HP Inc. Retiree Welfare Benefits Plan Summary Plan Description

HP Inc.

Effective: January 1, 2023

HP US Retiree Health and Welfare Benefits SPD

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Introduction

This summary plan description ("SPD") describes the health and welfare benefits available to eligible retired employees of HP Inc. (the "Company") and their eligible dependents effective as of January 1, 2023. These health and welfare benefits together compose the HP Inc. Retiree 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.

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.

Eligibility overview

An individual may qualify for one of the Retiree Medical Programs, depending on eligibility requirements summarized in sections below.

Described herein are the classes of retirees and certain Terminated LTD Participants (as defined below) who are generally eligible for the programs and benefits contained in this SPD. Some classes of retirees and/or certain Terminated LTD Participants may have additional restrictions on a benefits program basis. See "Special eligibility considerations" below for this additional information. For more information on enrolling, see "Enrollment/effective date."

Special eligibility considerations

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

Terminated LTD Participants

Terminated LTD Participants are defined as former employees whose employment was terminated while they were receiving Long-Term Disability (LTD) benefits under HP's programs.

Coverage under HP benefits for Terminated LTD Participants generally ends upon the earlier of the individual's attainment of their full Social Security age or no longer qualifying for HP LTD benefits. If a Terminated LTD Participant also qualified for retiree medical based on their satisfaction of the applicable age and years of service requirements at the time of their termination of employment, they will then become eligible for benefits as a retiree, under this Plan.

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 the HP Inc. Comprehensive Welfare Benefits Plan Summary Plan Description will apply to you (for instance, you are not eligible for COBRA coverage under the Plan). When you become eligible for Medicare due to disability or age, you will need to refer to this HP Inc. Retiree Welfare Benefits Plan Summary Plan Description. Information regarding eligibility, enrollment, cost of coverage, and other important terms and details are covered under this HP Inc. Retiree Welfare Benefits Plan Summary Plan Description. It is to your advantage to read through both this SPD, the HP Inc. Comprehensive 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.

If a retiree is re-hired by HP

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

If a retiree left HP under an EER Program or Phased Retirement Program

If a retiree left HP under an Enhanced Early Retirement (EER) Program or Phased Retirement Program (PRP) that provides access to retiree medical, the retiree may qualify for HP medical coverage as outlined in the 2019 or 2023 EER or 2016 PRP summary plan description, following retirement. During that period, some special considerations apply to your medical benefits:

- If the former employee and covered dependents are not eligible for Medicare, the medical options may be similar to those offered to active HP employees.
- If the former employee and covered dependents are eligible for Medicare, Medicare will become your primary coverage, and you will need to participate in HP medical options that coordinate coverage with Medicare.

Pre-2003 HP Retiree Medical Program

The Pre-2003 HP Retiree Medical Program applies if all of the following criteria are satisfied.

The former employee:

- Is benefits-eligible when they are an active employee (working more than 20 hours per week);
- Has been employed by HP continuously since December 31, 2002;
- Had 62 or more age-plus-service "points" as of December 31, 2005;
- Was born on or before June 30, 1957;
- Completed 10 years of qualifying HP service as of June 30, 2007; * and
- Retires from a benefits-eligible status at age 55 or later with at least 15 years of qualifying HP service.

* For purposes of determining qualifying HP service under this program, service for pre-merger Compaq employees is counted starting January 1, 2003, and does not include pre-merger service. With respect to retiree medical coverage, the term "pre-merger Compaq employee" refers only to an individual who was employed by Compaq as of May 3, 2002, the date of the merger with HP.

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

- You left HP under a Workforce Reduction program with a termination date that fell within one year of the date you would have otherwise satisfied the eligibility criteria described above;
- You left HP under an EER Program or PRP that provided access to the Pre-2003 HP Retiree Medical Program; or
- You were otherwise notified of your eligibility to participate in the Pre-2003 HP Retiree Medical Program.

HP Retiree Medical Program

Employees who do not qualify for the Pre-2003 HP Retiree Medical Program may qualify for the HP Retiree Medical Program if any one or more of the following criteria are met:

- The employee leaves HP at age 55 or later with at least 10 years of qualifying service; or
- The employee leaves HP on or after January 1, 2011, with at least 80 age-plus-service "points."

