1-800-890-3100 (Dependent Care FSA, Health Care FSA, Limited Purpose Health Care FSA, HRA) ARAG legal insurance 400 Locust Street, Ste 480 Des Moines, IA 50309 araglegal.com/myinfo 1-800-762-3217 (prepaid group legal insurance)

Eligibility

You and your eligible dependents are eligible for the health and welfare benefits under the plan as follows.

Your eligibility

Generally, you are eligible for coverage under the Plan on the first day of employment if you are a regular active employee (as determined by HP) on US Payroll and regularly scheduled to work at least twenty (20) hours per week. Eligible employees also include:

- US interns (see "Special eligibility considerations" below);
- US employees on foreign assignment (expatriates or foreign-service employees) paid on the US Payroll; and
- Non-US employees on temporary assignment to the US (see "Special eligibility considerations" below).

See the "Eligibility for dependents" section for dependent eligibility rules. If you were terminated from HP due to disability, you may have the option to continue certain coverages. See the "Eligibility for certain disabled former employees" section for additional information.

The following categories of individuals are not eligible for the health and welfare benefits under the Plan:

- Individuals classified by HP as independent contractors, contingent workers, consultants, leased employees (within the meaning of the Internal Revenue Code or otherwise), or other similar categories;
- Employees who are covered by a collective bargaining agreement;
- Nonresident aliens with no US source of income (other than non-US employees on temporary assignment to the US as described above); and
- Residents of Puerto Rico who are employees paid on HP Puerto Rico Payroll.

If any of the above ineligible individuals later becomes an eligible employee, as determined by HP, eligibility begins as of the date of the change to an eligible status.

If you are excluded from the Company's definition of an eligible employee, you will not be eligible for benefits under the plan even if a court, the Internal Revenue Service (IRS), or any other enforcement authority finds that you should be considered an eligible employee.

Special eligibility considerations

In certain situations, there are special eligibility considerations to be aware of.

- **If an employee leaves HP as an eligible retiree**

  Medical option eligibility can continue, subject to certain changes in medical options and costs. More information regarding eligibility for post-employment retiree coverage is available in the HP Inc. Retiree Welfare Benefits Plan Summary Plan Description.

- **Interns**

  Interns are not eligible for Short-Term Disability (STD) and Long-Term Disability (LTD) coverage, LTD Dependent Health Continuation, or participation in the Retirement Medical Savings Account.

- **Employees on assignment in the US (inpats)**

  Inpats are only eligible for medical, dental, and vision benefits in the Cigna International Plan.

- **Terminated LTD Participants**

  If you are a Terminated LTD Participant, you are eligible for medical, dental, vision, life insurance, and Accidental Death and Dismemberment (AD&D) insurance benefits under the **HP Inc. Comprehensive Welfare Benefits Plan**. Although you are eligible for certain benefits under the Plan, not all of the provisions in this SPD apply to you (for instance, you are not eligible for COBRA coverage under the Plan). Information regarding eligibility, enrollment, cost of coverage, and other important terms and details are covered under the **HP Inc. Retiree Welfare Benefits Plan Summary Plan Description**. It is to your advantage to read through both this SPD, the **HP Inc. Retiree Welfare Benefits Plan Summary Plan Description**, and the incorporated documents to learn about your coverage and how the benefits work. You can also visit MyHPBenefits at www.myhpbenefits.com for more information.

  Terminated LTD Participants are eligible for medical, dental, vision, life insurance, and AD&D insurance benefits as outlined in this SPD. When you become eligible for Medicare due to disability or age, you will need to refer to the HP Inc. Retiree Welfare Benefits Plan Summary Plan Description. It is to your advantage to read through both this SPD, and the HP Inc. Retiree Welfare Benefits Plan SPD and the incorporated documents, to learn about your coverage and how the benefits work. You can also visit MyHPBenefits at www.myhpbenefits.com for more information.

If you become ineligible

If you remain an employee of the Company but become ineligible because you no longer meet the eligibility requirements (for example, you no longer qualify as an eligible employee working at least 20 hours per week), you immediately will become eligible once you meet the eligibility requirements again.

If you become disabled

If you should become disabled, you may be able to continue your eligibility for some or all of the health and welfare benefits under the Plan. Please refer to the incorporated documents for each specific benefit to determine your eligibility to continue your benefits. In addition, you may be able to continue health benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). See the "COBRA continuation rights" section for more details.

Eligible dependents

Dependent eligibility

For purposes of all benefits available to dependents under the Plan, your spouse or your domestic partner is considered an eligible dependent.

Working Spouse Surcharge

If you choose to cover a spouse or domestic partner under HP medical benefits, your payroll deduction costs will include a Working Spouse Surcharge per pay period (see "Annual enrollment materials" section for cost of surcharge) if your spouse or domestic partner has access to other employer coverage outside of HP (regardless of whether your spouse or domestic partner actually participates in the other employer coverage). For this purpose, other employer coverage includes medical coverage made available as an employee or retiree of another employer, or coverage made available through the federal government or the military (i.e., as a federal government employee or member of the military). If your spouse or domestic partner does not have access to other employer coverage, you'll need to certify this fact as part of your enrollment, and the surcharge will not apply.

Please note the surcharge will not apply if:

- Your spouse's or domestic partner's employer simply makes medical coverage available but requires employees to pay the full premium cost of coverage (with no employer contributions);
- Your spouse or domestic partner has access to medical coverage through HP as either an eligible employee or retiree of HP;
- Your spouse or domestic partner is covered by Medicare (Medicare is not considered to be other "employer" coverage for this purpose.); or
- Your spouse or domestic partner also works for HP.

Additional information about the Working Spouse Surcharge, is available by contacting the plan administrator.

Your child is eligible for coverage offered to dependents under the Plan based on the following rules:

- **Coverage for children under age 26:** Any child of the participant or spouse/domestic partner who is under age 26 is an eligible dependent under the Plan.
- **Coverage for children with disabilities:** Any child of a participant or spouse/domestic partner who is incapable of self-sustaining support by reason of physical or mental

disability is an eligible dependent under the Plan so long as all the following qualifications are met:

- The child must have become disabled before reaching age 26;
- The child must be enrolled in the applicable Plan coverage prior to the age limit applying, or within 31 days of the child's initial plan eligibility, if later, for medical, dental, and vision benefits; and
- The child must remain continuously enrolled in the applicable Plan coverage thereafter.

Eligibility for this continued coverage is subject to periodic certification and approval by the plan administrator or a claims administrator. If you change medical options following a qualified status change or during an annual enrollment period, you may need to recertify the previously eligible child with the new medical option to continue coverage.

The following definitions apply for purposes of this "Eligible dependents" section:

- "Child" means:
  - Biological children;
  - Stepchildren (only so long as the marriage or domestic partnership lasts);
  - Adopted children or children placed for adoption;
  - Foster children and/or children under legal guardianship;
  - Other children who qualify as federal tax dependents; and
  - Children for whom a Qualified Medical Child Support Order (QMCSO) has been issued by a US court or state agency.
- "Spouse" means a person who is lawfully married under any state law to the enrolling employee (unless legally separated from the employee pursuant to a court order), including common law marriage if the marriage is recognized in the employee's state of residence as valid under its state laws, and the employee registers the marriage with the appropriate public official (if permissible in their state).
- "Domestic partner" means a person of the same sex or opposite sex who meets the following eligibility requirements:
  - You and your partner have registered the partnership with a state or local government that accepts such registrations; or
  - You and your partner satisfy the following criteria for six months by:
    - Being each other's sole domestic partner and intending to remain so indefinitely;
    - Residing together in the same principal residence and intending to remain so indefinitely;
    - Being emotionally committed to one another, sharing joint responsibilities for common welfare, and being financially interdependent;

- Each being at least age 18 and mentally competent to consent to a contract;
- Not being related by blood closer than would bar marriage under applicable law in effect where the employee and partner reside; and
- Not being legally married to anyone else or involved in any other domestic partnership.

If an employee and the employee's spouse or qualifying partner both work at HP, both employees can each elect coverage separately, including covering each other and both covering eligible dependent children. Keep in mind, however, that covering a person twice usually will not increase benefits beyond the level provided by the higher of the two coverage options.

Other relatives are not eligible for coverage unless they qualify under the provisions above. Parents of the employee or parents of the employee's spouse or qualified partner do not qualify for coverage even if they are tax dependents.

Please note the plan administrator has the sole right to determine who is eligible for health and welfare benefits under the Plan and may require documentation proving a dependent's status. If you are unable to provide the required documentation, your dependent will not be eligible for benefits under the Plan. In addition, you may be required to reimburse the Company for any costs associated with covering an individual who is not an eligible dependent, and your, as well as your dependent's (or dependents'), coverage may be terminated.

Note: Any attempt to enroll an ineligible dependent is considered a material misrepresentation and evidence of fraud on the Plan. If a dependent is enrolled who is not eligible, that dependent's coverage may be dropped retroactively without any refund of premium payments.

State eligibility laws and ERISA

States sometimes pass laws that require employee benefit plans to provide benefits to individuals who otherwise are not eligible. For example, a state might require an employer to provide benefits to an ex-spouse or a child who exceeds the plan's age requirements.

However, the Plan is governed by a federal law known as the Employee Retirement Income Security Act of 1974, as amended (ERISA), which supersedes any state law. As such, a state's eligibility laws do not apply to the Plan and will not govern the rights of your dependents to benefits under the Plan. The claims administrators will rely upon the Company and the plan administrator to determine whether or not a person meets the definition of a dependent to be eligible for benefits under the Plan. This determination will be conclusive and binding upon all persons for the purposes of the Plan.

Federal tax implications for dependent coverage

Payments for dependent benefits are usually exempt from federal income tax. Generally, if you can claim an individual as a dependent for federal income tax purposes, then the payment for that dependent's benefits will not be taxable to you as income. However, if you enroll an individual in the Plan who does not meet the federal definition of a dependent, such as a domestic partner, the payment will be taxable to you as income.

The Company assumes all dependents, except a domestic partner and the domestic partner's dependents, are federal tax dependents for health benefit purposes under Section 152 of the Internal Revenue Code. You must contact the plan administrator if you enroll dependents who are not IRS tax dependents. You also must contact the plan administrator if your enrolled domestic partner and enrolled dependents of your domestic partner qualify as your federal tax dependents.

If you have questions concerning your specific situation, you should consult your own tax consultant or attorney.

Your health and welfare benefits

Health and welfare benefits

In general, employees are eligible for the following health and welfare benefits under the Plan:

- Medical/substance use/mental health benefits/with possibility of Health Savings Account (HSA) or Health Reimbursement Account (HRA)
- Prescription drug benefits
- Dental benefits
- Vision benefits
- Employee Assistance Program (EAP) benefits
- Short-Term Disability (STD) insurance
- Long-Term Disability (LTD) insurance
- Life insurance
- Accidental Death and Dismemberment (AD&D) insurance
- Dependent Care Flexible Spending Account
- Health Care Flexible Spending Account
- LTD Dependent Health Continuation insurance
- Prepaid group legal insurance

Employees classified as **Interns** are eligible for the health and welfare benefits listed above under the Plan excluding:

- Short-Term Disability (STD) insurance
- Long-Term Disability (LTD) insurance
- LTD Dependent Health Continuation insurance

Employees classified as **on assignment to the US (inpats)** are eligible for the following health and welfare benefits under the Plan:

- Medical/substance abuse/mental health benefits
- Prescription drug benefits
- Dental benefits
- Vision benefits
- Employee Assistance Program (EAP) benefits

Individuals classified as **Terminated LTD** are eligible for the following health and welfare benefits under the Plan:

- Medical/substance abuse/mental health benefits
- Prescription drug benefits

- Dental benefits
- Vision benefits
- Life insurance
- Accidental Death and Dismemberment (AD&D) insurance

The details of each of these health and welfare benefits are described in the incorporated documents.

Cost of coverage

The Company provides the following benefits with no premium by the employee:

- Basic life insurance
- Basic Accidental Death and Dismemberment (AD&D) insurance
- Short-Term Disability (STD)
- Basic Long-Term Disability (LTD)
- HRA contributions (limits apply)
- HSA contributions (limits apply)
- Employee Assistance Program (EAP) benefits

Premiums shared between you and the Company:

- Medical/substance abuse/mental health
- Prescription drug
- Dental

Premiums paid entirely by the employee:

- Any contributions made by you for the Health Savings Account (HSA)
- Working Spouse Surcharge contribution (if applicable)
- Vision
- Employee supplemental and dependent supplemental life insurance.
- Employee supplemental and dependent supplemental Accidental Death and Dismemberment (AD&D) insurance
- Prepaid group legal insurance
- Supplemental Long-Term Disability
- Health Care Flexible Spending Account contributions
- Dependent Care Flexible Spending Account contributions
- Long-Term Care (the Long-Term Care benefit option is closed to new participants)

Depending on the particular benefits selected, your employee contributions may be deducted from your paycheck on a pre-tax basis or paid with after-tax dollars. See the

annual enrollment materials and Summary of Benefits and Coverage (SBC) for more information about paying for your benefits.

The Company determines the amount of your employee contributions prior to each enrollment period and will provide you with this information in your enrollment materials. You may also contact the plan administrator to receive information about your employee contributions.

Enrollment/effective date

The plan year runs from January 1 through December 31.

Generally, you can participate in the Plan on the first day of employment. You must notify the plan administrator in a timely manner of your intent to enroll in the Plan (see the enrollment materials to determine when you are eligible for benefits). The plan administrator will provide the appropriate information for your enrollment in the Plan.