For this purpose, service for former EDS employees generally includes prior EDS service if an employee was employed by EDS on August 26, 2008. Service for pre-merger Compaq employees also includes pre-merger service if the employee was employed by Compaq on May 3, 2002.

An individual is not eligible for this program if they previously retired under or otherwise qualified for the Pre-2003 HP Retiree Medical Program or the former Digital Retiree Health Program.

You may also qualify as a retiree under the HP Retiree Medical Program if any of the following applies:

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

How age-plus-service "points" are calculated

Age-plus-service "points" may determine eligibility for certain HP Retiree Medical Programs and access to any HP credits in the Retirement Medical Savings Account. Points as of December 31, 2005, also help determine eligibility for the Pre-2003 HP Retiree Medical Program and having at least 80 points at an employee's date of termination may help the employee qualify for retiree benefits if leaving HP on or after January 1, 2011. For this purpose, points are calculated based on an employee's combined age and years of qualifying service, as described in the following chart.

Calculating an employee's age	Age is calculated as both full and partial years of age, with any partial months treated as full months. For example, if an employee was born on January 26, 1968, and leaves HP on October 5, 2020, they would be considered to be age 52 plus 10 months at the time of leaving HP.
Calculating an employee's qualifying service	In most cases, an employee's qualifying years of service are based on the employee's continuous service date as reflected in Workday (this is also the date commonly used to determine an employee's annual vacation amount). It may be different than an employee's hire date, especially if the employee left HP in the past and was rehired, or if an employee joined HP through certain acquisitions. As an exception, if an employee joined HP through a merger, acquisition, or outsourcing arrangement that did not recognize past service for retiree medical purposes, then the employee's qualifying service will typically be calculated using the employee's HP hire date instead. As with an employee's age, when calculating years of qualifying service, any partial months are treated as full months.
Calculating an employee's total age-plus-service "points"	To determine an employee's total age-plus-service "points," add the results of the age and service calculations above. For example, if an employee was age 45 and 10 months and had qualifying service of 20 years and three months, the total would be 66 years and one month, and the employee would have 66 "points." Points are counted in whole years only and are not rounded.

Former Digital Retiree Health Program

To be eligible for HP retiree health benefits under the former Digital Retiree Health Program, you must have satisfied all of the following criteria on the date you left Digital, Compaq, or HP (as applicable).

If you left Compaq or HP on after March 1, 1999, and you met all of the following criteria on February 28, 1999:

- You were an active Compaq US employee eligible for health benefits;
- You were being paid from the payroll systems of the former Digital Equipment Corporation; and
- You were at least age 50 with at least five years of vesting service under the Cash Account Pension Plan (CAPP).

- You met all of the following criteria at the time you first left Compaq or HP (as applicable) on or after March 1, 1999:
- You were a regular employee scheduled to work at least 20 hours per week; and
- You were at least age 55 and had completed at least 10 years of CAPP vesting service (or your most recent hire date was before January 1, 1994, and you were at least age 65).

Certain employees who were notified of termination under a former Compaq or HP severance program after March 26, 2001, may also qualify if the employee's termination date fell within one year of satisfying these requirements. You may also qualify if you left HP under an EER Program or PRP that provided access to the former Digital Retiree Health Program.

If you reached age 65 and retired from Digital before January 1, 1993, please note that you are only eligible to participate in HP medical and dental benefits. You are not eligible to participate in HP vision benefits. Your eligibility for HP dental benefits may also be limited to certain dental options.

Eligible dependents

For purposes of all benefits available to dependents under the Plan, your spouse, unless legally separated from you pursuant to a court order (former spouses are not eligible, even if you are required to provide coverage as part of a divorce decree), or your domestic partner is considered an eligible dependent.

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 open 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 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 retiree (unless legally separated from the retiree 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 retiree 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 a retiree and the retiree's spouse or qualifying partner are eligible retirees under the Plan, each retiree can 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.

IMPORTANT NOTE: If you die after declining HP medical coverage, your surviving dependents will not be eligible to participate in HP benefits following your death. Only dependents who are covered on the date of death can continue HP benefits as a survivor or through COBRA continuation coverage.

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, coverage for a domestic partner is subject to taxable imputed 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 Code Section 152. 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.

IMPORTANT NOTE: It is your responsibility to ensure that the dependents you cover meet program eligibility requirements. If you continue to cover a dependent who is no longer eligible, that dependent's coverage will be dropped retroactively to their date of ineligibility, but you will not receive retroactive premium refunds. Dependent eligibility is also subject to periodic audits that could result in termination of benefits if you fail to provide the required information by the due date, or you are covering an ineligible dependent. If benefits are terminated due to failure to comply with a dependent eligibility audit, you may not be able to reinstate your eligible dependent's coverage until a subsequent annual enrollment period or within 60 days of a qualified status change that would otherwise allow you to add the dependent who was dropped from coverage.

Your health and welfare benefits

As an eligible retiree of HP Inc., you may be eligible for some or all of the following health and welfare benefits under the Plan. Please refer to the applicable annual enrollment materials and other communications that detail the specific benefits and levels of coverage you are eligible for:

- Medical benefits
- Substance use/mental health benefits
- Prescription drug benefits
- Dental benefits (if applicable)
- Vision benefits (if applicable)
- Medicare Supplement benefits, Medicare Advantage benefits, or Alight Retiree Health Solutions
- Retirement Medical Savings Account (if applicable)
- Retiree Reimbursement Account (if applicable)
- Long-Term Care insurance (closed to new participants)
- Prepaid group legal insurance

Cost of coverage

For participants in the Pre-2003 HP Retiree Medical Program and the former Digital Retiree Health Program, HP will pay a portion of the cost of coverage, as communicated in the applicable annual enrollment materials. Participants in the HP Retiree Medical Program pay the full cost of coverage, as communicated in the applicable annual enrollment materials.

Retiree Reimbursement Account (RRA) (if applicable)

The Retiree Reimbursement Account (RRA) reimburses premium costs for Alight Retiree Health Solutions participants under the Pre-2003 HP Retiree Medical Program and the former Digital Retiree Health Program, as communicated in the applicable annual enrollment materials.

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) generally may be required or permitted to designate a primary care provider. If that is the case, you have the right to designate any primary care provider 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 provider.

For information on how to select a primary care provider and for a list of the participating primary care providers, 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 provider, you (or your covered family member) do not need prior authorization from the plan or from any other person (including a primary care provider) to obtain access to obstetrical or gynecological care from a health care professional in 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 plan administrator or the claims administrators for your coverage at the address provided in this SPD.

Qualified Medical Child Support Orders ("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 plan administrator follows certain procedures to determine if a medical child support order is "qualified." You may request, free of charge, a copy of the Plan's QMCSO administrative procedures from the plan administrator. If you become subject to an order, you will receive a copy of the QMCSO administrative procedures, free of charge, from the plan administrator.

If the plan administrator 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 plan 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 option and prescription drug benefits provide you with certain protections—sometimes referred to as "group market reforms" or "consumer protections" under the Patient Protection and Affordable Care Act (PPACA, or Affordable Care Act), including:

- Prohibition of pre-existing condition exclusions
  - The Plan does not impose any pre-existing 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 option 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 a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) in effect; 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 copayment or coinsurance, for example, for out-of-network emergency services than for in-network emergencies services, but in certain circumstances 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, copayments, 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 provisions

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 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 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 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 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.

How Medicare works with your retiree benefits

If you or a covered dependent is eligible for Medicare, Medicare Parts A and B are your primary coverage (pay benefits first), and HP coverage pays benefits on a secondary basis. It's important to enroll in Medicare Parts A and B immediately, since your HP benefits will assume these coverages even if you do not actually enroll. The only exception is if you are covered under another employer's health plan as an active employee or the dependent of an active employee. In this case, that employer's coverage will generally be your primary coverage, and you can wait to enroll in Medicare Part B until that active employee coverage ceases.

Even if you are required to enroll in Medicare Parts A and B, you may not want to enroll in Medicare prescription drug coverage (Part D) since your HP coverage generally includes Medicare Part D.

When enrolling in Medicare Parts A and B, you may have several choices available to you under the federal Medicare Advantage program. For more information about Medicare, contact the Social Security Administration or check out the Medicare website at medicare.gov.