Initial enrollment

You need to enroll in the Plan to be covered by the health benefits and certain other benefits as specified in the enrollment materials. Eligible employees are automatically covered by some programs, but there are benefits that require employees to enroll within 31 days after being hired (or upon initially meeting eligibility requirements, whichever comes later). If you do not enroll during the initial annual enrollment period, and you do not waive coverage, you will automatically be enrolled in the medical, dental, Employee Basic Life insurance, Employee Basic AD&D insurance, and basic Long-Term Disability benefit options designated by the plan administrator.

Once default coverage is assigned, changes are only allowed during the annual enrollment period (with coverage generally effective the following January 1) or within 60 days of a qualified status change (with changes generally effective on the date of the qualified status change). If default coverage is assigned, applicable payroll deductions will apply. For additional information on qualified status changes, please contact the plan administrator.

Information regarding enrollment procedures will be provided to you by the plan administrator. When you enroll your eligible dependents, you will need to provide relevant documentation as requested by the plan administrator.

As a rehired employee

If you terminate your employment and are rehired by the Company, you must enroll again in the Plan to receive benefits.

Annual enrollment

If you choose to change your benefit elections during the annual enrollment period, your new elections will become effective on January 1 of the following plan year. If you do not enroll during annual enrollment, you will continue participating in the benefits package options you elected in the prior plan year, except that your participation in the Health Care and Dependent Care Flexible Spending Accounts will terminate. If you need to make an election change after the annual enrollment period, you may change your elections during the next annual enrollment period, a special enrollment period, or if you have a qualified status change. See the “Changing your coverage during the year” section.

Information regarding enrollment procedures will be provided to you by the plan administrator.

Effective date of your coverage

New employees

Generally, you and your dependents will become covered under the Plan on the date set forth above, if you are actively employed on that date (see the enrollment materials to determine when you are eligible for benefits). If you are not actively employed on that date due to your health status, your coverage will become effective on the date determined by the plan administrator. However, you will not be denied health coverage due to your health status.

Current employees

If you enroll or make an election change during the annual enrollment period, participation for you and your dependents begins on the next January 1.

Changing your coverage during the year

Once you enroll in or decline health and welfare benefits under the Plan, your election generally stays in effect for the plan year. However, you can make changes during the year if you have a qualified status change, a special enrollment right, or other changes in circumstance.

Qualified status change

A qualified status change is a specific change in circumstance that affects your eligibility for benefits and coverage under the Plan. Changes in eligibility or coverage must be due to and consistent with the qualified status change, which is any of the following:

- You get married, divorced, or legally separated or your marriage is annulled.
- You have a baby, adopt, or have a child placed in your care for adoption.
- Your dependent gains or loses eligibility status.
- You or your dependent moves to a new place of residence outside of your present coverage area.
- You or your dependent has a change in employment status, such as:
  - Switching from full-time to part-time employment (or vice versa)
  - Beginning or ending employment (this provision does not apply if rehired within 30 days)
  - Experiencing a strike or a lockout
  - Commencing or returning from an unpaid leave of absence
  - Changing your worksite to a location that offers different benefits than are currently available to you
- Your dependent dies.
- You experience a significant change in the cost of benefits or coverage.
- You or your dependent become entitled to a premium tax subsidy or premium credit for enrollment in individual health insurance on the federal or state Marketplace, provided that you or your dependent become immediately covered by individual coverage secured through the Marketplace.
- Such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with the rulings and regulations under Code Section 125.

Special enrollment rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you additional flexibility in whom you can enroll for the health benefits under the Plan due to marriage, birth, adoption, or placement for adoption:

- Non-enrolled employee: If you are eligible but not enrolled, you can enroll.

- Non-enrolled spouse: If you are enrolled, you can enroll your spouse when you marry. In addition, you can enroll your spouse if you acquire a child through birth, adoption, or placement for adoption.

- New dependents/spouse of a non-enrolled employee: If you are eligible but not enrolled, you can enroll your spouse or child who becomes your eligible dependent as a result of the event. However, you also must enroll.

Revocation of election due to enrollment in qualified health plan

You can revoke a coverage election with respect to coverage under the plan's medical benefits due to your enrollment in a qualified health plan through a Health Insurance Marketplace if you satisfy the following conditions:

(1) You are eligible for a special enrollment period to enroll in a qualified health plan through a Health Insurance Marketplace pursuant to guidance issued by the Department of Health and Human Services and any other applicable guidance, or you seek to enroll in a qualified health plan through a Health Insurance Marketplace during its open enrollment period; and

(2) The revocation of the election of coverage under the plan's medical benefits corresponds to your intended enrollment for yourself and any related individuals who cease coverage due to the revocation in a qualified health plan through a Health Insurance Marketplace for new coverage that is effective beginning no later than the day immediately following the last day of the original coverage that is revoked.

Other changes in circumstance

Certain other events also permit you to change your coverage during the year. The change you make must be consistent with the event:

- A QMCSO requires you or another individual to provide health benefits for a dependent.
- You or your dependent becomes eligible for or loses Medicaid coverage.
- You elected "no coverage" because you had coverage elsewhere (for example, under a spouse's plan or through the public health exchange) and there is a substantial change to or termination of that coverage, provided:
  - The coverage must end because of a loss of eligibility, such as a divorce, termination of employment, the other employer stops contributing to the other plan, or the cost of coverage through the other employer increases significantly.
  - You cannot make a change during the year if your "other coverage" is lost because of something you do or do not do, such as not making your required contributions.

- Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) coverage from another employer for you or your dependent is exhausted.

- The enrollment period of another plan—for example, your spouse's—is different from the Company's annual enrollment period.

- If you or your dependent is eligible, but not enrolled, for health benefits, you are eligible to enroll if you meet either of the following conditions and you request enrollment no later than 60 days after the date of the event:
  - You or your dependent loses eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage.
  - You or your dependent becomes eligible for premium assistance, with respect to coverage under the plan, due to coverage with Medicaid or CHIP.

How to make changes during the year

You can report your mid-year change to the plan administrator. However, you must submit the required paperwork within 60 days (60 days if due to Medicaid- or CHIP-related events as described above) in order to make the change. If you do not report your mid-year change and provide the required paperwork within the 60-day period, you will not be able to make changes until the next annual enrollment period, unless you again meet one of the conditions for a change during the year.

As long as you notify the plan administrator within the required time frame, coverage changes will take effect on a date determined by the plan administrator that will be no later than the first day of the month following receipt of your notice (except that, in the case of birth, adoption, or placement for adoption, the coverage change will take effect on the date of the event).

Continuing coverage

Uniformed Services Employment and Re-Employment Rights Act

The Uniformed Services Employment and Re-Employment Rights Act of 1994, as amended ("USERRA"), sets requirements for continuation of health coverage and re-employment in regard to an employee's Military Leave. These requirements apply to health coverage for you and your dependents.

Continuation of coverage

For leaves of less than 31 days, health coverage will continue, but you must make employee contributions for your coverage to continue. For leaves of 31 days or more, you may continue health coverage for yourself and your dependents as follows:

- You may continue coverage by paying the required contributions to the Company, until the earliest of the following:
  - 24 months from the last day of employment with the Company
  - The day after you fail to return to work
  - The day the plan terminates
- The Company may charge you and your dependents up to 102% of the total cost.

Reinstatement of benefits

If your health coverage ends during the Military Leave because you do not elect coverage under USERRA and you are re-employed by the Company, health coverage for you and your dependents may be reinstated if:

- You gave the Company advance written or verbal notice of your Military Leave.
- The duration of all Military Leaves while you are employed with the Company does not exceed five years.

You and your dependents will be subject to only the balance of a waiting period, if appropriate, that was not yet satisfied before the leave began. However, if an injury or illness occurs or is aggravated during the Military Leave, full plan limitations will apply.

If your health coverage under this plan terminates as a result of your eligibility for military health coverage and your order to active duty is canceled before your active duty service commences, these reinstatement rights will continue to apply.

Family and Medical Leave Act

Your health coverage will be continued during a leave of absence under the Family and Medical Leave Act of 1993, as amended (FMLA). The plan administrator will give you more detailed information about the FMLA. The FMLA allows eligible employees to take a leave for up to a total of 12 work weeks in a 12month period for one or more of the following reasons:

- The birth of your child and to care for the newborn child
- The placement of a child with you for adoption or foster care
- To care for a family member (child, spouse, or parent) with a serious health condition

- Your own serious health condition that makes you unable to perform the functions of your job
- Any qualifying exigency arising out of the fact that your spouse, child, or parent is a covered member in the armed forces on active duty (or has been notified of an impending call or order to active duty) in support of a contingency operation

If eligible, you may also take leave for up to a total of 26 work weeks in a single 12-month period to care for a covered member of the armed forces with a serious injury or illness.

Contact the plan administrator for more details about FMLA Leave and non-FMLA Leave.

Benefits coverage while on FMLA Leave

The Company will continue your health coverage under the plan during your FMLA Leave just as if you were still working. The cost of your health coverage during an FMLA Leave must be paid, and you must make all required employee contributions on an after-tax basis in accordance with the agreement reached between you and the Company prior to your FMLA Leave becoming effective.

A newly acquired dependent is eligible for coverage while your coverage is continued during an FMLA Leave.

Continued coverage ends on the earliest date that you:

- Terminate employment.
- Do not make required contributions.
- Exhaust your approved period of FMLA Leave and do not return to work from your FMLA Leave.

If your employment does not terminate during your FMLA Leave, but you do not return to work once your FMLA Leave ends, you can choose to continue health coverage under the COBRA continuation rules. See the “COBRA continuation rights” section for more details.

Reinstatement of canceled coverage following FMLA Leave

Upon your return to your employment following an FMLA Leave, any terminated health coverage will be reinstated as of the date of your return. You will not be required to satisfy any eligibility or benefit waiting period, if appropriate, to the extent that they had been satisfied prior to the start of the FMLA Leave.

State Family and Medical Leave Act laws

The Company’s FMLA policy must comply with any state law that provides greater family or medical leave rights than those provided under its FMLA policy. If your leave qualifies under the FMLA and under a state law, you will receive the greater benefit.

If Company changes benefits

If the Company offers new benefits or changes its benefits while you are on an FMLA Leave, you are eligible for the new or changed benefits, but your contributions for these benefits may increase.

Contact the plan administrator for more details about the Company policy on other leaves of absence.

Termination of coverage

Employees

Your coverage under the Plan will cease when any one of the following events described below occurs:

- You terminate employment (in which case participation shall cease in accordance with the terms of related documents, individual plans, programs, insurance contracts, and benefit components).
- You cease to be an employee who is eligible for coverage.
- If participant contributions are required, you cease making contributions to the Plan.
- One or more benefits under the Plan are terminated by action of the Company.

Dependents

Coverage for your dependents will cease when any one of the following events described below occurs:

- You terminate employment (in which case participation shall cease in accordance with the terms of related documents, individual plans, programs, insurance contracts, and benefit components).
- You cease to be an employee who is eligible for coverage.
- If participant contributions are required, you cease making contributions to the Plan.
- A dependent ceases to qualify as a dependent.
- One or more benefits under the Plan are terminated by action of the Company.

Coverage under the Plan may also be terminated for any individual (or any employee or dependent covered under the same family coverage as that individual) who engages in fraud or who makes a material misrepresentation of fact relating to the coverage. For example, if someone knowingly files a claim for benefits for medical services or supplies that were not actually provided, that would be considered fraud and would lead to termination of coverage. An example of a material misrepresentation of fact would include an employee signing an enrollment form indicating that an individual is eligible for coverage as a dependent at a time when the employee knows that the individual does not qualify as the employee's dependent. In such cases, coverage may be terminated retroactively, if appropriate, based on the details.

For medical coverage that is subject to the Affordable Care Act, a retroactive termination of coverage may occur in only two situations. First, as indicated above, or if you fail to make any required contribution toward the cost of coverage by the applicable deadline, coverage would be terminated retroactive to the end of the period for which the required contributions were made. A retroactive termination also may occur if you or your dependent (or any person seeking coverage for you or your dependent) engages in fraud with respect to the Plan, or makes an intentional misrepresentation of a material fact. In

that case, the Plan will provide at least 30 days advance written notice to any person who will be affected by the retroactive termination of coverage.

Continuation of coverage

When coverage ends, you and/or your dependents may be eligible to continue health benefits under COBRA. See the "COBRA continuation rights" section for more details. You may also have the right to apply for individual coverage for certain benefits. See the incorporated documents for more information. Terminated LTD Participants are not eligible for COBRA benefits under the Plan.

Note: COBRA continuation coverage does not extend to a domestic partner or a domestic partner's children. However, HP offers similar coverage continuation opportunities subject to the same notification requirements listed above. You can contact the plan administrator for more details.

REQUIRED NOTICES

Participating provider networks and directories

You may, without charge, obtain the participating provider directories from the claims administrator for a particular benefit. See the "Plan contacts" section for contact information.

Patient protection statement regarding provider designation

For purposes of the plan's medical coverage, you (or your covered family members) may be required or permitted to designate a primary care physician. If that is the case, you have the right to designate any primary care physician who participates in the claims administrator's network and who is available to accept you or your family members. If you do not make this designation, the plan may designate one for you. For your covered child, you may designate a pediatrician as the primary care physician.

For information on how to select a primary care physician and for a list of the participating primary care physicians, contact the plan administrator or the claims administrator for your coverage at the address provided in this SPD.

For purposes of the plan's medical coverage, if the plan requires the designation of a primary care physician, you (or your covered family member) do not need prior authorization from the plan or from any other person (including a primary care physician) to obtain access to obstetrical or gynecological care from a health care professional in the claims administrator's network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the claims administrator for your coverage at the address provided in this SPD.