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 claim 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.

When coverage begins

The plan year runs from January 1 through December 31.

Initial enrollment

To participate in HP retiree coverage, you must enroll on MyHPBenefits at www.myhpbenefits.com or by calling the HP Benefits Center no later than 60 days from your retirement date (or from the date you are notified of COBRA rights, if later).

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

- If you enroll your dependents within 60 days of a qualified status change, coverage generally begins on the date you make your change by calling the HP Benefits Center. If you enroll dependents following your marriage, divorce, the birth or adoption of your child, or the loss of other coverage, however, coverage can begin as of the date of your status change instead. If you enroll your dependents during the annual enrollment period, coverage begins on the following January 1 as long as you and your dependents are still in an eligible status on that date.

As a rehired retiree

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

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 benefit package options you elected in the prior plan year if those benefit options are still available. 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 change in status. See the "Changing your coverage" section.

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

Effective date of your coverage

Newly eligible retirees
Generally, coverage begins as communicated to you in your enrollment materials.

Currently enrolled retirees
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.

If you decline HP medical coverage

If at any time you are eligible but decline HP retiree coverage (for reasons other than enrolling in an Alight Retiree Health Solutions benefits option for Medicare-eligible retirees), or if your HP coverage is dropped due to nonpayment of premiums, your future ability to enroll will be limited. You will only be eligible to enroll in the future if you do so within 60 days of losing coverage under another employer group medical program. This could include the loss of your own coverage through another employer, or the loss of coverage under your spouse's or domestic partner's employer's plan (even if your spouse or domestic partner works for HP or is an HP retiree). This 60-day enrollment opportunity may be used more than once if you lose coverage under another employer group program at a different time. **However, you will not be permitted to enroll during the annual enrollment period or under any other circumstances.**

For purposes of your future ability to enroll in HP coverage, an "employer group program" is defined as group health coverage provided to you or your spouse or domestic partner by an employer or a similar organization (whether as an employee, retiree, or COBRA participant), including coverage through an employer, a union, a school system, the federal, a state, or a local government (in their capacity as employers), or the US military. Coverage provided through a government-sponsored health program outside the US also qualifies, even if the coverage is not provided in the government's capacity as an employer. Coverage purchased on an individual basis directly from an insurance company, or through a group like AARP, is not considered to be "employer coverage." Medicare and Medicaid are also not considered to be employer coverage, even though they are provided through the federal government. To enroll in HP coverage following the loss of coverage under another employer group program, you must contact the HP Benefits Center within 60 days of losing your other coverage. In order to enroll, you also must continue to meet all other eligibility requirements under the applicable HP Retiree Program.

Changing your coverage during the year

As a participant in an HP Retiree Program, you can change your HP benefits over time as your needs change. You can also make changes under certain other HP benefit programs.

Here's a summary of your change opportunities under HP benefits and other programs that allow changes. Information on how to make changes is provided later in this section.

Based on the Retiree Program rules, changes can only be made:

- During the annual enrollment period (with new coverages generally effective the following January 1); or
- Within 60 days of a qualified status change.

  Once you enroll in or decline 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 dies.
- Your dependent gains or loses eligibility status.
- You or your dependent moves to a new place of residence outside of your present coverage area.
- If you change your principal residence and no longer reside within a ZIP code where HP offers your current medical option, you will automatically be defaulted to an alternative medical option based on your new ZIP code. If you do not want to be automatically assigned to the default medical option, you must elect a new medical option as soon as possible, but within 60 days after you move.
- 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
- You experience a significant change in cost of benefits or coverage

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 retiree: 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 the marketplace's annual 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 or domestic partner's plan or through the Health Insurance Marketplace) 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 must report your mid-year change to the HP Benefits Center within 60 days in order to make the change. If you do not report your mid-year change 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.

Coverage changes 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 your marriage, divorce, the birth or adoption of your child, or the loss of other coverage, the coverage change will take effect on the date of the event).

When coverage ends

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

HP retirees

Once you enroll in one of the Retiree Programs as an eligible HP retiree, your HP coverage generally continues until the first of the following to occur:

- The date your coverage is terminated for nonpayment of premiums;
- The date you drop coverage;
- The date you die (in this case, your covered dependents may be eligible to continue current coverage for up to 48 months); or
- One or more benefits under the Plan are terminated by action of the Company.

If your HP retiree coverage is dropped for any reason (including nonpayment of premiums but not including enrollment through the Alight Retiree Health Solutions benefit option), or if you elect to drop coverage during the annual enrollment period or within 60 days of a qualified status change, you will only be able to enroll in the future if you do so within 60 days of losing coverage under another employer group medical program.

If you fail to make timely payments for coverage, your coverage will be canceled as of the end of the last month for which payment was made in full. If your coverage is canceled, you will have a one-time 90-day grace period from the date of your termination notice to request that coverage be reinstated retroactively to the date it was dropped for nonpayment. If you do not request reinstatement before the end of this 90-day grace period, you will never be able to request reinstatement of coverage in the future. You will only be eligible to enroll in the future if you do so within 60 days of losing coverage under another employer group medical program.

Continuation of coverage for a covered dependent under an HP Retiree Medical Program

HP offers coverage for covered dependents of an eligible HP retiree who died while participating in an HP Retiree Program, provided HP continues to offer benefits under the applicable HP Retiree Program, and any covered dependent continues to qualify for and meet the Plan's definition of an eligible dependent.

Please note: Eligibility for coverage, types of benefits and duration of coverage are different for each HP Retiree Medical Program. If you are an eligible covered dependent, your continuation of coverage benefits will be determined in accordance with the terms of the applicable HP Retiree Program. Details of your coverage will be provided to you by the HP Benefits Center Survivor Support Team. You can also call the HP Benefits Center or visit myhpbenefits.com for more information and to access additional resources

Dependents

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

- The date your coverage ends;
- The date you discontinue coverage for your dependents;
- The date the dependent no longer meets the definition of eligible dependents (in this case, your dependents may be eligible to continue coverage for up to 36 months under COBRA); or
- One or more benefits under the Plan are terminated by action of the Company.

When your dependents are no longer eligible for dependent status

When any of your covered dependents cease to meet the eligibility requirements under the Retiree Program (for example, you divorce or a covered child reaches the maximum age limit), they are no longer eligible for coverage effective as of the date they cease to meet eligibility requirements. In this case, you must notify the HP Benefits Center immediately. If you wish to make available changes to your coverage, this must be done by calling the HP Benefits Center within 60 days (be sure to call as soon as possible because retroactive premium refunds are not available).

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

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.

Paying your monthly health benefit premiums

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

- **Direct debit.** For convenience, you have the option of having your benefit premiums automatically deducted from your checking or savings account on the payment due date. There are two ways to sign up for this convenient service:
    - **Through MyHPBenefits** at myhpbenefits.com or
    - By calling the HP Benefits Center at 1-800-890-3100.
- **Billing.** If you don't elect the direct debit option, you'll receive a monthly bill for your benefits cost. To keep your coverage active, you'll need to pay this bill on time. To pay your required premiums by mail, make a check payable to HP Inc. and write the account number listed on your billing statement on the check. Send the check along with your payment coupon to the address shown on the coupon. Be sure to mail your payment and coupon in plenty of time to allow your payment to be processed by the due date.

Because services such as Federal Express or UPS are not able to deliver overnight mail to a P.O. Box, overnight delivery service will only be accepted if sent through the US Postal Service.

Important reminder regarding premium payments

Payment for benefits must be made in full before the due date reflected on your monthly invoice. Failure to make payment by the due date (including any grace period) will cause your coverage to be dropped for nonpayment. If coverage is dropped for nonpayment, you will receive a termination notice.

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 on individual coverage rights.

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) 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

- Retiree

- Spouse or domestic partner. Your spouse or domestic partner 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 and domestic partner 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 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.

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 HP Benefits Center 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 HP Benefits Center within 60 days after the qualifying event, then your dependent will not be entitled to elect COBRA coverage.

How COBRA coverage is offered

After the HP Benefits Center 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 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 HP Benefits Center 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.

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 of 150% of the monthly cost of coverage is paid, 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, become entitled to Medicare benefits (under Part A, Part B, or both); 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 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.