Qualified Medical Child Support Order (QMCSO)

A QMCSO is a judgment from a state court or an order issued through an administrative process under state law that requires a parent to provide health benefits for a child (often because of legal separation or divorce). A QMCSO cannot require the plan to cover any type or form of benefit not otherwise offered. However, an order may require the plan to comply with state laws regarding a child's coverage.

The plan provides health benefits for your child pursuant to the terms of a QMCSO. This coverage may apply even if you do not have legal custody of the child; the child is not dependent on you for support, and regardless of any enrollment season restrictions that might exist for dependent coverage.

Federal law requires that a QMCSO must meet certain form and content requirements to be valid. The Company follows certain procedures to determine if a Qualified Medical Child Support Order is "qualified." If you become subject to an order, you will receive a copy of the QMCSO administrative procedures, free of charge, from the plan administrator or you may request a copy, free of charge from the third party administrator.

If the Company receives a valid QMCSO, you may enroll a dependent child for health benefits under the plan pursuant to the QMCSO's terms. The change you elect takes effect as of the date the third party administrator processes the QMCSO.

Standards for mothers and newborns

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Your rights following a mastectomy

The plan includes health benefits for a medically necessary mastectomy and patient-elected reconstruction after the mastectomy. Specifically, for you or your covered dependent who is receiving mastectomy-related benefits, benefits will be provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.
- Treatment of physical complications at all stages of mastectomy, including lymphedema.

Benefits will be subject to the same annual deductibles and coinsurance provisions that apply for all other medically necessary procedures under the plan.

Consumer protections under the Affordable Care Act

The Company's medical and prescription drug plan benefits provide you with certain protections—sometimes referred to as "group market reforms" or "consumer protections" under the Affordable Care Act, including:

- Prohibition of preexisting condition exclusions
  - The Plan does not impose any preexisting condition exclusions.
- Prohibiting discrimination against participants and beneficiaries based on a health factor
  - The Plan does not discriminate against participants and beneficiaries based on a health factor.
- Prohibition on waiting periods that exceed 90 days
- See the "Eligibility" section of this SPD for more details.
- Prohibition on lifetime or annual dollar limits on essential health benefits
  - The Plan does not impose any lifetime or annual dollar limit on essential health benefits.
- Prohibition on rescissions
  - The Plan will not retroactively rescind your coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is defined as a retroactive cancellation or discontinuance of coverage. If coverage is canceled or discontinued prospectively, that is not considered a rescission. It is also not a rescission if you do not pay your required premium and your coverage is canceled or discontinued back to the date that the premium was not paid. The Plan will provide you with at least 30 calendar days' advance notice before your coverage is rescinded. If your coverage is or will be rescinded, you have the right to file an appeal.
- Eligibility of children until at least age 26
  - The Plan extends coverage to adult children until the end of the month in which a child attains age 26.
- Summary of benefits and coverage and uniform glossary
  - Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC), which summarizes important information about any health coverage option in a standard format, to help you compare across options. You may request a paper copy free of charge from the plan administrator.
- Solely with respect to insured medical benefit options, the medical loss ratio requirements

- Accommodations in connection with coverage of preventive health services
  - The Company's medical and prescription drug options provide preventive care benefits in-network without cost sharing. See the summary of your medical plan benefits for more details on what constitutes preventive care for this purpose; the list changes periodically. Preventive care generally includes items and services with a rating of "A" or "B" under the United States Preventive Services Task Force; immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC); and with respect to children and women, certain preventive care and screenings based on guidelines supported by the Health Resources and Services Administration.
    - General information pertaining to other preventive services and a prescription drug list is available at healthcare.gov/preventive-care-benefits. The list of in-network preventive care items and services with no cost sharing includes certain screenings (e.g., blood pressure, cholesterol, diabetes and lung cancer screenings), immunizations, counseling (e.g., alcohol misuse, obesity and tobacco use counseling), colonoscopies (including many related items and services, such as bowel preparation medications, anesthesia, and polyp testing) and other items and services that are designed to detect and treat medical conditions to prevent avoidable illness and premature death.
    - For women, the medical and prescription drug options also will cover an annual well-woman visit (and additional visits in certain cases); screening for gestational diabetes; testing for the human papilloma virus; counseling for sexually transmitted diseases; counseling and screening for human immunodeficiency virus (HIV); FDA-approved contraceptive methods and counseling as prescribed for women; breastfeeding support, supplies, and counseling (including lactation counseling services); and screening and counseling for interpersonal and domestic violence. In addition, a woman who is at increased risk for breast cancer may be eligible for screening, testing, and counseling and if at low risk for adverse medication effects, may be eligible to receive risk-reducing medications, such as tamoxifen or raloxifene, in-network, without cost sharing. If your physician prescribes this type of medication to reduce your risk of breast cancer, contact the claims administrator to ensure that you satisfy the administrative requirements necessary to receive this benefit. You may be required to meet requirements beyond just submitting the prescription. For example, you and/or your physician may need to demonstrate that you are at an increased risk for breast cancer.

Note: The Plan generally may use reasonable medical management techniques to determine frequency, method, treatment, age, setting, and other limitations for a recommended preventive care service. When preventive and non-preventive care is provided during the same office visit, special rules apply regarding whether or not cost sharing will be imposed.

- Internal claims and appeals and external review process

- See the "Claims and appeals procedures" section of this SPD for more information.

- Consumer patient protections (prevention of surprise medical bills, choice of health care professional and coverage of emergency services)
  - If you need "emergency services," the medical options offered by the Company will provide you with coverage regardless of whether the provider for such emergency services is in-network or out-of-network. Also, emergency services are subject to special cost-sharing rules that require non-grandfathered group health plans like the Company's to not impose a higher copay or coinsurance, for example, for out-of-network emergency services than for in-network emergencies services. In certain circumstances, however, you may be balance billed. For details on this requirement, including what constitutes an emergency service, contact the claims administrator.
  - The medical and prescription drug options offered to you will not discriminate against an eligible health care provider based on their license or certification to the extent the provider is acting within the scope of their license or certification under state law. This rule is subject to certain limitations and does not require the medical options to accept all types of providers into a network.
- Limitations on cost sharing (i.e., the out-of-pocket expense maximum requirements)
  - As required by the Affordable Care Act, your total in-network out-of-pocket costs will not exceed the IRS maximum, as indexed annually. The Affordable Care Act's individual out-of-pocket expense maximum applies to each covered individual, whether the individual has self-only, family, or another coverage tier. So, it's possible that this limit will result in payment for an individual before the family out-of-pocket expense maximum is hit for a High Deductible Health Plan (HDHP) if the HDHP has a family deductible that is less than the self-only limit under the Affordable Care Act.
  - The maximum imposed by the Affordable Care Act creates a separate, legally required limit on in-network out-of-pocket costs, which requires that additional costs count toward these limits even if they do not apply toward your medical option's out-of-pocket maximum. Costs that apply toward your total in-network out-of-pocket maximum include, for example, deductibles, copays, coinsurance, and eligible prescription drug expenses. Out-of-pocket expenses that do not apply toward your in-network out-of-pocket maximums include, for example, premium contributions, spending for non-covered items and services, out-of-network items and services, and the additional cost if you purchase a brand-name prescription drug in a situation where a generic drug was available and medically appropriate as determined by your physician.
  - The actual out-of-pocket expense maximums under the medical and prescription drug option that you elect may be lower than the legal maximums. Please contact your medical claims administrator for more information. See the "Plan contacts" section for contact information.
- Coverage for individuals participating in approved clinical trials

- You are eligible for coverage of routine costs for items and services furnished in connection with your participation in an approved clinical trial. The clinical trial must relate to the treatment of cancer or another life-threatening disease or condition. Contact your medical claims administrator for more information. See the "Plan contacts" section for contact information.

Continuity of care provision

In certain circumstances, the Plan will provide continuing coverage for courses of treatment if your network provider moves out-of-network due to a contract termination between the Plan (or insurer) during the course of the plan year. In these situations, you may be able to temporarily maintain access to your provider or facility under the same terms and conditions as if they were available in-network.

In order to qualify for continuity of care coverage (also called transitional care), you must already be:

(1) Undergoing a course of treatment for a serious and complex condition;

(2) In institutional or inpatient care;

(3) Scheduled for non-elective surgery (including receipt of post-operative care with respect to such surgery);

(4) Pregnant; or

(5) Terminally ill.

For purposes of this provision, a serious and complex condition can be either an acute or chronic illness. In the case of an acute illness, it is a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. In the case of a chronic illness, it is a condition that is life threatening, degenerative, potentially disabling, or congenital, and requires specialized medical care over a prolonged period of time.

If a provider's network status changes during the plan year, the Plan (or insurer) will notify you of the network status change in a timely manner and inform you of the right to request transitional care. If you qualify for continuity of care coverage, you may be able to access services for up to 90 days after this notice is provided or until you are no longer a continuing care patient (whichever comes first).

Providers will not balance bill you for services provided under the continuity of care provisions; they must accept in-network payments from the Plan (or insurer) and cost-sharing amounts from you as payment in full.

Provider directory provisions

In order to provide participants with the most current network information, the Plan (and insurer) is required to maintain a database on a public website that lists accurate information for providers and facilities that participate in its network (either directly or indirectly). The database information will be verified and updated as necessary, no less than every 90 days. You can access this information by phone or by going to the websites listed in the "Plan contacts" section of this SPD. For telephone requests, you should

receive a response within one business day through a written electronic or print communication.

If you are provided information via the online directory or as a response to a telephone request regarding a provider's in-network status that turns out to be incorrect, you will not be responsible for paying a cost-sharing amount higher than the in-network amount that would have applied if you had seen a participating provider. Further, any cost-sharing amounts paid by you will count towards your in-network deductible and out-of-pocket maximum.

Coordination of benefits

The incorporated documents detail the way health and welfare benefits are paid if you or any one of your dependents is covered under more than one benefit plan.

Expenses for which a third party may be responsible

Reimbursement and subrogation.

(a) **Overview:** The Plan is not required by law to cover health expenses that you or dependents may be able to recover from a third party.

(b) **Provisions that apply if the Plan pays benefits for expenses for which a recovery may be available:** By participating in the Plan, you and your dependents agree to the following provisions with respect to any expenses that you have the Plan advance for which a recovery may be available. The Plan would not have covered any of those expenses, but for this agreement to reimburse the Plan in full in accordance with this section.

(i) Definitions:

(1) "Insurance coverage" means any non-Plan coverage providing medical expense coverage or liability coverage. It includes such things as uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, Workers' Compensation coverage, no-fault automobile insurance coverage, or any other insurance coverage.

(2) "Responsible party" means any party (other than the Plan) actually or potentially responsible for making any payment to you or your dependent due to your or your dependent's injury, illness, or condition, including the party's insurer.

(3) "Recovery" means any amount you or your dependent receives from any responsible party or insurance coverage as a result of an injury, illness, or condition, including amounts designated as pain and suffering damages, non-economic damages, non-medical damages, or general damages, and even if the responsible person is not liable or denies liability. A recovery includes amounts family members receive because of or related to your or your dependent's injury, illness, or condition.

(ii) Right of the Plan to be reimbursed: The amount the Plan advanced to pay for treatment of your or your dependent's injury, illness, or condition must be fully repaid (to the extent your or your dependent's net recoveries (i.e., after reduction for reasonable attorney's fees and recovery costs) for or relating to that injury, illness, or condition) before you and/or your dependent or anyone else may keep any portion of the recoveries.

(iii) Promise to pay Plan amount it is due: You and your dependents promise to pay the Plan the amount it is due under this section. This promise shall be an enforceable contract governed by Delaware law. You or each of your dependents agree to pay to the Plan any amount you or they receive because of your or your dependent's injury, illness, or condition, to the extent necessary to fully reimburse the Plan.

(iv) Participant will hold recovery in trust for the Plan: You and your dependents shall hold any recovery in trust for the Plan's benefit to the extent of the Plan's repayment right. Each person holding any recovery in trust for the Plan shall be a plan fiduciary for that limited purpose and shall be personally liable to the Plan for any loss the Plan suffers as a result to their fiduciary breach. However, such a person shall not have any other fiduciary powers or rights. For example, such a person will not be eligible for the indemnification or insurance protection provided to other plan fiduciaries, notwithstanding anything else to the contrary.

(v) Plan's lien on recoveries: The Plan will automatically have a first priority lien on any recovery to the extent of benefits advanced by the Plan for the treatment of the illness, injury, or condition to which the recovery relates. The lien shall arise on any recovery whether by settlement, judgment, insurance, net of reasonable attorney's fees, and recovery costs. The lien may be enforced against any party who possesses the recovery.

(vi) Assignment of recovery to Plan: In order to secure the rights of the Plan under this section, you and your dependents hereby assign to the Plan any amounts they may recover that relate to expenses the Plan advanced under this section, to the extent of such advances.

(vii) Unavailability of equitable or other defenses: No equitable defenses, including such things as make-whole, common fund, and unjust enrichment principles, shall reduce the Plan's rights under this section. For example, if you or your dependent recovers less than all the damages sought, the Plan's repayment rights shall not be reduced. You and/or your dependents promise not to assert, and hereby, waive any equitable defenses to or limitations on the Plan's right to recover the amount due under this section.

(viii) Obligation to cooperate: You and/or your dependents shall fully cooperate with the Plan's efforts to recover the amount it is due, including permitting the Plan or its agents to conduct investigations reasonably needed to enforce the Plan's rights under this section. You and/or your dependents must notify the plan administrator that you are considering seeking a recovery or similar amounts no later than 30 days after you begin

considering pursuing such a claim. You and/or your covered dependents shall provide all information requested by the Plan, any claims administrator, or their representatives, including submitting forms or statements as the Plan may reasonably request. You and/or your covered dependents shall do nothing to prejudice the Plan's rights under this section.

(ix) Plan's right to recover collection expenses: If the Plan incurs costs, such as attorney's fees, to recover amounts it is due under this section, those costs shall be added to the amount the Plan is entitled to recover under this section.

(x) Suit to enforce this section: The participant and their covered family members agree that the Plan may bring suit to recover amounts due under this section in federal or state court in Delaware or in any other court of competent jurisdiction, and they agree to submit to each such jurisdiction, waiving whatever rights they might have by reason of their present or future domicile.

(xi) Right of Plan to pursue recovery independently: The Plan shall be subrogated to (stand in the place of) you and/or your covered dependents, and you and/or your covered dependents hereby assign, all rights of recovery you have against anyone due to injury, illness, or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert this right independently of you and/or your covered dependents. Nothing in this subsection shall preclude you or your dependents from pursuing such a claim while the Plan is not independently pursuing it.

(xii) Attorneys and agents: Your and your covered dependent's attorneys and agents shall be bound by all the provisions of this section, to the same extent as you and your covered dependents. Your and your covered dependents attorneys' and agents' violations of this section shall be treated as a violation by you and your covered dependents of your or your dependent's obligations.

Consequences of violating obligations. If you and/or your covered dependents, or your attorneys or agents, fail to repay the Plan, cooperate with the Plan in its efforts to recover such amounts, or do anything to hinder or prevent such a recovery, in addition to any other remedies available to the Plan, you and/or your dependents shall forever cease to be entitled to any further Plan benefits, except to the extent prohibited by the Affordable Care Act or ERISA. In addition, the participant and their covered family members, by accepting Plan benefits, authorize the Company and the Plan to use the self-help remedy of withholding any amounts due under this section from any other amounts they are owed by the Company, Plan, or any other Company-sponsored arrangement, subject to any applicable state laws, including laws governing wage deductions.

Recovery of overpayments. If Plan benefits are paid by mistake, the recipient must repay the mistaken payment to the Plan immediately. By accepting Plan coverage, you

and/or your covered dependents are deemed to agree that if you or they do not repay the mistaken payment to the Plan promptly after it requests repayment, then you and/or your covered dependents will pay all attorneys' fees the Plan incurs in successful attempts to recover such amounts. In addition to any other recovery rights it may have, the Plan shall have the right to recoup the overpayment from any future benefits payable to you and/or your covered dependents. To enforce its repayment rights, the Company shall have a first priority, equitable lien on all Plan benefits paid to you and/or your covered dependents. The Company's rights under this section are in addition to any other remedies it may have in law or equity, and the administrators enforcement of the Company's rights under this section shall not curtail the Company's right to enforce any other remedies it may have.

Alienation of interests. To the maximum extent permitted by law, you and/or your covered dependents rights under the Plan may not be voluntarily or involuntarily assigned or alienated. As a matter of convenience, the Plan may provide health benefits on behalf of such individuals by paying their respective health care providers directly rather than requiring such individuals to first pay the provider and then request reimbursement from the Plan. However, such providers shall not be considered plan participants or beneficiaries for any Plan purpose.

Flexible Spending Accounts

Health Care Flexible Spending Account

If you are eligible to participate in the Plan, you may elect to have salary reduction contributions, in an aggregate amount not to exceed $2,850 per plan year (as may be adjusted for cost-of-living increases), credited to your Health Care Flexible Spending Account (Health Care FSA). You can receive amounts from this account, in cash, as reimbursement for eligible medical expenses (as defined in the Plan) incurred during the plan year and while you are a participant in the Health Care FSA.

Health Care FSA: Generally, eligible medical expenses are expenses that you, your spouse, or your dependent (determined as described in the next paragraph) have incurred that are not covered under any plan or employer-provided medical coverage, that meet the Internal Revenue Code's definition of medical expenses (including legally obtained prescription drugs), and that have not been taken as a deduction in any tax year. Normally, expenses are reimbursable only if you have already incurred the expense (that is, if you have already received the services or medicine or supplies to which the expense applies). However, otherwise eligible expenses for orthodontia services that you pay before the services are actually provided can be reimbursed at the time the advance payment is actually made but only to the extent that you are required to make the advance payment to receive the services.

Limited Purpose Health Care FSA: The Limited Purpose Health Care FSA benefits provided under the Plan are for individuals participating in a medical option that is a High Deductible Health Plan with a Health Savings Account (HDHP w/HSA). The Limited Purpose Health Care FSA is for the reimbursement of eligible out-of-pocket dental and vision expenses as well as certain preventive care expenses. Generally, eligible out-of-pocket dental, vision, and preventive care expenses are expenses that you, your spouse, or your dependent have incurred that are not covered under any plan or employer-provided medical coverage, that meet the Internal Revenue Code's definition of out-of-pocket dental, vision, and/or preventive care expenses (including legally obtained prescription drugs associated with dental, vision, and/or preventive care services), and that have not been taken as a deduction in any tax year.

Note: Effective March 26, 2021, you may use your Health Care FSA to reimburse expenses for over-the-counter (OTC) drugs without a prescription, menstrual products, and personal protective equipment (PPE), such as masks, hand sanitizer, and sanitizing wipes, for the prevention of the Coronavirus Disease 2019, as defined by the IRS. Please contact the spending account administrator for additional instructions regarding reimbursement of such amounts.

For purposes of Health Care FSA reimbursements, "dependent" includes anyone who is your dependent for federal income tax purposes, as well as your biological child, adopted child, stepchild, or your eligible foster child if the child will be younger than age 27 on the last day of the calendar year, even if the child is not a dependent for federal income tax purposes.

To be reimbursed from your Health Care FSA or Limited Purpose Health Care FSA, you must submit to the claims administrator a request for reimbursement on a form provided by the claims administrator. You also must provide evidence of the amount, nature, and payment of the underlying medical expense for which reimbursement is sought, as required by the claims administrator. Unless a later date is designated by the plan administrator, you must submit your requests by no later than March 31 following the end of the plan year in which the expenses were incurred if you were an active employee on the last day of the plan year. If, as of the end of the claims period for the plan year, you incurred expenses less than the maximum reimbursable amount, the remainder of the unused Health Care Flexible Spending Account in excess of $550 shall be forfeited. If your employment terminates during the plan year, you must submit your request for reimbursement of expenses incurred while you were an active employee, within 60 days following your employment termination date, unless you elect to continue Health Care FSA benefits under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). See the "COBRA continuation rights" section for more details.

Please note that amounts held in your Health Care FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited.

Dependent Care Flexible Spending Account

If you are eligible to participate in the Plan, you may elect to have salary reduction contributions credited to your Dependent Care Flexible Spending Account (Dependent Care FSA). All contributions, in the aggregate, must not exceed $5,000 per calendar year or, for married participants filing separately, $2,500 per calendar year (as may be adjusted for cost-of-living increases). You can receive amounts from this account, in cash, as reimbursement for Employment-Related Expenses incurred during the calendar year and while you are a participant in the Dependent Care FSA.

The amount of any reimbursement for Employment-Related Expenses may not exceed the amount credited to your account at the time of your reimbursement request. Generally, under federal law, Employment-Related Expenses are expenses for household services and expenses related to the care of a "Qualifying Individual," which you incur to enable you to work.

A Qualifying Individual is defined under federal law and currently means someone who is:

- Your child (including a stepchild), brother, sister, stepbrother, or stepsister (or a descendent of any of those, such as your grandchild or your niece or nephew) who is under the age of 13, who has the same principal residence as you for at least half of the calendar year, and who does not provide at least half of their own support for the current calendar year;
- Your spouse (for purposes of federal tax law) who is physically or mentally incapable of taking care of themself and who has the same principal residence as you for at least half of the calendar year; or
- Your dependent for federal income tax purposes who is physically or mentally incapable of taking care of themself and who has the same principal residence as you for at least half of the tax year.

You are responsible for determining if someone is your dependent for purposes of this benefit (although the plan administrator always has the right to deny benefits if it determines that expenses for any person are not eligible for reimbursement). If you have any question about whether someone qualifies as your dependent for purposes of the Dependent Care FSA, you should consult a tax adviser. Also, note that the determination of whether someone is a Qualifying Individual must be made each time expenses are incurred. For example, if your child is age 12 at the start of the calendar year, otherwise eligible expenses for that child can be reimbursed under the Dependent Care FSA only for services provided before the child's 13th birthday (unless the child is mentally or physically incapable of taking care of themself and satisfies the principal residence requirement).

The amount of reimbursements that you may receive from your Dependent Care FSA on a tax-free basis in a calendar year cannot exceed the lesser of your Earned Income (as defined in the Plan) or your spouse's Earned Income. Any amount that you receive in excess of that amount will be taxable to you. For example, if you have $5,000 in your Dependent Care FSA and you and your spouse have Earned Income of $20,000 and $4,000, respectively, you can receive $4,000 worth of reimbursement from the account on a tax-free basis, and you will be taxed on $1,000 worth of the reimbursement you receive. If your spouse is either a full-time student or is incapable of self-care, your spouse will be deemed to have Earned Income for each month that they are a full-time student or incapacitated. The amount of deemed earnings will be $250 a month, if you provide care for one Qualifying Individual, or $500 a month, if you provide care for more than one Qualifying Individual.

Employment-Related Expenses that are incurred for services outside your household may be reimbursed only if incurred for the care of (i) a Qualifying Individual who is a qualifying child under 13 years of age, or (ii) another Qualifying Individual who regularly spends at least eight hours each day in your household. In addition, if the services are provided by a Dependent Care Center (as defined below), the center must comply with applicable laws and regulations of a state or local government. A Dependent Care Center is any facility that provides care for more than six individuals who do not reside at the center and receives a fee, payment, or grant for providing services for any of the individuals.

No reimbursements will be made for Employment-Related Expenses for services rendered by any person for whom you or your spouse is entitled to a deduction on your federal income tax return for the applicable calendar year or who is your child (including a stepchild or a foster child) who will be under the age of 19 at the end of your calendar year.

To be reimbursed from your Dependent Care FSA, you must submit a reimbursement request to the claims administrator on a form provided by the claims administrator. You also must provide evidence of the amount, nature and payment of the underlying expense for which reimbursement is sought, as required by the Claims Administrator. Unless a later date is designated by the plan administrator, you must submit such requests no later than December 31 of the last day of plan year in which the expenses were incurred if

you were an active employee on the last day of the plan year. If your employment terminates during the plan year, you must submit your request for reimbursement of expenses incurred while you were an active employee, within 60 days following your employment termination date.

Please note that amounts held in your Dependent Care FSA for which a valid request for reimbursement has not been received by the deadline described above will be forfeited.

Under the Internal Revenue Code, you also may reduce your taxes by taking a dependent care tax credit. However, any amounts that you exclude from income under the Dependent Care FSA will reduce, dollar for dollar, the tax credit available.

Dependent Care FSA benefits are not subject to the federal law known as ERISA, so the "Your rights under ERISA" section of this SPD does not apply to these benefits.

Health Savings Account

Health Savings Account (HSA)

You are eligible to participate in this feature of the Plan if you are a participant in a High Deductible Health Plan (HDHP) offered under the Plan and qualify as an HSA-eligible individual under rules that apply under federal tax law. If eligible, you may elect to make salary reduction contributions to a Health Savings Account (HSA) established in your name. Any limits on the amount you may contribute to your Health Savings Account will be determined by the plan administrator and announced to participants in advance of the dates they become effective. You may increase, decrease, or revoke your contribution elections once a month during the plan year. Your election changes only affect your future contributions and will become effective as soon as administratively practicable following the date your election change was made. Health Savings Account contributions also are subject to annual limits that apply under the Internal Revenue Code. If you are an HSA-eligible individual, the maximum annual amount that you may elect to contribute to your HSA shall be the statutory maximum amount for HSA contributions applicable to your High Deductible Health Plan coverage option (i.e., single or family) for the calendar year in which the contribution has been made. You may also make an additional catch-up contribution if you are age 55 or older, subject to statutory maximums.

For the 2022 plan year, HP Inc. will allocate $500 for individual coverage/$1,000 for family coverage to your HSA. The Company contribution will be allocated to your HSA on a per-pay-period basis, to help you pay for some of the costs of covered medical expenses specific to the coverage category you enroll in. For each claim presented to the HSA, available funds will be used to pay for your HSA-eligible expenses, within the meaning of the Internal Revenue Code's definition of medical expenses. This includes legally obtained prescription drugs, over-the-counter (OTC) drugs without a prescription, menstrual products, and personal protective equipment (PPE), such as masks, hand sanitizer, and sanitizing wipes, for the prevention of the Coronavirus Disease 2019. The Company may limit the amount you may contribute to your Health Savings Account through the Plan if it appears that contributions to the HSA exceed any limit that applies to you, but it is your responsibility to ensure your contributions do not exceed the statutory maximum amount.

To be an "eligible individual" for purposes of HSA contributions, in addition to being enrolled in a High Deductible Health Plan, note that you may not be enrolled at the same time in certain other types of medical coverage that does not qualify as a High Deductible Health Plan. For example, if you are covered under a spouse's health plan that is not a High Deductible Health Plan, including a spouse's Health Care Flexible Spending Account, or if you are covered under Medicare, you are not considered an eligible individual and so you may not receive or make HSA contributions through the Plan. Also, if you are covered under the Plan's Health Care FSA, you are not considered an eligible individual. Whether you are an eligible individual is determined on a monthly basis. If you have any questions about whether any other coverage you have disqualifies you from being an eligible individual, please contact the plan administrator.