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 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 25th of the month preceding the next coverage period, but there is a 30-day grace period (for example, June payment is due June 1, but will be accepted if postmarked by June 30).

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.
- 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 open 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 fraud).

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).

Claim procedures

The following summary of the Plan's claim procedures is intended to reflect the Department of Labor's claim 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 claim procedures will apply instead of the claim procedures described in this SPD. The insurer's claim procedures are described in the benefits booklet that describes the specific benefit. If you have questions about claim 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 Department of Labor's regulations do not apply. For those claims, including claims for Dependent Care Flexible Spending Account benefits, the claim 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 options" 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 claim 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 orally submitted claims are permitted for urgent care claims, as described below), 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 Flexible Spending Account (FSA), and Employee Assistance Program (EAP) coverage.)

Non-health and non-disability benefit claims

For any claim that is not a health claim or a disability 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. Retiree Welfare Benefits Plan Summary Plan Description must be submitted either via email at hpi-hr-connect-us@hp.com or in writing to the following address:

Plan Administrator
HP Inc. Plan Committee
Welfare Plan Claims
10300 Energy Drive
Spring, TX 77389

Health benefit claims

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 in oral form 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.

2. 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 in oral form unless written notice is requested by the claimant.

3. 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.

4. 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.

5. 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 in oral form unless written notice is requested by the claimant.

6. 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.

7. Post-Service 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.

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

9. 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.

10. 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.

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.

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 not 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.

    (i) 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.

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

        a. 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.

b. 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 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.

c. 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.

(iii) For purposes of any benefit package option that is subject to the PPACA, 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.

(iv) For purposes of any benefit 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:

a. 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

b. 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

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 which is 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.

Adverse determination

For purposes of this "Claim 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 benefit 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 PPACA 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):

1. 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);
2. 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;
3. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
4. Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the PPACA 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 PPACA 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 claim decisions. Decisions regarding hiring, compensation, termination, promotion, or similar matters will not be made based on the likelihood that any person involved in making claim decisions will support the denial of benefits.

Calculation of time periods

For purposes of the time periods specified in this claim procedures 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 claim 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 claim procedures.

Statute of limitations for Plan claims

Please note 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 exhausted the plan's internal claim and appeal process, if required; and (d) The claimant 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 the following 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: a) 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 (b) 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.

3. 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 from the applicable claims administrator.

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, benefits booklets issued by other claims administrators, this SPD, and other governing documents referenced herein.

The HP Inc. Retiree 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 Plan number for the HP Inc. Retiree Welfare Benefits Plan is 557.

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.
10300 Energy Drive
Spring, TX 77389
Telephone: 1-800-890-3100

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

Participating employers

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

Plan administrator

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

HP Inc. Plan Committee
10300 Energy Drive

Spring, TX 77389
Telephone: 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
Phone: 1-800-890-3100

Agent for service of legal process

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

HP Inc. c/o CT Corporation System
818 West 7th Street, Suite 930
Los Angeles, CA 90017
Phone: 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 plans, 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 plans 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 which 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 benefit administration purposes, the Company generally takes the position that ERISA preempts such state laws.

Your rights under ERISA

As a participant in the HP Inc. Retiree 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 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, spouse, or 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 which 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 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 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 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. They apply only for a limited time, as described below.

The Department of Health and Human Services (HHS) ended the federal Public Health Emergency (PHE) for COVID-19, declared under Section 319 of the Public Health Service (PHS) Act, at the end of the day on May 11, 2023.

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.

Benefits 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%.

Extension of certain deadlines

Certain deadlines that impact the HP Inc. Retiree 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, the end date of the national emergency is May 11, 2023, which means, at present, the Outbreak Period will end on July 10, 2023.

What deadlines are extended?

Continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA)

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, 2023, the national emergency ends May 11, 2023, and therefore the Outbreak Period ends 60 days later on July 10, 2023. The qualified beneficiary has 60 days after the end of the Outbreak Period, or September 8, 2023, 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: An employee declined coverage during the annual enrollment period for 2023. On March 1, 2023, the employee had a baby and would like to enroll themself and the baby into the Plan's medical coverage. The Outbreak Period is disregarded for purposes of determining timing for up to one year, so they have until August 9, 2023, (assuming the Outbreak Period ends on July 10, 2023) to make the election to enroll themself and their baby, as long as they pay their contributions for the entire period of coverage.