Your HSA is considered your property and is not a Company-sponsored plan. Payments provided through your HSA are not provided under this Plan and are not subject to the federal law known as ERISA or to the claims procedures described in this SPD. The "Your rights under ERISA" section of this SPD does not apply to these benefits. Generally, your HSA can be used to pay or reimburse eligible medical expenses, including amounts that are counted towards the deductible for your High Deductible Health Plan. For details about the HSA that may be funded through the Plan, you should contact the financial institution that maintains your HSA or contact the plan administrator if you need help in getting those details.

Health Reimbursement Account

Health Reimbursement Account (HRA)

The Health Reimbursement Account is an “unfunded" account, otherwise known as a demand deposit account. HP Inc. is not required to prepay into it; instead, funds allocated to the HRA are made available to reimburse you for claims as they occur. All contributions allocated to your HRA are owned, controlled, and payable solely from the general assets of HP Inc. You are not permitted to make any contribution to the HRA, whether made on a pre-tax or after-tax basis.

You must be covered under a medical option with an HRA component in order to participate in the HRA. You are enrolled in the HRA at the same time you enroll in your medical option. You cannot elect it separately.

Each year during annual enrollment, you have the opportunity to review and change your benefit election. You are permitted during annual enrollment, or upon termination, to permanently opt out of coverage for the year and waive future reimbursements.

HP Inc. will allocate $500 for individual coverage/$1,000 for family coverage to your HRA on a calendar year basis specific to the coverage category you enroll in. For each claim presented to the HRA, available funds will be used to pay for your HRA-eligible expenses.

Not all health-related expenses qualify for reimbursement under the HRA. Generally, eligible medical expenses are expenses that you, your spouse, or your dependent have incurred that are not covered under any plan or employer-provided medical coverage, that meet the Internal Revenue Code’s definition of medical expenses (including legally obtained prescription drugs), and that have not been taken as a deduction in any tax year. Section 213(d) of the Internal Revenue Code of 1986, as amended from time to time, defines what health care expenses are considered "qualified" medical expenses for federal income tax purposes. Only amounts that are paid specifically to reimburse eligible medical care expenses, as defined in Section 213(d), will be covered under the HRA.

HP Inc. has designed your HRA to allow certain claims to be automatically submitted to your account for reimbursement. There are some types of claims that will not be processed automatically for which you will need to submit a claim manually. For HRA-eligible expenses, proof can include a bill, invoice, or an explanation of benefits (EOB) from the medical option under which you are covered. An EOB will be required if the expenses are for services usually covered under group medical plans, for example, charges by surgeons, doctors, and hospitals. In such cases, an EOB will verify what your out-of-pocket expenses were after payments under other group medical plans.

If you have allocated funds available in your HRA, you may submit a claim for reimbursement for the HRA-eligible expenses from your HRA. If you submit a request for reimbursement for network claims, the request must be received no later than 90 days following the end of the calendar year in which you are eligible under this Plan. All claim forms for non-network claims must be submitted within 365 days of the date of service. If

you don't provide this information to the claims administrator within this time frame, your claim will not be eligible for reimbursement, even if there are funds available in your HRA.

You cannot be reimbursed for any expense paid under your medical option, and any expenses for which you are reimbursed from your HRA cannot be included as a deduction or credit on your federal income tax return.

If you don't spend all the funds in your HRA during the initial calendar year, and you re-enroll in a medical option with an HRA component for the following year, your remaining HRA balance rolls over into your account for the next calendar year. In this manner your HRA may grow almost like a savings account. If you don't re-enroll in a medical option with an HRA component for the following year, you will forfeit any unused funds remaining in the account. HP Inc. will decide how to handle unused funds at the end of the calendar year. Unused funds are not transferable if your employment with HP Inc. ends.

For specific benefits under the Health Reimbursement Account (HRA), please refer to the Health Reimbursement Account information on www.myhpbenefits.com and other incorporated documents.

COBRA continuation rights

Coverage continuation rights under COBRA

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (COBRA), created the right to continue health coverage in certain circumstances.

COBRA coverage is a temporary continuation of health (e.g., medical, dental, vision, Health Care Flexible Spending Account, and Employee Assistance Program) coverage when it otherwise would end because of a "qualifying event." After a qualifying event, COBRA coverage must be offered to each "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if you have health coverage under the Plan on the day before the qualifying event and that coverage is lost because of the qualifying event. Qualified beneficiaries also include any children born to you or placed for adoption with you during the COBRA continuation period. The Plan also offers COBRA coverage to certain non-qualified beneficiaries such as your domestic partner and the dependent children of your domestic partner. Your domestic partner and the dependent children of your domestic partner could become eligible for COBRA coverage if you have health coverage under the Plan on the day before the qualifying event and that coverage is lost because of the qualifying event.

COBRA qualified beneficiaries

- Employee. You become a COBRA qualified beneficiary if you lose your health coverage under the Plan because of one of the following qualifying events:
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than your gross misconduct.

- Spouse. Your spouse becomes eligible for COBRA coverage if they lose health coverage under the Plan because of one of the following qualifying events:
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than gross misconduct.
  - You die.
  - You become divorced or legally separated from your spouse.
  - You enroll in Medicare benefits (under Part A, Part B, or both).

- Dependent children. Dependent children become eligible for COBRA coverage if they lose health coverage under the Plan because of one of the following qualifying events:
  - Your hours of employment are reduced.
  - Your employment ends for any reason other than gross misconduct.
  - You die.
  - You become divorced or legally separated from your spouse.
  - The child loses eligibility for coverage as a "dependent child" under the Plan.
  - You enroll in Medicare benefits (under Part A, Part B, or both).

If you cover individuals under the Plan who are not your spouse or your dependent children, those individuals are not qualified beneficiaries for purposes of COBRA coverage. Although these individuals do not have an independent right to elect COBRA coverage, if you elect COBRA coverage for yourself, you may also cover these individuals through **similar coverage continuation offered through HP,** even if they are not considered qualified beneficiaries under COBRA. However, these individuals' coverage will terminate when your COBRA coverage terminates. Note in the "How long COBRA coverage lasts" section, the provisions regarding "Disability extension of 18-month period of COBRA coverage" and "Second qualifying event extension of 18-month period of COBRA coverage" are not applicable to these individuals. **Please contact the plan administrator for more details.**

When COBRA coverage is available

The Plan offers COBRA coverage to qualified beneficiaries and non-qualified beneficiaries only after the plan administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of your employment, the reduction in your work hours, or your death, the Company will notify the plan administrator of the qualifying event.

For other qualifying events (your divorce or legal separation or a dependent child losing eligibility for coverage as a dependent child) or the occurrence of a second qualifying event, you or your qualified beneficiary or non-qualified beneficiary must notify the plan administrator within 60 days after the later of the date the qualifying event occurs or the day you lose coverage because of the qualifying event. If you or your qualified beneficiary or non-qualified beneficiary fails to notify the plan administrator within 60 days after the qualifying event, then your dependent will not be entitled to elect COBRA coverage or similar coverage continuation offered through HP Inc.

How COBRA coverage is offered

After the plan administrator receives notice that a qualifying event has occurred, COBRA coverage is offered to each qualified beneficiary and each non-qualified beneficiary.

You may elect COBRA coverage on behalf of your spouse (or similar coverage continuation for a domestic partner), and parents may elect COBRA coverage on behalf of their children. It is critical that you (or anyone who may become a qualified beneficiary or a non-qualified beneficiary eligible to elect COBRA coverage) maintain a current address with the plan administrator to ensure that you receive a COBRA enrollment notice following a qualifying event.

You and your eligible dependents have 60 days from the date coverage ends due to a qualifying event or from the date of your COBRA notice, whichever is later, to elect COBRA coverage. If you fail to elect COBRA coverage within the applicable time frame, then you will lose the opportunity to continue coverage under COBRA.

Note: Domestic partners and a domestic partner's children are considered non-qualified beneficiaries under the Plan. COBRA continuation coverage does not extend to domestic partners or a domestic partner's children. However, HP offers similar coverage

continuation opportunities subject to the same notification requirements listed above. Please contact the COBRA administrator if you wish to elect similar continuation coverage for a non-qualified beneficiary such as a domestic partner and/or children of a domestic partner.

How long COBRA coverage lasts

COBRA coverage is a temporary continuation of coverage. It lasts for up to a total of 36 months when the qualifying event is:

- Your death.
- Your divorce or legal separation.
- A dependent child losing eligibility as a dependent child.

COBRA coverage generally lasts for up to a total of 18 months when the qualifying event is the end of your employment or reduction of your work hours. This 18-month period of COBRA coverage can be extended in two ways.

Disability extension of 18-month period of COBRA coverage

If your eligible dependent covered under the Plan is determined by the Social Security Administration to be disabled, and you notify the plan administrator in a timely fashion, you and all other eligible dependents may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months, if all of the following conditions are met:

- Your COBRA qualifying event was your termination of employment or reduction in work hours.
- The disability started at some time before the 60th day of COBRA coverage and lasts at least until the end of the 18-month period of COBRA coverage.
- A copy of the Notice of Award from the Social Security Administration is provided to the plan administrator within 60 days of receipt of the notice and before the end of the initial 18 months of COBRA coverage.
- An increased premium may be required of 150% of the monthly cost of coverage, beginning with the 19th month of COBRA coverage.

Second qualifying event extension of 18-month period of COBRA coverage

If another qualifying event occurs during the first 18 months of COBRA coverage, your eligible dependents can receive up to 18 additional months of COBRA coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan administrator.

This extension may be available to your spouse and any dependent children receiving COBRA coverage if you die; you become entitled to Medicare benefits (under Part A, Part B, or both); you get divorced or legally separated; or your dependent child is no longer eligible under the Plan as a dependent child, but only if the event would have caused your

spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Medicare extension for your dependents

If the qualifying event is your termination of employment or reduction in work hours and you became enrolled in Medicare (Part A, Part B, or both) within the 18 months before the qualifying event, COBRA coverage for your dependents will last up to 36 months after the date you became enrolled in Medicare. Your COBRA coverage will last for 18 months from the date of your termination of employment or reduction in work hours.

Other coverage options besides COBRA continuation coverage

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an eight-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late-enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

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[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

For more information visit medicare.gov/medicare-and-you.

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the US Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit dol.gov/ebsa. (Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website.) For more information about the Health Insurance Marketplace, visit healthcare.gov.

What COBRA coverage costs

COBRA participants must pay monthly premiums for coverage.

Premiums are based on the full cost per covered person set at the beginning of the year, plus 2% for administrative costs. Dependents making separate elections are charged the same rate as a single employee.

Payment is due at enrollment, but there is a 45-day grace period from the date you mail your enrollment form to make the initial payment. The initial payment includes coverage for the current month, plus any previous month(s).

Ongoing monthly payments are due on the 5th of the month preceding the next coverage period, but there is a 30-day grace period (for example, June payment is due June 5, but will be accepted if postmarked by July 5).

If you or your dependent elects COBRA coverage:

- You or your dependent can keep the same level of coverage you had as an active employee or choose a lower level of coverage (if applicable).
- You or your dependent's coverage is effective as of the first day of the month following the qualifying event; however, if you waive COBRA coverage and then revoke the waiver within the 60-day election period, your elected coverage begins on the date you revoke your waiver.
- You or your dependent may change your coverage:
  - During the Plan's annual enrollment period.
  - If you have a mid-year qualified status change.
  - If you have a change in circumstance recognized by the Internal Revenue Service (IRS).
- You may enroll any newly eligible spouse or child under Plan rules.

When COBRA coverage ends

COBRA coverage ends before the maximum continuation period if one of the following occurs:

- You or any of your covered dependents become covered under another health plan not offered by the Company.
- You or your covered dependent fails to make contributions by the due date as required.
- The Company stops providing health benefits to any employee.

COBRA coverage also may be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as non-payment of premiums or fraud).

Trade Act

The Trade Act of 2002 created a tax credit for certain individuals who become eligible for trade adjustment assistance (TAA). Under the tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health coverage, including COBRA coverage. The TAA Health Coverage Improvement Act of 2009 made several amendments to these provisions, including an increase in the amount of the credit to 80% of premiums for coverage before January 1, 2011. If you have questions about these tax provisions, you can call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TDD/TYY callers can call toll-free at 1866-626-4282. More information about the Trade Act is also available at dol.gov/agencies/eta/tradeact.

In addition, if you initially declined COBRA coverage and, within 60 days after your loss of coverage under the Plan, you are deemed eligible by the US Department of Labor or a state labor agency for TAA benefits and the tax credit, you may be eligible for a special 60-day COBRA election period. The special election period begins on the first day of the month that you become TAA-eligible. If you elect COBRA coverage during this special election period, COBRA coverage will be effective on the first day of the special election period and end on the same day that it would have ended if COBRA coverage had been elected during the regular election period available as a result of your trade-related termination of employment or reduction in work hours (generally, 18 months, unless you experience one of the events discussed under "When COBRA coverage ends" above). If you receive a determination that you are TAA-eligible, you must notify the plan administrator immediately.

Special rules for Health Care Flexible Spending Accounts

For a Health Care Flexible Spending Account (Health Care FSA), COBRA continuation coverage is available only if the amount that a qualified beneficiary would be required to pay for the coverage for the remainder of the plan year is less than the amount of reimbursements that would be available to the qualified beneficiary if he or she elected COBRA coverage. Also, even if COBRA continuation coverage is available, it is available only for the remainder of the plan year in which the qualifying event occurs. COBRA continuation coverage for the Health Care FSA cannot be extended beyond that time for any reason.

Example: Assume an employee elected to contribute a total of $1,200 to her Health Care FSA account for plan year and then her employment terminates six months after the start of that plan year. By that time, she has contributed $600 to her Health Care FSA account through payroll deductions. Assume she has already received $800 in reimbursements from her account for eligible expenses she paid before her employment terminated. In that case, the maximum benefit she could receive from her account for any eligible expenses she incurs for the rest of the plan year is $400. However, if she were permitted to continue to participate in the Health Care FSA for the rest of the plan year, she would be required to pay a total of $600 (plus about $12 in additional premiums allowed under COBRA) to continue that coverage. In that case, the amount she would be required to pay (about $612) is more than the maximum that she would be eligible to receive in reimbursements ($400), so she would not be offered COBRA continuation coverage under the Health Care FSA.

If you do not elect COBRA, you can only submit claims that were incurred up to the date of your qualifying event.

Any filing deadlines or other rules for filing a request for reimbursement under the Health Care FSA, as described earlier in this SPD, will continue to apply if you elect continuation coverage under the Health Care FSA.

Claim determination procedures under ERISA

Disagreements about the payment of plan benefits can arise. The Company has formal appeal procedures in place for the plan under the Employee Retirement Income Security Act of 1974 (ERISA).

Claims procedures

The following summary of the Plan's claims procedures is intended to reflect the US Department of Labor's claims procedures regulations and, for certain medical benefits, the applicable requirements of regulations issued under federal health care reform law, and should be interpreted accordingly. If there is any conflict between this SPD and those regulations, the regulations will control. In addition, any changes in applicable law will apply to the plan automatically effective on the date of those changes.

For any insured benefits, the insurer's claims procedures will apply instead of the claims procedures described in this SPD. The insurer's claims procedures are described in the benefits booklet that describes the specific benefit. If you have questions about claims procedures for any insured benefit, you should contact the insurer directly.

Note that, for any claim for a benefit under the plan that is not subject to ERISA, the US Department of Labor's regulations do not apply. For those claims, including claims for Dependent Care Flexible Spending Account benefits, the claims procedures described in this section that apply for benefits other than health or disability benefits will apply, but any requirement that the plan administrator provide notice to a claimant about any right under ERISA will not apply to such a claim.

Note that certain requirements described below apply only to medical coverage and are based on regulations issued pursuant to the Affordable Care Act. Those requirements include the requirements described in the "Additional requirements for non-grandfathered medical plans" subsection later in this claim determination procedures summary.

To receive plan benefits, you must follow the procedures established by the claims administrator, which has the responsibility for making the particular benefit payments. If you do not follow the Plan's claims procedures, you may lose your right to a benefit under the Plan, including any right you may have to file a legal action for benefits.

Initial claims

Initial claims for plan benefits are made to the applicable claims administrator administering that benefit. The remainder of these procedures uses the term "reviewer" to refer to the claims administrator that is responsible for reviewing a claim. All claims must be submitted, in writing (except to the extent that oral claims are permitted for urgent care claims, as described on next page), to the reviewer. The reviewer will review the claim itself or appoint an individual or an entity to review the claim. (For purposes of these procedures, "health benefits" or "health claims" refers to benefits or claims involving medical, dental, vision, Health Care FSA, and EAP coverage.)

Non-health and non-disability benefit claims

For any claim that is not a health claim or a disability claim (e.g., an eligibility claim), the claimant will be notified within 90 days after the claim is filed whether the claim is allowed or denied, unless the claimant receives written notice from the reviewer before the end of the 90-day period stating that special circumstances require an extension of the time for decision, in which case the extension will not extend beyond 180 days after the day the claim is filed.

Eligibility claims for benefits

Claims related to eligibility to participate in ERISA-covered plans described in the HP Inc. U.S. Health and Welfare Benefits Summary Plan Description must be submitted in writing to the following address:

Plan Administrator
HP Inc. Plan Committee
Welfare Plan Claims
3800 Quick Hill Road, Bldg. 2-150
Austin, TX 78728-1343

Health benefit claims. Applies to medical (including mental health, substance use, and prescription drug), dental, vision, spending accounts (including Health Care FSA and HRA), and the Employee Assistance Program (EAP).

The timing for benefit decisions and the opportunities to appeal a denied claim depend on the type of claim an employee files. There are four different types of claims to receive benefits that may apply under group health plans:

1. Urgent care claims. If a claim is for urgent care health benefits, the reviewer will notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the plan. In cases where the claimant fails to provide sufficient information to decide the claim, the reviewer will notify the claimant as soon as possible, but not later than 24 hours after the plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by the claimant. The claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The reviewer will notify the claimant of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

   If any person fails to follow the Plan's procedures for submitting an urgent care claim, but provides information to a person or organizational unit that is customarily responsible for handling benefit matters and the information provided

identifies a specific participant or dependent, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested. The plan administrator or reviewer will notify the potential claimant, as soon as reasonably possible but no later than 24 hours after the information is provided, of the failure to properly submit a claim and of the proper procedures for submitting the claim. The notification may be oral unless written notice is requested by the claimant.

A health benefits claim is considered an urgent care claim if applying the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

2. Pre-service health benefit claims. For a pre-service health benefit claim, the reviewer will notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the reviewer needs additional time to process a claim, the claimant will be notified, within 15 days after the Plan receives the claim, of those circumstances and of when the reviewer expects to make its decision. Under no circumstances may the reviewer extend the time for making its decision beyond 30 days after receiving the claim. However, if an extension is necessary because the claimant failed to submit all information necessary to decide the claim, the notice of extension will specifically describe the required information and the claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

   If any person fails to follow the Plan's procedures for submitting a pre-service health benefit claim but provides information to a person or organizational unit that is customarily responsible for handling benefit matters and the information provided identifies a specific participant or dependent, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested, the plan administrator or reviewer will notify the potential claimant, as soon as possible but no later than five (5) days after the information is provided, of the failure to properly submit a claim and of the proper procedures for submitting a pre-service claim. The notification may be oral unless written notice is requested by the claimant.

   A health benefit claim is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

3. Post-service health benefit claims. For a post-service health benefit claim, the reviewer will notify the claimant of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to matters beyond the control of the plan, the reviewer needs additional time

to process a claim, the claimant will be notified, within 30 days after the reviewer receives the claim, of those circumstances and of when the reviewer expects to make its decision. Under no circumstances may the reviewer extend the time of making its decision beyond 45 days after receiving the claim. However, if such an extension is necessary because the claimant failed to submit all information necessary to decide the claim, the notice of extension will specifically describe the required information and the claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

A health benefit claim is considered a post-service claim if it is a request for payment for services that the claimant has already received.

4. Concurrent care claims. If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments will constitute an adverse initial benefit determination. These determinations will be known as "concurrent care" decisions. The reviewer will notify the claimant of the adverse concurrent care decision at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

   Any request by a claimant to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies, and the reviewer will notify the claimant of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim, provided that any such claim is submitted to the Plan at least 24 hours before the expiration of the prescribed period of time or number of treatments.

- **Disability benefit claims**

If a claim for disability benefits is denied, in whole or in part, the claimant will receive a written notice from the reviewer within a reasonable period of time, but no later than 45 days after it receives the claim. Under special circumstances, the reviewer may take up to an additional 30 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the claimant will be notified before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the reviewer expects to render a decision. If, prior to the end of the first 30-day extension period, the reviewer determines that an additional extension is necessary due to matters beyond its control, the reviewer may take up to an additional 30 days to review the claim. If an additional extension of time is required, the claimant will be notified before the end of the initial 30-day extension period of the circumstances requiring the extension and the date by which the reviewer expects to render a decision. If the reviewer extends its period of reviewing a claim due to special circumstances, the notice of extension

the claimant receives will include an explanation of the standards on which entitlement to benefits is based, the unresolved issues that prevent a decision on the claim and any additional information needed to resolve these issues. The claimant has at least 45 days to provide the specified information.

Manner and content of denial of initial claims. If the reviewer denies a claim, it will provide to the claimant a written or electronic notice that includes:

1. A description of the specific reasons for the denial;
2. A reference to any Plan provision or insurance contract provision upon which the denial is based;
3. A description of any additional information that the claimant must provide in order to perfect the claim;
4. An explanation of why such additional material or information is necessary;
5. A statement that the claimant has a right to request a review of the claim denial and information on the steps to be taken if the claimant wishes to request a review of the claim denial; and
6. If applicable, a statement of the participant's right to bring a civil action under ERISA Section 502(a) following any denial on review of the initial denial.

In addition, for a denial of health benefits or disability benefits, the following must be provided:

7. A copy of any rule, guideline, protocol, or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon request by the claimant and without charge); and
8. If the adverse determination is based on a medical necessity requirement, experimental treatment exclusion or a similar restriction, either an explanation of the scientific or clinical judgment applying the restriction to the claimant's medical circumstances or a statement that an explanation will be provided upon request and without charge.

For any adverse determination concerning an urgent care health claim, the information described in this section may be provided to the claimant orally within the permitted time frame, provided that a written or electronic notification in accordance with this section is furnished not later than three (3) days after the oral notification.

Manner and content of denial of initial disability claims. In addition to the requirements set forth above, the following provisions apply to disability benefit claims made under the Plan:

1. If a reviewer denies a disability claim, the written or electronic notice provided to the claimant shall also include the following information:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; and

(ii) 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 claimant's claim for benefits. Whether a document, record, or other information is relevant to a claim for benefits shall be determined by reference to Section 2560.503-1(m)(8) of the ERISA Regulations.

(iii) A statement that prior to issuing any adverse determination on review of a disability benefit claim:

a. The plan administrator shall provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan, insurer, or such other person) in connection with the claim; such evidence must be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse determination on review is required to be provided (as described in Disability benefit claims" above) to give the claimant a reasonable opportunity to respond prior to the date; and

b. If such adverse determination is based on a new or additional rationale, the plan administrator shall provide the claimant, free of charge, with the rationale as soon as possible and sufficiently in advance of the date on which the notice of adverse determination on review is required to be provided under the "Disability benefit claims" section to give the claimant a reasonable opportunity to respond prior to that date.

2. Any notice of adverse determination provided with respect to disability benefits shall be provided in a culturally and linguistically appropriate manner.

- **Review procedures**

1. Non-health and non-disability benefit claims. A request for review of a denied claim for a benefit other than health or disability benefits must be made in writing to the reviewer within 60 days after receiving notice of denial. The decision on review will be made within 60 days after the reviewer receives the request for review, unless special circumstances require an extension of time for processing, in which case a

decision will be rendered no later than 120 days after the request for review is received. A notice of such an extension must be provided to the claimant within the initial 60-day period and must explain the special circumstances and provide an expected date of decision.

(i) The reviewer will afford the claimant an opportunity to review and receive, without charge, all relevant documents, information, and records and to submit issues and comments in writing to the reviewer. The reviewer will take into account all comments, documents, records, and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

2. Health benefit claims. A request for review of a denial of an initial claim for health benefits must be submitted in writing to the reviewer no later than 180 days after the claimant receives the notice of denial of the initial claim.

– Notwithstanding the preceding, following a denial of an initial urgent care health benefits claim, the claimant may request an expedited review of the claim and such a request may be submitted orally or in writing at the discretion of the claimant. If an expedited review is requested, all necessary information, including the Plan's benefit determination on review, will be transmitted between the reviewer and the claimant by telephone, facsimile, or other available similarly expeditious method, whenever possible.

– In addition to providing the claimant the right to review documents and submit comments (as described in (1) on previous page), a review of a denial of a health benefits claim will meet the following requirements:

(i) The Plan will provide a review that does not afford deference to the initial adverse determination and that is conducted by an appropriate named fiduciary of the Plan who did not make the initial determination that is the subject of the appeal, nor is a subordinate of the individual who made the determination.

(ii) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse initial determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate. The professional engaged for purposes of a consultation noted in the preceding sentence will be an individual who was not consulted in connection with the initial determination that is the subject of the appeal, or the subordinate of any such individual.

(iii) The Plan will identify to the claimant the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the

review, without regard to whether the advice was relied upon in making the benefit review determination.

(iv) For purposes of any Benefit Package Option that is subject to the Affordable Care Act, the Plan or insurer will allow a claimant to review the claim file and to present evidence and testimony as part of its internal claims and appeals process.

For purposes of any benefits option that is subject to the Affordable Care Act that is not a grandfathered plan, the Plan or insurer will comply with the following requirements:

(i) The Plan or insurer will provide the claimant, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan or insurer in connection with the claim as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse determination is required to be provided (as described in these claims procedures and applicable regulations) to give the claimant a reasonable opportunity to respond before that date; and

(ii) Before the Plan or insurer issues a final adverse determination based on a new or additional rationale, the claimant will be provided, free of charge, with the rationale for the Plan's decision as soon as possible and sufficiently in advance of the date on which the notice of final internal adverse determination is to be provided (as described in these claims procedures and applicable regulations) to give the claimant a reasonable opportunity to respond before that date.

- **Deadline for review decisions**

1. Urgent health benefit claims. For urgent care health claims, the reviewer will notify the claimant of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claimant's request for review of the initial adverse determination by the Plan; unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan.

2. Other health benefit claims.

   – For a pre-service health claim, the reviewer will notify the claimant of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after receipt by the Plan of the claimant's request for review of the initial adverse determination.