Claim 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 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 (which, at present, ends on July 10, 2023).

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.

Incorporated documents

This SPD incorporates by reference the following documents:

- UnitedHealthcare, Group #24435
- UnitedHealthcare Medicare Supplement, Group #227037
- Tufts Health Plan, Group #1062
- Tufts Health Plan, Group #1062D/S
- Kaiser Permanente Senior Advantage HMO Plans – GA, Group #8218
- Kaiser Permanente Senior Advantage HMO – CO, Group #904
- Kaiser Permanente Senior Advantage HMO N CA & S CA, Group #1501
- Kaiser Permanente Senior Advantage HMO Northwest (HMO), Group #1400
- Kaiser Permanente Senior Advantage HMO Hawaii, Group #1661-001
- Tufts Health Plan, Group #16039, #16049, #16059, #16069
- Kaiser Foundation Group Health Plans Mid-Atlantic States, Group #4843-0016
- Kaiser Foundation Group Health Plans N CA, Group #1501
- Kaiser Foundation Group Health Plans S CA, Group #104601
- Kaiser Foundation Group Health Plans Hawaii, Group #1661-003
- Aetna (PPO, EPO), Group #476696
- Anthem BCBS (PPO, EPO), Group #174000
- Cigna Group (PPO, EPO), Group #3171768
- ComPsych, Group #HP
- MetLife Dental, Group #312876
- Aetna DMO, Group #868497
- CVS Caremark, Group #3663
- EyeMed Vision Care, Group # Std 9756669; Group Prem # 9756677
- NY Life (formerly Cigna Group Benefits), retiree life policy #FLI980026.
- ARAG, Group # 15461

- HP Inc. Retirement Medical Savings Account
- John Hancock, policies #28982 & #27178-600
- MetLife policy #114752

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 for the HP Inc. Retiree Welfare Benefits Plan.

For information regarding the HP 401(k) Plan, HP Retirement Plan, HP Deferred Profit Sharing Plan, HP Cash Account Pension Plan, EDS Retirement Plan, or Retirement Medical Savings Account, see the separate summary plan descriptions that apply to these programs or contact the HP Benefits Center.

Please note the word "Plan" or "plan" is used throughout this SPD. When capitalized, "Plan" refers to the HP Inc. Retiree Welfare Benefits Plan. When lowercased, "plan" may refer 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. Retiree Welfare Benefits Plan.

Plan contacts

Vendor	Program	Phone	Online/Email	Mailing
HP Inc.	• Eligibility claims and appeals • Plan document requests		hpi-hr-connect-us@hp.com	HP Inc. Plan Committee Welfare Plan Claims 10300 Energy Drive Spring, TX 77389
HP Inc.	Retiree medical savings account (RMSA)	1-800-890-3100 1-847-883-0465 outside the US, Puerto Rico, or Canada)	myhpbenefits.com	HP Inc. Plan Committee Welfare Plan Claims 10300 Energy Drive Spring, TX 77389
HP Benefits Center	**Third-party administrator** • Verify your eligibility • Review your benefits • Get answers to most questions • Get information about premium payments	1-800-890-3100 1-847-883-0465 outside the US, Puerto Rico, or Canada)	myhpbenefits.com	
Alight Retiree Health Solutions	Medicare exchange	1-800-975-0355	retiree.alight.com/hp	
United Healthcare (UHC)	Retiree Medicare Advantage medical plan customer service	1-877-456-7240	retiree.uhc.com/hp	P.O. Box 30770 Salt Lake City, UT 84130-0770
United Healthcare (UHC)	Retiree Medicare Advantage medical plan claims	1-877-468-1029	myuhc.com	UHC claims P.O. Box 30555 Salt Lake City, UT 84130-0555
United Healthcare (UHC)/Optum Behavioral Health	Mental health/substance use claims	1-877-468-1029	myuhc.com	P.O. Box 29044 Hot Springs, AR, 71903
Tufts	Medicare Preferred HMO/Medicare Preferred Medical Supplement	1-800-462-0224	tuftshealthplan.com	705 Mount Auburn St Watertown, MA 02472-15089