   – For a post-service health claim, the reviewer will notify the claimant of the Plan's benefit determination on review within a reasonable period of time, but in no event later than 60 days after the Plan receives the claimant's request for review of the initial adverse determination.

3. Disability benefit claims. A request for review of a denial of an initial claim for disability benefits must be submitted in writing to the reviewer no later than 180 days after the claimant receives the notice of denial of the initial claim. The request must be submitted in writing and must include:

    (a) The reasons why the claimant feels the claim is valid; and

    (b) The reasons why the claimant feels the claim should not be denied.

    Documents, records, written comments, and other information in support of the appeal should accompany the request. This information will be considered by the reviewer in reviewing the claim. The claimant may request to examine and receive copies of all documents, records, and other information relevant to the claim. The reviewer will review the claim without granting any deference to the initial decision regarding the claim. Also, no reviewer may be a person who was involved in making the initial decision regarding the claim, or subordinate to that person. In addition, if the claim was based in whole or in part on a medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. This person will not be a person or a subordinate of a person consulted by the reviewer in deciding the initial claim.

    The reviewer will notify the claimant of its decision on the appeal within 45 days after receipt of the appeal. Under special circumstances, the reviewer may take up to an additional 45 days to review the claim if it determines that such an extension is necessary due to matters beyond its control. If an extension of time is required, the claimant will be notified in writing before the end of the initial 45-day period of the circumstances requiring the extension and the date by which the reviewer expects to render a decision. The claimant has at least 45 days to provide the specified information.

4. Manner and content of notice of decision on review of non-disability benefit claims. Upon completion of its review of an adverse initial claim determination, the reviewer will provide the claimant a written or electronic notice of its decision on review. For any adverse determination on review, that notice will include:

    (1) A description of its decision;

    (2) A description of the specific reasons for the decision;

    (3) A reference to any relevant Plan provision or insurance contract provision on which its decision is based;

    (4) A statement that the claimant is entitled to receive, upon request and without charge, reasonable access to, and copies of, all documents, records, and other information in the Plan's files that are relevant to the claimant's claim for benefits;

    (5) If applicable, a statement describing the claimant's right to bring an action for judicial review under ERISA Section 502(a).

In addition, for any adverse determination on review of health benefits or disability benefits, the following must be provided:

(6) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol, or other similar criterion will be provided without charge upon request; and

(7) If the adverse determination on review is based on a medical necessity requirement, an experimental treatment exclusion or a similar restriction, either an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant's medical circumstances, or a statement that an explanation will be provided without charge upon request.

Also, upon request, the reviewer will provide the claimant with a statement identifying those medical or vocational experts whose advice was obtained in connection with the appeal.

5. Manner and content of notice of decision on review of disability benefit claims. In addition to the requirements set forth above, the following provisions shall apply to notices of decision on review of disability benefit claims.

(1) Upon completion of its review of an initial adverse determination, the reviewer will provide the claimant written or electronic notice of its decision on review. For any adverse determination on review, that notice will include:

(i) A discussion of the decision, including an explanation of the basis for disagreeing with or not following: (a) the views presented by the claimant to the Plan of health care professionals treating the claimant and vocational professionals who evaluated the claimant; (b) the views of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse determination, without regard to whether the advice was relied upon in making the benefit determination; and (c) a disability determination regarding the claimant presented by the claimant to the Plan made by the Social Security Administration; and

(ii) Either the specific internal rules, guidelines, protocols, standards, or other similar criteria of the Plan relied upon in making the adverse determination or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist.

(2) In the case of an adverse determination on review with respect to a claim for disability benefits, the notification shall be provided in a culturally and linguistically appropriate manner.

With respect to claims for disability benefits, if the Plan fails to establish and follow reasonable claims procedures, the following is applicable:

(1) A claimant shall be deemed to have exhausted the administrative remedies available under the Plan and shall be entitled to pursue any available remedies under Section 502(a) of ERISA on the basis that the Plan failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

(2) Notwithstanding the preceding paragraph, administrative remedies will not be deemed exhausted where the violation is: (i) de minimis; (ii) non-prejudicial with respect to the claimant; (iii) for good cause or due to matters beyond the plan's control; (iv) in the context of an ongoing, good faith exchange of information; and (v) not part of a pattern or practice of violations by the Plan.

(3) The claimant may request a written explanation of any violation described in this section. Such explanation must be provided by the Plan within 10 days and must include a specific description of its bases, if any, for asserting that administrative remedies should not be deemed exhausted.

(4) If a court rejects the claimant's request for immediate review on the basis that the Plan satisfied the requirements for providing a reasonable claims procedure, the claim shall be considered re-filed on appeal upon the Plan's receipt of the court's decision, and the Plan shall provide claimant with a notice of the resubmission within a reasonable period of time.

Adverse determination

For purposes of this "Claims determination procedures under ERISA" section, an adverse determination is a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in a Benefit Package Option, and including, with respect to any group health plan, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. For purposes of any benefits package that is subject to the Affordable Care Act but is not a grandfathered plan, adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission. An adverse determination also means any rescission of disability coverage with respect to a participant or beneficiary (whether or not in connection with the rescission, there is an adverse effect on any particular benefit at that time). For this purpose, the term "rescission" means a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

Additional notice requirements for non-grandfathered plans

For any adverse determination involving coverage that is subject to the Affordable Care Act that is not a grandfathered plan, any notice of an adverse determination will be

provided in a culturally and linguistically appropriate manner in accordance with applicable regulations or other authoritative guidance regarding such notices and will include (in addition to other requirements described above):

(a) Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code (and an explanation of its meaning), and the treatment code (and an explanation of its meaning);

(b) As part of the explanation of the adverse determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning), and a description of the Plan's or insurer's standard, if any, that was used in denying the claim;

(c) A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and

(d) Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Affordable Care Act to assist individuals with internal claims and appeals and external review processes.

Avoiding conflicts of interest

For claims involving coverage that is subject to the Affordable Care Act that is not a grandfathered plan, the Plan or insurer will ensure that claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of individuals involved in claims decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claims decisions will support the denial of benefits.

Calculation of time periods

For purposes of the time periods specified in this "Claims procedures under ERISA" section, the period during which a benefit determination must be made begins when a claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the claim. If a time period is extended because a claimant fails to submit all information necessary for a claim for non-urgent care health benefits, the period for making the determination will be tolled from the date the notification requesting the additional information is sent to the claimant until the date the claimant responds or, if earlier, until 45 days from the date the claimant receives (or was reasonably expected to receive) the notice requesting additional information.

Claimant's failure to follow procedures

A claimant must follow the claims procedures described above to be entitled to file any legal action with respect to any claim for benefits under the plan (unless the plan fails to follow those procedures).

Insured benefits and state law

For any insured benefit under this Plan, nothing in the Plan's claims procedures will be construed to supersede any provision of any applicable state law that regulates insurance, except to the extent that such law prevents application of the Plan's claims procedures.

Statute of limitations for Plan claims

Please note that the Plan provides that no legal action may be brought more than one year after the earlier of: (a) the date of the notice of your final appeal decision or (b) the date a timely notice of your final appeal decision should have been issued. However, if no initial claim is filed, no legal action may be brought more than two years after the last date to file an initial claim.

Voluntary external review

If a claimant is enrolled in a medical benefit subject to the Affordable Care Act that is not subject to a state external review process, then upon exhausting the Plan's internal claim and appeal procedures (or earlier, if the claimant is deemed to have exhausted such procedure due to the Plan's failure to comply with the procedure) with respect to any claim that involves medical judgment or rescission of coverage, the claimant may request an external (i.e., independent) review of the adverse benefit determination or final internal adverse benefit determination within four months after receiving the notice of denial or review determination notice.

Within five business days after receiving a claimant's request, a preliminary review will be completed to determine whether: (a) the claimant is/was covered under the Plan; (b) the denial was based on an issue involving medical judgment or a rescission of coverage (i.e., the claim does not relate to the claimant's eligibility to participate in the Plan); (c) the claimant has exhausted the Plan's internal claim and appeal process, if required; and (d) the claimant has provided all information necessary to process the external review. Within one business day after completing the preliminary review, the claimant will be

notified in writing if their request is not eligible for an external review or if it is incomplete. If the claimant's request is complete but not eligible, the notice will include the reason(s) for ineligibility and current contact information for the Employee Benefits Security Administration. If the claimant's request is not complete, the notice will describe any information needed to complete the request. The claimant will have the remainder of the four-month filing period or 48 hours after receiving the notice, whichever is greater, to cure any defect. If eligible for an external review, the claimant's request will be assigned to an independent review organization (IRO). The IRO will provide written notice of its final external review decision within 45 days after the IRO receives the request for external review. If the IRO reverses the adverse benefit determination or final internal adverse benefit determination, then the Plan will immediately cover the claim.

In addition, a claimant has the right to an expedited external review in these situations:

1. Following an adverse benefit determination involving a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize the claimant's life or health or would jeopardize their ability to regain maximum function and the claimant has filed a request for an expedited internal appeal.
2. Following a final internal adverse benefit determination involving: (i) a medical condition for which the time frame for completion of a standard external review would seriously jeopardize the claimant's life or health or would jeopardize their ability to regain maximum function or (ii) an admission, availability of care, continued stay, or health care item or service for which you received emergency services but have not been discharged from a facility.

The IRO will provide notice of its final external review decision as expeditiously as the claimant's medical condition or circumstances require, but not more than 72 hours after the IRO receives the request for expedited review.

HIPAA privacy rights

The HIPAA Privacy Rule applies to "protected health information," which is defined as any written, oral, or electronic health information that meets the following three requirements:

- The information is created or received by a health care provider, the Plan, or the health carrier (i.e., covered entity).
- The information includes specific identifiers that identify you or could be used to identify you.
- The information relates to one of the following:
  - Providing health care to you
  - Your past, present, or future physical or mental condition
  - The past, present, or future payment for your health care

The Notice of Privacy Practices for the Plan contains a complete explanation of your rights under the HIPAA Privacy Rule. The notice describes how protected health information may be used and disclosed and how you can get access to that information.

For more information regarding your rights with respect to protected health information and the privacy policies of the Plan, please review the Notice of Privacy Practices for the Plan. The Notice of Privacy Practices for the Plan is available at www.myhpbenefits.com.

Administrative information

This section contains important information about how your benefits are administered and funded. It also contains information about your rights and responsibilities as a participant and steps you can take if certain situations arise.

Plan name/Identification

As indicated in the "Introduction" section, the benefits described in this SPD are governed by the official Plan documents. The official Plan documents are the certificates of insurance issued by insurers, benefit booklets issued by other claims administrators, this SPD, and other governing documents referenced herein.

The HP Inc. Comprehensive Welfare Benefits Plan is an employer-sponsored welfare benefit plan governed by the Employee Retirement Income Security Act of 1974 (ERISA) and subject to the reporting and disclosure requirements of this law. The HP Inc. Cafeteria Plan is a "cafeteria plan" under Code Section 125, which allows you to pay for certain Plan benefits on a pre-tax basis. (Some benefits may require that you make after-tax contributions.) The cafeteria plan is not subject to ERISA. The HRA benefit is not part of the cafeteria plan.

The Plan number for the HP Inc. Comprehensive Welfare Benefits Plan is 511.

Plan information

This SPD includes this document and the incorporated documents listed in the "Introduction" section. In addition, you can get information about the Plan and your health and welfare benefits from:

- Applicable summaries of material modifications (SMMs) to this SPD,
- Enrollment materials and other general communications identified as containing Plan information.

Plan employer/plan sponsor/Employer Identification Number

The employer/plan sponsor for the Plan is:

HP Inc.
3800 Quick Hill Road, Bldg. 2-150
Austin, TX 78728-1343
1-650-857-1501

The HP Inc. Employer Identification Number is 94-1081436.

Participating employers

There are no other employers participating in the HP Inc. Comprehensive Welfare Benefits Plan.

Plan administrator

The plan administrator for the HP Inc. Comprehensive Welfare Benefits Plan is:

HP Inc. Plan Committee
3800 Quick Hill Road, Bldg. 2-150
Austin, TX 78728-1343
1-800-890-3100

COBRA administrator

The COBRA administrator for the Plan is:

HP Benefits Center
Dept. 09429
P.O. Box 1590
Lincolnshire, IL 60069-1590
1-800-890-3100

Agent for service of legal process

The agent for service of legal process under the HP Inc. Comprehensive Welfare Benefits Plan is:

HP Inc.
c/o CT Corporation System
818 West 7th Street, Suite 930
Los Angeles, CA 90017
1-213-337-4615 or 1-800-888-9207

Plan year

The plan year runs from January 1 to December 31.

Funding and source of contributions

The benefits under the Plans are funded by employer and employee contributions. The Company reserves the right to change the amount of required employee contributions for coverage under the Plans at any time, with or without advance notice to employees. Employer contributions are made from Company general assets. For the fully insured benefits under the Plan, the Company pays an insurance company or other provider a premium, from Company general assets and employee contributions, for providing coverage under the insured options.

Claims administrators and authority to review claims

Your eligibility for, and the provision of, health and welfare benefits is determined by the Plan. The plan administrator has the full discretionary authority to interpret the Plan in accordance with its terms and the provisions of ERISA and determine eligibility under the Plan, including the discretionary authority to make factual determinations. The plan administrator has delegated its authority for the administration of the Plan and its authority to make final claims determinations to the claims administrators. In some cases, the claims administrators may delegate this authority to certain other organizations on behalf of the Company. Benefits under the Plan are paid only if the

claims administrators, or their delegates, decide in their discretion that the claimant is entitled to them.

The claims administrators' decisions are final and binding on all parties to the full extent permitted under applicable law.