Vendor	Program	Phone	Online/Email	Mailing
Kaiser Foundation Group Health Plans (Georgia)	Deductible HMO and Medicare HMO Sr. plans	1-404-261-2590 (local) or 1-888-865-5813	kpr.org	Nine Piedmont Center 3495 Piedmont Road, NE Atlanta, GA 30305-1736
Kaiser Foundation Group Health Plans (Colorado)	Deductible HMO plan	1-800-632-9700	kpr.org	KFHP of CO 2500 S Havana St. Aurora, CO 80014-1622
Kaiser Foundation Group Health Plans (Colorado)	Medicare HMO Sr. plan	1-800-476-2167	kpr.org	KFHP of CO 2500 S Havana St. Aurora, CO 80014-1622
Kaiser Foundation Group Health Plans (Mid-Atlantic states)	Deductible HMO plan	1-800-777-7902	kpr.org	P.O. Box 2101 Rockville, MD 20852
Kaiser Foundation Group Health Plans (Northwest)	Deductible HMO and Medicare HMO Sr. plans	1-503-813-4480 (Portland) 1-800-813-2000 (all areas)	kpr.org	500 NE Multnomah Street, KPB-14 Portland, OR 97232
Kaiser Foundation Group Health Plans (Northern California)	Deductible HMO and Medicare HMO Sr. plans	1-800-464-4000	kpr.org	Kaiser Permanente Health Plan, Inc. Claims Department P.O. Box 12923 Oakland, CA 94604-2923
Kaiser Foundation Group Health Plans (Southern California)	Deductible HMO and Medicare HMO Sr. plans	1-800-443-0815	kpr.org	Kaiser Permanente Health Plan, Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004
Kaiser Foundation Group Health Plans (Hawaii)	Deductible HMO and Medicare HMO Sr. plans	1-800-966-5955	kpr.org	711 Kapiolani Blvd. Honolulu, HI 96813
Aetna	CDHP w/HRA, HDHP, EPO, Premium PPO, Value PPO medical plans	1-800-545-5810	aetna.com	Attn: National Account CRT P.O. Box 14463 Lexington, KY 40512
Anthem Blue Cross Blue Shield	CDHP w/HRA, HDHP, EPO, Premium PPO, Value PPO medical plans	1-800-364-3301	anthem.com/ca	ATTN: Appeals P.O. Box 54159 Los Angeles, CA 90054
Cigna	CDHP w/HRA, HDHP, EPO, Premium PPO, Value PPO medical plans	1-800-Cigna-24	cigna.com	4616 South US Hwy 75 Denison, TX 75020
ComPsych	Mental health/substance use for CDHP w/HRA, HDHP, EPO, Premium PPO, Value PPO medical plans	1-844-819-4773	guidanceresources.com	P.O. Box 8379 Chicago, IL 60680
CVS Caremark	Prescription drug coverage for CDHP w/HRA, HDHP, EPO, Premium PPO, Value PPO medical plans	1-844-740-0599	caremark.com	P.O. Box 52136 Phoenix, AZ 85072-2136
MetLife	Dental plan	1-800-942-0854	metlife.com/dental	P.O. Box 981282 El Paso, TX 79998-1282

Vendor	Program	Phone	Online/Email	Mailing
Aetna	Dental maintenance plan (DMO)	1-877-238-6200	aetna.com	P.O. BOX 14094 Lexington, KY 40512
EyeMed	Vision plan	1-866-504-9021	eyemed.com	Attention: Quality Assurance 4000 Luxottica Place Mason, OH 45040
John Hancock Life Insurance Company	Group Long-Term Care	1-800-482-0022	johnhancock.com	P.O. Box 111 X-3 Boston, MA 02117 Phone: 1-800-482-0022
Metropolitan Life Insurance Company	Group Long-Term Care	1-800-438-6388	metlife.com	P.O. Box 937 Westport, CT 06881
ARAG Services, LLC	Group legal plan	1-800-762-3217	araglegal.com/myinfo	400 Locust Street, Ste 480 Des Moines, IA 50309