No employment rights or guarantee of benefits

All terms of the Plan are legally enforceable. However, neither the Plan nor this SPD constitutes a contract of employment or guarantee of any particular benefit.

Amendment/termination

Although the Company presently intends to continue the Plan, it reserves the right to, at any time, change or terminate any and all health and welfare benefits under the Plan; to change or terminate the eligibility of classes of employees to be covered by the Plan; to amend or eliminate any other Plan term or condition; and to terminate the entire Plan, or any part, subject to applicable law. The procedures by which benefits may be changed or terminated; by which the eligibility of classes of employees may be changed or terminated; or by which part or all of the Plan may be amended or terminated are contained in the Plan document, which is available for inspection and copying from the plan administrator. No consent of any participant is required to terminate, modify, amend, or change the Plan. Termination of the Plan will have no adverse effect on any benefits to be paid under the Plan for any expenses incurred prior to the date that the Plan terminates. Likewise, any extension of income protection benefits under the Plan due to your or your dependent's total disability that began prior to and has continued beyond the date the Plan terminates will not be affected by the Plan's termination. No extension of benefits or rights will be available solely because the Plan terminates.

Company's right to use your Social Security number for administration of benefits

The Company retains the right to use your Social Security number for benefits administration purposes, including tax reporting. If a state law restricts the use of Social Security numbers for benefits administration purposes, the Company generally takes the position that ERISA preempts such state laws.

HP's commitment to data privacy and security

As part of operating HP benefit programs, information about HP employees and covered family members must be shared with benefit vendors and other providers who support HP programs. However, HP places critical importance on the protection of employee data, and HP has terms in the contracts with benefit vendors to ensure personal data is only used for limited purposes and kept secure.

Although HP strives to limit use and disclosure of Social Security numbers as much as possible, Social Security numbers are still the unique identifier typically used by most health care providers, as well as being the identifier required by the government and Medicare for reporting purposes. HP limits the use of Social Security numbers wherever possible.

Your rights under ERISA

As a participant in the HP Inc. Comprehensive Welfare Benefits Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive information about your Plan and benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series), if applicable, filed by the Plan with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable, and an updated summary plan description. The plan administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report, if applicable. The plan administrator is required by law to furnish each participant with a copy of this summary annual report, if this summary is applicable to the Plan.

Continue group health plan coverage

- Continue health care coverage for yourself, your spouse, or your dependents if there is a loss of coverage under the Plan 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.

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 your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce your rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance:

- If you request a copy of Plan documents or the latest annual report, if applicable, from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.
- If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.
- If you disagree with the Plan's decision or lack thereof concerning the qualified status of a Qualified Medical Child Support Order, you may file suit in federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with your questions

If you have any questions about your Plan, you should contact the plan administrator. For more information about your rights under the Employee Retirement Income Security Act (ERISA), COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest regional or district office of the US Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit dol.gov/ebsa. Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website or you can write to:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
US Department of Labor
200 Constitution Avenue N.W.
Washington, DC 20210

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

For more information about the Health Insurance Marketplace, visit healthcare.gov.

Keep your plan administrator informed of address changes

To protect your family's rights, let the plan administrator know about any changes in the addresses of family members (you can do this through MyHPBenefits at www.myhpbenefits.com). You should also keep a copy, for your records, of any notices you send to the plan administrator.

COVID-19 special provisions

This section addresses changes in the law that are effective as a result of the COVID-19 pandemic. These provisions may apply only for a limited time, as described below.

Benefits coverage for COVID-19

Benefits coverage for COVID-19 testing

The Plan will provide coverage for testing without cost sharing (i.e., you pay no deductible, copay, or coinsurance) when medically appropriate as determined by your attending health care provider for the detection of SARS-CoV-2, or the diagnosis of COVID-19, including tests that detect antibodies against SARS-CoV-2 virus to the extent required during the applicable public health emergency period. This cost of testing includes the cost of health care provider office visits (including in-person and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of a test for the detection of SARS-CoV-2 or the diagnosis of COVID-19, but only to the extent the items and services relate to the furnishing or administration of the test or your evaluation for purposes of determining if you need a diagnostic test. The cost of testing does not include testing conducted for general workplace health and safety or public health surveillance.

Benefit coverage for COVID-19 vaccines

The Plan will cover, without cost sharing, both the COVID-19 vaccination and its administration, by either in-network or out-of-network providers, within 15 business days of receiving an A or B recommendation from the United States Preventive Services Task Force (USPSTF) or a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC). Also covered are other qualifying coronavirus preventive items and services as they are recommended.

Benefits coverage for COVID-19 treatment

If you are diagnosed with COVID-19, treatment for COVID-19 will continue to be covered, to the extent medically necessary, at the same cost sharing that applies under the Plan terms to other conditions; it is not covered at 100%. The Plan will cover any telemedicine charges related to COVID-19 treatment at no cost sharing. For this purpose, telemedicine means contacting your doctor.

Changes to telemedicine

Effective April 1, 2022, if you participate in a High Deductible Health Plan (HDHP), the Plan will cover any telemedicine charges related to COVID-19 treatment at no cost sharing and before your deductible. For this purpose, telemedicine means contacting your doctor, (the telemedicine provider), or other health care provider through the phone or computer.

Health Care Flexible Spending Account (Health Care FSA), Limited Purpose Health Care FSA, and Dependent Care FSA carryover of unused money

For the Health Care FSA, Limited Purpose Health Care FSA, and Dependent Care FSA, you were allowed to:

- Carry over all unused money from your 2020 FSAs into 2021 to use for 2021 expenses, and
- Carry over all unused money from your 2021 FSAs into 2022 to use for 2022 expenses.

This means that while you still needed to submit your eligible 2020 expenses by March 31, 2021, you could carry over the remaining unused funds in your 2020 account to use in 2021. The $550 carryover limit for the Health Care FSA and Limited Purpose Health Care FSA did not apply under the Consolidated Appropriations Act (CAA). It also means that you could carry over unused Dependent Care FSA funds, which was not previously permissible under IRS rules.

There was no action required by you to carry over unused money in your spending account(s).

Unused funds of up to $550 in your 2020 Health Care FSA or Limited Purpose Health Care FSA were already carried over earlier in 2021. Any remaining unused 2020 Health Care FSA funds were included in your 2021 Health Care FSA balance(s) on the following dates:

- Health Care FSA: By February 19, 2021
- Limited Purpose Health Care FSA: By May 15, 2021 (**Note:** If you elected HP's High Deductible Health Plan with Health Savings Account (HDHP w/HSA) medical option in 2021, the carryover funds were placed into a Limited Purpose Health Care FSA.)
- Dependent Care FSA: By April 15, 2021

Expanded eligibility for Dependent Care FSA
If you participated in the Dependent Care FSA in 2020 and your child turned age 13 in 2020, you could continue to submit dependent care expenses incurred for the child until they reached age 14.

Updating your 2021 FSA elections
You had a one-time opportunity to enroll in or increase your 2021 Health Care FSA, Limited Purpose Health Care FSA, and/or Dependent Care FSA elections without a qualified life event. Changes were made prospectively and processed by the HP Benefits Center. This means that you could only use the funds that you added for claims incurred on or after the effective date of the change. For example, if you increased your 2021 Health Care FSA contributions from $500 to $1,000, the additional $500 were only available for reimbursement of eligible expenses that were incurred after the date that you updated your 2021 FSA elections.

Health Care FSA carryover under COBRA
If you have a carryover balance resulting from a prior plan year and terminate employment, you can continue the carryover Health Care FSA amount under COBRA for a period of 18 months. If you have a current year Flexible Spending Account election and a prior year carryover balance, you can elect COBRA coverage for the Flexible Spending

Account for the remainder of the year (and continue to make contributions). If you have an available balance on December 31, you will have the remainder of the 18-month COBRA period to submit claims.

Claims submission deadlines

As in prior years, for the Health Care FSA, Limited Purpose Health Care FSA, and Dependent Care FSA, you have until March 31 of the following year to submit claims for expenses incurred during the prior year. For example, you can submit claims for services received in 2021 by March 31, 2022.

Extension of certain deadlines

Certain deadlines that impact the cafeteria plan and the Health and Welfare Benefits Plan coverage as a result of the COVID-19 public health crisis have been extended, and the Plans' terms are amended to reflect these extensions. While HP Inc. encourages you to comply with original deadlines as communicated to you in your SPD(s) and/or notices to avoid any administrative complications, we also want you to know about this temporary relief if it is needed.

How does the extension work?

As a plan participant, you will be given extra time for certain health and welfare benefit claims, elections, and payments during what is known as the "Outbreak Period." The Plan will also be provided extra time to provide notices and respond to certain events during the Outbreak Period.

The Outbreak Period extends from March 1, 2020, until 60 days after the end of the declaration of a national emergency. For purposes of the extended deadlines specified below, the clock is stopped until the earlier of one year from the original deadline or the end of the Outbreak Period. Any days attributable to the deadline before and after the Outbreak Period will count towards the deadline.

As of the date of this notice, we do not know the ultimate end date of the national emergency. The president announced an extension of up to one year on February 24, 2021; the Department of Health and Human Services declared that the public health emergency would continue to at least July 20, 2021. Examples in this notice assume that the national emergency ends on July 20, 2021, but this may not be the final end date. Also, the end date may be different for different parts of the country. If the national emergency ends on July 20, 2021, then the Outbreak Period ends on September 18, 2021.

What deadlines are extended?

<u>Continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)</u>

If you recently elected COBRA, currently are covered by COBRA, or have a qualifying event that is impacted by the Outbreak Period, the following deadlines are subject to relief:

- 60-day deadline for notifying the plan administrator of the occurrence of a COBRA-qualifying event (e.g., divorce)

- 60-day deadline for notifying the Plan of a determination of disability
- 60-day deadline for electing COBRA coverage
- 45-day deadline for paying first premium payment and 30-day deadline for paying subsequent premium payments

Note: It's important to know that your premium payments are not waived. Instead, you are just given more time to make the payment before coverage is dropped.

> **Example:** A COBRA-qualified beneficiary has 60 days to elect COBRA coverage after receiving the COBRA election notice. Assume the qualified beneficiary received a COBRA election notice on March 1, 2021, the national emergency ends July 20, 2021, and therefore, the Outbreak Period ends 60 days later on September 18, 2021. The qualified beneficiary has 60 days after the end of the Outbreak Period (for purposes of this example, November 17, 2021) to elect COBRA coverage.

Mid-year enrollment under HIPAA

If you missed the special enrollment period for the following reasons, you may be eligible to enroll mid-year if you are still within the mid-year enrollment period after discounting time during the Outbreak Period:

- Enrollment period triggered when eligible employees or dependents lose group health coverage or when an employee acquires a dependent through marriage, birth, or adoption.
- Enrollment period triggered when eligible employees or dependents lose Medicaid or CHIP coverage, or when eligible employees or dependents become eligible for state premium assistance subsidy through Medicaid or CHIP.

Note: This change will give you more time to enroll in your medical, including prescription drug, coverage as a result of a delay during the Outbreak Period, but you will still have to make your contributions for that period of coverage.

> **Example 1:** An employee declined coverage during the annual enrollment period for 2020. On May 31, 2020, the employee had a baby and would like to enroll herself and the baby in the Plan's medical coverage. The Outbreak Period is disregarded for purposes of determining timing for up to one year, so she has until May 31, 2021, to make the election to enroll herself and her baby, as long as she pays her contributions for the entire period of coverage.
>
> **Example 2:** An employee declined coverage during the annual enrollment period for 2021. On May 31, 2021, the employee has a baby and would like to enroll herself and the baby in the Plan's medical coverage. The Outbreak Period is disregarded for purposes of determining timing, so she has until 30 days after the Outbreak Period to make the election, as long as she pays her contributions for the entire period of coverage. For purposes of this example, the employee would have until October 18, 2021, to enroll her baby.

Claims procedures under ERISA

If you file an ERISA claim or appeal, including an external review, the time frame will be extended to disregard the Outbreak Period. This extension includes the Health Care FSA runout period.

> **Example:** If you received a denial with respect to a medical or disability claim during the Outbreak Period, your 180-day deadline to appeal the decision will start as of the earlier of one year from the date of the denial or the end of the Outbreak Period.

Furnishing required notices under ERISA

HP Inc., as your plan sponsor, may take advantage of good faith disaster relief in its furnishing of a notice, disclosure, or document that must be furnished under ERISA during the Outbreak Period if the Plan acts in good faith and furnishes the notice, disclosure, or document as soon as administratively practicable under the circumstances. Good faith attempts include providing the disclosure electronically, including via email, text message, or a continuous access website, if the plan reasonably believes the electronic communication will reach the participant.

2022 summary of material modifications (SMM)

About this SMM

This is a summary of material modifications under the Employee Retirement Income Security Act of 1974, as amended (ERISA), and updates information provided in the HP Inc. U.S. Health and Welfare Benefits Summary Plan Description (SPD) for benefits under the HP Inc. Comprehensive Welfare Benefits Plan (plan number 511) and the HP Inc. Cafeteria Plan (plan number 525). This SMM is effective November 1, 2022, unless otherwise noted. It's important to keep this SMM for future reference and refer to it in combination with information provided in the SPD.

This document is organized by SPD sections where changes apply.

Incorporated documents

- Aetna (Poly Only) HDHP 1500 Group# 0187719 011 00001 (Medical)
- Aetna (Poly Only) HDHP 2500 Group# 0187719 012 00001 (Medical)
- Aetna (Poly Only) CHC POS Group # 0187719 010 00001 (Medical)